Ideological Hegemony or Shifting Perspectives? The Mental Health Ideologies of Psychiatrists and Clinical Psychologists in the Province of Manitoba

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ABSTRACT

An attempt was made to isolate the dominant ideological positions among clinical psychologists and psychiatrists in the province of Manitoba. Ideology was operationalized for use in this study, to convey the properties associated with the belief systems of particular occupational groups. A structural analysis of the mental health professions was provided to show how ideological content and professional practice are linked.

After providing a socio-historic account of the evolution of psychological and psychiatric ideologies, some of the conflicting ideological positions were examined. The study focused on within group differences as well as inter-group differences between the professions. Each profession was observed in terms of practitioner attitudes to other members of his profession, attitudes to the "ideology" of that profession and attitudes to the ideology of the other profession of which he is not a member.

The evidence suggests that "ideology" in the psychiatric profession has tended to coalesce around a dynamic, social, or somatic model. Among psychologists the most divisive ideological issues have centered around "behaviorist" and "humanist" differences.

The study examined the question of territoriality in the ideologies of both groups. The effects of hegemony over the mental health sector by the test groups was presented in terms of the goals of their professional associations and the general literature on mental health ideology. Analysis of the locus of ideological content

in each profession, its causes and effects, was attempted. The emergence of new ideological areas in mental health (particularly the community ideology) was discussed.

Lastly, a limited empirical study was conducted to ascertain the level of homogeneity between the ideological principles which emerged from the literature review, and the practice of psychiatry and clinical psychology in the province of Manitoba. Evidence seemed to support the notion that ideological content was a major factor in shaping the professional styles of practitioners in Manitoba in accordance with the larger psychological and psychiatric ideologies.

FOREWORD

The professionals themselves are sometimes dogmatic, sometimes eclectic, sometimes merely tolerant of one another, but all are inclined to plead for a moratorium on too strict judgment, since the psychiatric disciplines are young and public demand for their knowledge is urgent.

In this battle of convictions, the social scientist may also take sides and frequently does. But he need not. Through his special training and perspectives, the social scientist may hope to contribute to the eventual easement of the national health problem by taking as his very subject matter this battle of positions. He does not thereby achieve a godlike immunity from bias---but only asks license to attempt clarification of the issues through an examination of what the actors in the mental health drama are saying and doing.

(A. L. Strauss, 1964)

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"IDEOLOGY" OPERATIONALIZED, AND ITS EFFECTS ON PROFESSIONAL PRACTICE

INTRODUCTORY STATEMENT:

The purpose of this research is to analyze the "ideological" properties which are associated with the mental health professions. The study will attempt to: isolate the structural dynamics of mental-health "professionalism"; trace the evolution of mental health ideologies; and provide an empirical methodology to test the propositions which come out of the study. The test-groups used in this study are psychiatrists and clinical psychologists. The study will draw on the available literature as well as other diverse sources which deal with "mental-health ideology" in an attempt to integrate that material with a limited exploration of the provision of mental health services by psychiatrists and clinical psychologists in the province of Manitoba.

The following specific objectives will be included in order to test explicitly propositions generated in this research.

a) To obtain respondents' perceptions of the nature of their training, education, interests, values, abilities and achievements, as these relate to their ideological perspectives about mental health care.

b) To discover respondents' perceptions of the demands, expectancies, values and "ideological soundness" of the other profession being examined in this study.

c) To identify professional attitudes to a variety of social issues as they relate to ideological concerns within the mental health

field, eg., poverty, racism, "community" self-help-groups, professional hierarchies, levels of remuneration and other areas.

d) To construct an instrument for measuring professional attitudes to these ideological issues.

USE OF THE TERM IDEOLOGY IN THIS STUDY:

The invention of the term ideology is attributed to the French philosopher de Tracy. (1754-1836) Others who have used the term to denote the analysis of "mind" in the formation of ideas have been Marx and Engels in their German Ideology, (1872), Mannheim in Ideology and Utopia (1936), and a number of current writers (Berger and Luckmann 1967) who have addressed themselves to ideological issues in present society.

"Ideology" was employed as an eighteenth-century term to refer to an opponent's belief system in political exchanges between competing schools of thought. The term was employed as a means by which one could reveal the mythological or unproven components within a structured belief system. It was also used to expose where selfish interests were masked behind ideological presentations. The term "ideology" has over time and through extensive usage lost its' initial connotation of falsehood, referring in its present context to any systematically related set of beliefs around which an individual (or group) has built an explanation for "the way things are."

The term ideology has frequently been invoked with regard to social or political action. Use has been made of this term where individuals or groups have sought to reform or overthrow particular

social systems. (Mannheim 1935) In these cases, where people sought to change an on-going system, they defined the unwanted system as inconsistent with or as a distortion of social reality. Validation of their assertions was posited on ethical or normative rather than "empirical" grounds.

In the natural sciences, conflicting views about the nature of the universe and the appropriate method for studying scientific phenomena have been regarded by some writers as "ideological" rather than "scientific" areas of conflict. Kuhn (1962) referred to this form of conflict in his observations about the emergence of "competing paradigms." He demonstrated that even academic research did not escape the limitations of philosophical or meta-physical biases which guided that research. In professional practice too, ideological conflict (grounded in specific codified areas of knowledge) has frequently been shown to involve support for the "correctness" of certain brands of knowledge and discreditation of competing orientations based on non empirical criteria.

Since the ideologies which are relevant to this study are those of "mental health professionals," an attempt will be made to address the question of ideology at three different levels.

a) The ideological perspectives of individual practitioners.

b) The organizational and occupational ideologies, of each job sector a) psychiatrists and b) clinical psychologists

c) Their overall "professional" ideologies as mental health professionals.

Each of these three levels of ideological content will be identified and discussed with regard to its effect on the delivery of mental health services. Each will also be addressed as a potentially distinct level of ideological separation, an an attempt will be made to analyze the interactional effects of the three levels upon one another.[1]

Theoretical rules governing the study of groups or individuals along ideological dimensions have been provided in a number of studies on "ideology" in various domains and among different groups. (Parson's 1951, Brown 1973) This study will operationalize the term ideology to denote ideas about mental illness as they are entertained by the two groups investigated in this study. The range of the term ideology includes not only particular ideas, but subsumes whole sets of ideas as these are represented within a given belief system.

The study attempts to isolate the "dominant" or most visible ideological strains while recognizing that these are at best a crude approximation of the universe of psychiatric-psychological ideologies. The "visible" areas of conflict between these ideological fronts within the ranks of mental health professionals both gave rise to the focal issues selected for the study, and attested to the political adversarial qualities still present in ideological confrontation among mental-health professionals.

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[1]A more extensive separation of personal, occupational, and professional ideological systems is provided on pages12-20 in this chapter.

This research is concerned with the degree to which ideological positions shape professional styles, rather than with the degree of "scientific proof" which validates or negates a given ideological position. The universe of possible psychiatric-psychological belief-systems suggests a theoretically infinite range of ideological positions. An attempt is made to identify those positions which have emerged out of mental health professions in the past, and which represent the mainstream of ideological conflict at the present time. Those parts of professional ideology which are presently "unresolved," hence contributing to the evolution of future ideological positions, are deemed to be salient to the content of this research.

PROPERTIES OF IDEOLOGIES: "CONSTRUCTED AND CONSTANT"

Ideologies may characterize the explanation of any system of thought and its' underlying social or individual basis. They may serve as the stated or unstated propositions which guide social, political or economic action.

Some ideologies grow out of consensus at a particular period of time, others are inferred, deduced, "philosophized" or abstracted out of traditional behaviors. The presence of ideological content is observable in the common assertions made by any individual, or from other generalized responses within his behavioral repertoire.

Attempts to garner information about ideological content thus involve examination of the common assertions in the behavioral repertoire of a given individual, a measure of replicability of those assertions over time, and a subsequent test for the "truth content"

(i.e. validity) of those assertions. In its purist form, the vehicle of any ideological communication is a "linguistic integrated set of propositions about some important social area or domain." (Brown 1973)

In a formal context, ideological content may be evident in a political treatise, a corporate memorandum of association, or the published constitution of a professional group. The common factor in all ideological presentations is that they are part of a communicative force designed to influence attitudes and behavior in a particular direction. The purposive goal of persuasion underlies the manifest content of all ideological communication.

Ideologies serve as slogans for the mobilization of collective resources or the confusion of potential adversaries. They may polarize hostility, justify social oppression, rationalize confrontation or generate loyalty and cohesion. Ideologies may be seen as a lasting monument to the dictum that "differences of opinion" demand concerted action to produce a victory over a less-meritorious explanation.

Ideology appears to entail a specific set of dynamics in terms of the predictability of response that is generated by adherence to a given ideological position. While each ideology may differ in terms of its' applicability, explicitness and generality, a relatively constant response-set can usually be anticipated from such belief-systems which are sufficiently "robust" to allow predictions about matters which may be only loosely related to them. For example, the probability of a consistently "conservative" set of attitudes by a given respondent, even to a set of merely peripherally-related items

would be fairly high, where the ideological factor was held constant. (Brown 1973)

Mannheim (1936) emphasized the constructedness of ideology in its effect upon the study of sociology. He distinguished between ideology which constituted only a segment of an opponent's thought; ideology which constituted the whole of an opponent's thought, and ideology which was characteristic not only of an opponent's but of one's own thought. He stressed that no human thought was immune to the ideologizing influences of its' social context. Mannheim sought to abstract this central problem to the context of political usage, and to treat it as a problem of epistemology and historical sociology.

He used the term "relationism" to denote the epistemological perspective of the sociology of knowledge as clear recognition that knowledge was always "knowledge from a certain perspective." Mannheim believed that while ideologizing influences could not be eradicated completely they could be mitigated by the systematic analysis of as many social variables (contributing to that ideological position) as possible. The object of thought, he claimed, became progressively clearer with an accumulation of different perspectives upon the phenomenon under study.

In keeping with these assumptions, the constructed nature of ideology has been accepted in modern sociological theory as a phenomenon which accounts for a major part of the process by which "social reality" is defined.

The sociology of knowledge inherited from Marx is not only

the sharpest formulation of its central problem but also some of its' key concepts, among which should be mentioned particularly, the concepts of "ideology" (ideas serving as weapons for social interests) and "false consciousness" (thought that is alienated from the real social being of the thinker). (Berger and Luckmann 1967 p6)

Theorists such as Whyte (1956) have proposed that the laws governing occupational and professional ideologies are not very different from the rules governing organizations. The high-status properties of the mental health professionals manifested in the "corporate" aspirations of their professional bodies are held by Whyte to account for the emergence of "mental-health organizational ideologies." Whyte suggests that the ideology of the mental health worker is related to the aspirations of the group of which he is a member. In order to account for their group aspirations, it is necessary to identify the salient research on the nature of organizational ideologies.

Whyte (1956) has described the growth of organizational ideologies as an emergent social ethic "which makes morally legitimate the pressures of society against the individual." (Whyte 1956 p 67) He suggests that criticism of this facet of group-ideology has served mainly to make organizations more adept in sugar-coating their purpose. One way in which organizational ideology operates can be found in the implicit criteria used for admission to the ideologically-bound organization.

Similar criticism of organizational ideology has been voiced

by Janis (1966). He has proposed that there would be an increased probability of organizational error as a consequence of the group-think phenomenon. This type of error would occur in the ideologically-bound organization in the form of incomplete data being fed into the information base of such an organization, because it was "dissonant" with the ideological premises held by that organization. Strong resistance to such information might be expected where the information was at variance with group cohesion or the aspirations of that group. Janis was suggesting that a whole organization could fall prey to the defense mechanism of denial through ideological barriers to data input.

Two theories about organizational ideology currently enjoy some popularity. McGregor (1960) evolved a theory of organizational behavior out of a social control paradigm. The theory X of management suggests that occupational conformity rests on subtle coercive controls, while theory Y suggests that individual and organizational goal-attainment are not mutually exclusive.

The significance that McGregor's organizational ideologies have for the study of mental health professionals lies in the impact that "organizational" goals have on professional practice. This study has addressed itself to an analysis of "ideology" in mental health at three levels, the individual, the occupational and the professional. The model used by McGregor makes possible the analysis of ideological differences which interact with one another in the course of professional practice. To illustrate this point, one may assume that a

given mental health professional may, at any particular time be working under competing ideological assumptions with regard to "occupational" and "professional" goals while at the superficial level not acknowledging the incongruity of these competing ideological goals. McGregor's basic premise is that with regard to occupational ideology, theory X would preclude autonomous therapeutic action by mental health professionals where individual and organizational ideological goals were in conflict. Theory Y suggests that the goals of professional service to the client population, and conformity to the organizational ideology of the occupation are not mutually exclusive.

Of central importance to this research is the question of the degree to which organizational ideology operates to the detriment of the provision of mental-health services. The locus of interaction in mental health work is by and large "face to face" encounter between professional and client. Dual loyalty considerations by the professional or deceptive subterfuge on his part detracts from the authenticity of the relationship and from its' therapeutic intent. The implication is thus, that organizational goals do in fact detract from the quality of care in the delivery of mental health services.

A case in point would be the type of client-therapist relationship which exists in the "bureaucratic model of psychotherapy." (Szasz 1961) Under such a model, the nature of the relationship purports to be one of equals. But here, the therapist is employed as a double-agent whose contractual loyalties and obligations belong to the institution to which he is affiliated as much as to his patient. Such

a form of "welfare therapy" clearly implies a relationship of expert and supplicant. The patients' rights to privacy and confidentiality may easily fall prey to the impersonal administrative functioning priorities of such an institution.

OCCUPATIONAL AND PROFESSIONAL IDEOLOGY

From the properties associated with ideology at the individual or group level, one may draw inferences about the ideological content which characterizes more particularized occupational groups. This research seeks to isolate the ideological properties of the mental health professions as a specific "occupational sector."

Occupational Ideology:

An occupational ideology may be said to consist of a system of beliefs, values and shared attributes that exist to some degree within a particular job category. It forms part of the context and the symbolic environment in which men work. Occupational ideologies have been identified as varying in several basic ways to the extent that they are "parochial" or "ecumenic" in nature. (Dibble 1962)

A parochial ideology is specific to a particular occupation, being meaningless or non-generalizable to a lay public. An ecumenic ideology by contrast, moves beyond the specific occupational group with which it is identified and is interpretable as part of the perspective and orientation of other groups or segments of the society.

In order to define the nature of occupational ideologies, some general rules governing the acquisition of ideas or behavior by

members of that job sector, is required.

a) Ideas which are relevant to problem-solving are more readily adopted than irrelevant ones.

b) Different occupational groups are involved in different problem-solving activities.

From these two propositions one may conclude that people from different occupations will acquire differing world-views which in some degree are reflected in "occupational ideologies." If this statement is true, then one may anticipate that ideological content will not be passed from one occupational group to another unless the ideological content is universal, or is presented as ideologically consistent with the group toward which that ideological content is directed.

Some "translating" function is necessary in order to make one group's ideological base generalizable to or consistent with a competing world-view. To the extent that a particular group is successful in making such a transformation of ideology beyond its immediate sphere of applicability, it may be said to be advocating an "ecumenic" ideological position.

The "translating" function of an ideological position to larger groups is the active process which facilitates wider acceptance. A given ideological position may contain certain ideas of a non-parochial nature, but without effective advocacy, the non-parochial content remains a necessary but insufficient condition for wider acceptance.

Another factor which determines the acceptance or rejection

of an ideological stance, is the recipients evaluation of the source of that message. Osgood and Tannenbaum (1955) suggest that credibility is directly related to the social standing of the source and that downward mobility of ideas proceeds more easily and with greater frequency than upward mobility of ideas.

The importance of these assumptions is demonstrated in the structure of the mental health delivery system. High status individuals such as psychiatrists employ a professional communication system which restricts input of information from lower status occupational groups and exploits the hierarchy of the mental health professions in order to maintain an outward and downward system of communication flow. (Schulberg and Baker 1975 p 108) An example of such a downward flow of ideas is presented in Figure I, which demonstrates the existing hierarchic structure in the department of mental health in the state of Massachusetts; with psychiatric directives moving down to psychology and social service staff.

This research will address itself to the ideological conflict among mental health professionals with regard to the "direction of the flow of ideas" in clinical practice.

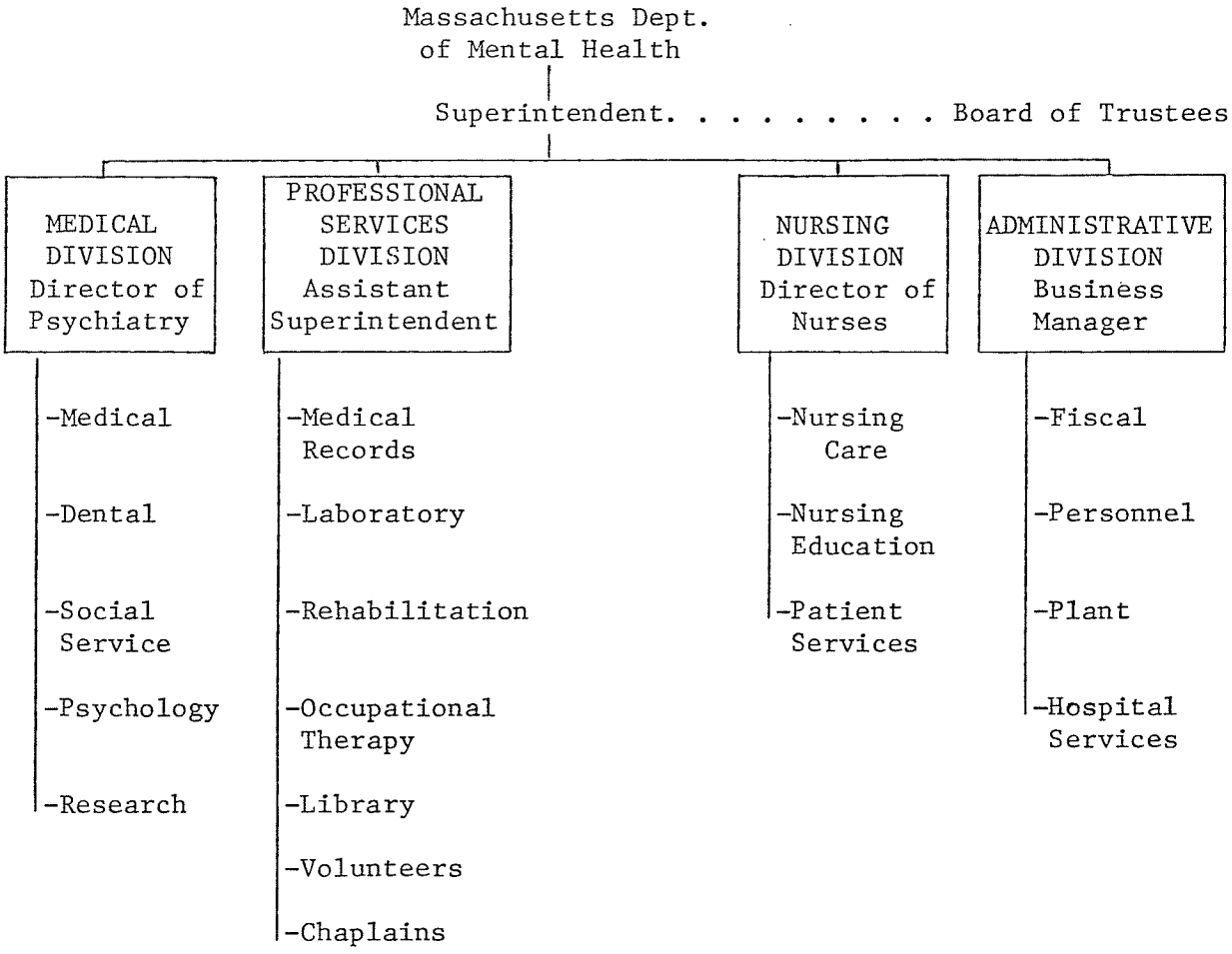
Dibble (1962) proposes that higher ranking occupations are more likely to have highly developed ideologies and that these are likely to be less parochial than the ideologies of lower ranking occupations. He attributes greater affiliation-value to higher occupational status. (People in higher ranking occupations develop more ideas about the problems posed by their occupational life, enhancing

Figure 1

Direction of flow of ideas in a Mental Hospital

TABLE 5-1

DIVISION STRUCTURE 1965



Source: Schulberg, H. C. and Baker, F.

The Mental Hospital and Human Services

Behavioral Publications, 1975, Table 5-1, p. 108

the degree of development of the occupational ideology.) He suggests that members of the high-ranking occupations feel more constrained than lower occupation groups to address their occupational ideologies to socially heterogeneous groups because:

a) The bestowed nature of power, rank, rewards and "specialized forms of knowledge" make those in positions of authority accountable to those in society who do not enjoy these prerogatives. (The assumption being that society conforms to a model of power through consensus and not through force.)

b) Those who wish to sway everyone in a heterogeneous audience (certainly a principle of the medical profession, in its' attack on "pathology" in all its' forms) to their ideological view, must espouse ecumenic principles.

Understanding the methodology employed in the fusion of "ecumenic" and "parochial" ideologies is of great importance to this study. If the politics and practice of psychiatry and/or clinical psychology do conform to the model that Dibble has suggested, this study may help to identify ideological factors which are generalizable to other occupational groups in varying degrees. Dibble's methodology suggests two possible "signals" that identify the presence of an occupational ideology.

a) The parochial goals of the particular occupational group are linked to values held in common throughout the society, and serve as a justification for the privileges which that occupation enjoys for its' membership.

b) Ideas which emerge out of the occupational subculture are so generalized as to appear applicable to the society at large.

Three further propositions of this study suggest that:

a) in the two test groups, both of the ideological "indicants" advanced by Dibble play a role among mental health professionals and

b) the manifest ideological content shown to be present in professional practice has direct consequences for the provision of mental health services in both professions and

c) to the degree that ideological content operates in the provision of mental health service, it will have a direct effect upon:

i) The nature of service offered.

ii) The perceptions of the professionals administering that service.

iii) The nature of the interaction between professional and client.

Professional Ideology:

Since the focus of this study is upon "mental health professionals," the properties which define "professional" as opposed to other "occupational" ideologies must be isolated.

> As members of a profession, individuals perform specialized roles in relation to clientele. In so doing they encounter certain strains; these in part, are resolved both verbally and symbolically by the reiteration of the basic values, or themes which shape the professional ideology. (Blishen 1969 p 14)

Blishen proposes that the increasing need for specialized brands of knowledge and the social-prizing which accompanies those forms of knowledge are the social forces which account for the evolution

of "professional" practice. The "consciousness of purpose" which evolves among these practitioners (as presented by their professional body) may be regarded as the "professional ideology."

Membership in a "profession" implies that an individual has undertaken an extensive course of study at an accredited institution from which he has acquired the corpus of knowledge and the practical skills of his profession. In non-professional services a market-exchange system operates, where the presumption is that both parties to the transaction come to the exchange with an equal level of competence. In the administration of "professional" services however, the professional determines the nature of the clients' needs, based on his expertise in the field in question. The professional in fact enjoys a monopolistic position, since his level of accountability to the client is minimal. (If the client professed to have equal "knowledge" he would not be in need of the services of the professional.)

Enforcement of the norms of ethics and practice is achieved by the profession policing its own membership in order to maintain the level of competence and ethical behavior that is demanded of the membership. At the "organization" level, interaction with the community (the ecumenic function) and incorporation of the generally held views of the larger society, are effected by the profession. The prestige features associated with the high-status enjoyed by the professions is directly linked to:

a) the high levels of remuneration and power allotted to the profession by the society it serves;

b) public recognition that while exploitation of this privileged

position is possible, the expectancy is that the professional typically refuses to do so. (Freidson 1969)

IDEOLOGICAL REPRESENTATION BY PROFESSIONAL BODIES:

An occupational ideology may be extremely elaborate, complex and intellectualized, involving a number of assumptions and assertions about the occupational group it describes. In the high-ranking occupations, a centralized professional body acts as the spokesperson of that occupation, serving to represent the "coalesced" ideological position of that occupation. Where the ideology of the occupation is more complex, a more vigorous representation of the ideological position is demanded of that professional body in accordance with the model proposed by Dibble.

In order to offset the purely parochial content of each profession, extensive use is made of the professional association in order to further the common interests which are reflected in the ideology of that profession. Hence the issue of ideological complexity is dealt with at the highest levels of the professional associations, by introducing a "professional response" to issues affecting the general membership.

The ecumenic function of the profession is performed by office-holders of the associations who serve as spokespersons, lobbyists, and public relations experts for their membership, and who "translate" issues from the parochial sphere of applicability of the profession into larger public and lay concerns. This centralized function of the professional associations allows each profession to make its

"group" opinion known and to influence others in the direction of its interests.

Effective use of the professional organization to propagate ideological orthodoxy among practitioners, and as a vehicle for mobilizing the professional membership is explicitly demonstrated in Appendix I. The use of the professional journal as an ideological instrument is apparent in Tyler's (1969) article on political organization in order to secure membership support at the grass-roots and national levels on any issues in which the profession of psychology might have an interest. Equally, for the medical profession as Berger states:

> Physicians, at least through their professional organization, have found it necessary to develop a whole theory of free enterprise, government and individual rights to serve as the backdrop for their ideological propositions. (Berger 1964 p 232)

An example of such a highly centralized representative body, espousing the ideological (cum professional) stance of its membership is evident in the profession of medicine. All issues pertaining to the practice of medicine in Canada come under the nominal representation of the Canadian Medical Association (C.M.A.). A professional counterpart exists for the Psychiatric Profession, (C.P.A.) the Canadian Psychiatric Association, while the profession of Psychology falls largely under the direction of (A.P.A.) the American Psychological Association. Each profession maintains an ideology which is both complex and sophisticated, and a professional association which both differentiates from, and bridges the gap between that group and

other social bodies.

Occupational ideologies like other "ideologically-bound" entities may contain many elements that are mythical and of limited validity in relation to social values outside that profession. The status enhancing and justification functions provided by these ideologies fit the criteria employed in the early usage of the term "ideology."

Occupational ideologies may serve to facilitate and provide the rationale for a social status-quo. They provide no objective contribution to improving the level of delivery of services to the larger public, except where the parochial interests of the profession and the interests of the larger public are not ideologically discrepant. Where the interests of the larger society are at variance with the parochial interests of the occupational group, the line of least resistance taken by the occupational group lies in the direction of the interests of that group at cost to the rest of society.

Figure 2 illustrates an example where professional interests supersede questions of quality of care as a concern of the medical profession in Canada. This is an example of how professional dominance or territoriality impinges upon the delivery of services which are implicitly of an ideologically neutral type, and which should theoretically be impervious to professional rivalries.

While occupational ideologies may vary in terms of the dimensions discussed, a single factor does seem to run through all professional ideological groups. It has been suggested by Berger (1964) that

Figure 2

Hegemony of the Medical Profession in Canada

Professional dominance as an Ideological priority

over Quality of Care.

TABLE 11

Frequency of Specific Themes Appearing in Periodic Statements on Health by Canadian Medical Association, 1943-65

	1943	1944	1949	1955	1960	1965	Total
Professional control		5		4	5	2	16
Freedom		2		1	4	6	13
Quality of medical care	1	2		5	1	3	12
Public responsibility			3	3		1	7
Privacy		2		1	1	1	5
Personal responsibility			2	1		1	4
Voluntary participation			1	2		1	4
Universal availability			1		1	2	4

Source: Blishen, B. R.

Doctors and Doctrines. The Ideology of Medical Care in Canada.

Toronto, University of Toronto Press, 1969, (Table 11, p. 152).

at a minimum level, the ideology of an occupation functions to interpret the nature of the work in such a form that its importance will be enhanced both in the eyes of its' practitioners and the eyes of the public or some other significant social body such as the courts and the social agencies with which many mental professionals come into contact in their day-to-day activities.

A further proposition of this study then, is that enhancement of the occupation (from within and without) may be a direct function of the maintained professional ideology, and not directly correlated with the "real" value of the service provided. The occupational ideology does, however, provide a real value to the membership of the occupational group in such areas as protection of members of the particular occupation from legal or political attacks from others outside the profession.

> It aids in the internal discipline within the occupational group, contributes to the self-respect of practitioners of that profession, and provides a specific, interpretable, communicable representation about the nature of the work done by that profession. (Freidson 1973 p 217)

IDEOLOGICAL "SHIFT" AS A CONSEQUENCE OF SOCIAL CHANGE:

Social movements with ideological bases have had some effect on changing prevalant mental-health ideological attitudes, bringing pressure to bear on the conventional underpinnings about the theory and practice of mental health services. These movements introduced (or gave further import to) social variables such as civil rights and poverty as legitimate concerns in the construction of mental health treatment models. The ideological response of professionals

to external input into their treatment procedures has varied between "psychotherapeutic quietism or activism" depending on the nature of their response to these innovations. (Bartz 1971)

Established "schools" of intervention (particularly the adherents of the medical model) had in the past brought pressure to bear on ongoing therapeutic practices, largely out of ideological concerns. Their model had emphasized "individual adjustment to society" as an end goal, and hence identified itself with a professional value judgment as part of accepted practice. The conflict over value-laden intervention forms finally prompted a reaction from within the ranks of mental health professionals themselves. (Laing 1964, Szasz 1961,) who viewed these goals as:

> professional transformation of methodological concerns, to an ideological stand which acts as a form of social control for an existing status-quo. (Szasz 1961 p 37)

As a consequence of the increase in information about the ideological and moral stance of mental health professionals, some practitioners have modified their own orientation to include a more humanistic and democratic application of their psychiatric and psychological procedures. Focus has been directed towards institutional change and role function variation to accommodate changing social attitudes towards intervention. The ideological shift has been most pronounced among psychotherapeutic activists within the ranks of the community psychiatric and psychological movements. (Bartz 1971, Schulberg and Baker 1975)

A study by Kaplan (1964) focused on the question of normalcy

as an ideological concern. Psychoanalytic practice had involved "fitting the individual into ascribed, socially-regulated forms of behavior," but Kaplan's work pointed out the value-laden stance of the medical model descriptions of disturbed behavior. His objections to subjective psychiatric diagnosis were reported by earlier writers (Fromm 1947, Sullivan 1947) and replicated by several distinguished theorists and practitioners in the profession. (Jourard 1967, Laing 1964, Scheff 1967, Szasz 1961)

Hurvitz (1973) traced an emergent process of ideological evolution leading to further democratization of therapeutic efforts. He examined the wide range of "self-help" groups which grew out of community efforts to be part of the mental health movement, in reaction to conventional mental health procedures. This innovative force met varying degrees of resistance from the ranks of mental health professionals, particularly among the psychiatric profession. (Hurvitz 1973) The initial studies and findings such as that of Kaplan, laid the groundwork for a greater "visibility" for the mental-health models which lay outside the traditional psychiatric domain.

The increasing number of lay-therapists, self-help groups (eg. alcoholic anonymous) and innovative intervention agencies (store-front mental health services, suicide-prevention centres, etc.) indeed gave the appearance of a new accessibility to mental health care systems.

The following proposition of this research however, suggests that there is still a basic need to examine whether the movement towards

democratised mental health services evolved as a consequence of changing professional ideologies or was merely a cosmetic administrative shift (in the area of availability) of services which retained ideological hegemony with the original professional (psychiatric) interests. Wertham (1963) suggests that ideological "shift" among mental health professionals is still more illusionary than real at this time.

PROBLEMS IN IDEOLOGICAL RESEARCH AND MEASUREMENT:

Sociological research (Greenblatt et al., 1957, Caudill 1958, Stanton and Schwartz 1954) has focused on the structure of social institutions and their interaction with disordered individual behavior. Little research has been addressed to how professional definitions of social reality have affected the nature of therapeutic intervention. Sociological observation about the social regulation of mental illness has however, served to shape new forms of psychotherapy and to change existing ones. (Erikson 1961, Goffman 1961, Haley 1969, Spitzer and Denzin 1968)

One study which clearly broke with traditional sociological study was that of Kai Erikson, which dealt with social group-attitudes toward homosexuality in the light of changing social values. (Erikson 1961) Lemert's (1962) social construction of paranoid states represented an equally innovative sociological methodology which focused on the social-labelling processes of mental illness.

As an extension to these studies, this research addresses itself to the following questions which have not been adequately resolved

in the available literature.

1. What are the major premises upon which the ideological dimensions of professionalism turn within the two practitioner groups (psychiatrists and clinical psychologists) used in this study?

2. What are the "group" attitudes to the nature of their work in terms of an ideological stance of the profession? How do these attitudes or world-view evolve?

3. How do they (the professionals) account for the ideological differences which separate practitioners in each of the two professions, where delivery of services (therapies) is viewed as a homogeneous enterprise (relief of client's discomfort) despite differences of technique and methodology?

The clinical psychological literature has also been relatively meagre in attempting to describe how professional attitudes are shaped by changing social conditions. There have been wide disparities in the outcome research on the delivery of clinical services, without adequate analysis of the ideological factors influencing the choice of treatment modalities, as these affect the outcome of intervention. (Shlien 1964, Zax and Klein 1960)

Psychological study of ideology has typically focused on detailed specification and content analysis of "opinion-type" data, using forced choice methodology in order to accommodate the traditional stimulus-response research paradigm. (Brown 1973) The present research, however, will attempt to identify and correlate the belief systems of the individuals who make-up the test-groups in this study

and to compare them with the psychiatric/psychological ideologies which have been identified by the earlier research. A high positive correlation between practitioner responses and "identified ideologies" will contribute to the validity of the proposition that these ideologies are still a major force in shaping mental-health theory and practice among the test-groups under study. They will also reinforce the assumption that the "constant" properties of a particular ideology are present.

Most research (Fishbein 1967, Abelson 1968) which has attempted a form of measurement of ideology has related to the ideology itself and has disregarded behavioral components, other than those behaviors which suggested intention or commitment to disseminate ideas. The Abelson (1968) and Feldman (1966) studies omitted the presence of "knowledge" as being a salient variable in their ideological indices. Facts used to support an ideological position in these studies varied from person to person, while commitment to the ideological position remained constant.

Levinson (1954) developed particular scales to assess ideologies in political, religious and social domains. He considered ideology to be a relatively stable, organized pattern of thought within the individual and an aspect of the human personality. Selection of ideological material was viewed as occurring at a personal, cognitive-affective, motivational level within each individual, hence Levinson's study could not deal with ideology as a group dynamic in the way that he operationalized the term for his study.

A basic methodological problem has been evident in much of the ideology literature with regard to the unit of analysis of ideological material. "Ideology" may be present in a collective sphere (eg., by a whole social movement) or in the response repertoire of a single individual. Since Levinson's definition of ideological content involves cognitive-affective and motivational components the logical unit of analysis to be employed in measuring ideology would seem to be at the individual rather than the group level.

This methodological difficulty has been present in efforts to isolate other social phenomena which have characteristics of individual and group behavior (eg., "anomie," or "alienation.") The major problem in attempting to measure these social phenomena is that they may not exist in the same qualitative form at the individual and group levels. (The "nature" of ideology at the group level may be greater than the sum of the "natures" of individual ideologies.)

This research attempts to test the generalizability of "mental health ideologies" by observing the responses of individuals and groups of individuals. It attempts to find out whether qualitative changes in ideology occur when generalizing from an individual to a group model.

Some effort has been made to measure ideological content in the mental-illness domain. These studies have been confronted with the same methodological difficulties which have been present in the research and measurement of ideology in other domains.

Gilbert and Levinson (1957) studied the distribution of

ideologies using the Custodial Mental Illness Scale (CMI). Armor and Klerman (1968) and Cohen and Streuning (1962) employed a factor-analytic methodology to measure ideological data. Strauss (1964) sought to integrate and refine other ideological scales by including a range of items within a comprehensive, Psychiatric Ideologies Scale (PSI). A scale for the single ideological variable "attitude to community mental health work" (CMHI) was devised and administered to mental health workers by Schulberg and Baker. (1975)

This research will draw on all of these instruments in attempting to delineate the similarities and differences in the on-going dominant ideological dimensions among two of the mental health professions in the province of Manitoba.

STATEMENT INTERRELATING EXISTING KNOWLEDGE AND PROPOSITIONS TO BE INVESTIGATED:

A great deal of research has been done on the theory and practice of mental health work, yet only a small part of that research has been directed to a study of the ideologies of those professions, particularly so, in the case of research with empirical data to support the findings. This fact may be due to the "non-empirical" nature of ideological issues. However, since the ideological base of mental health practitioners shapes the nature of intervention forms to such a strong degree, some effort to isolate the ideological factors must be made.

There has been a general trend in the literature to focus on ideological concerns of each profession to the exclusion of comparable

dimensions operating in related professions. (Cohen and Struening 1962, Rogers and Skinner 1956). This methodological separation has precluded the examination of mental health professionals across varying occupations as a homogeneous group with regard to ideological content. The studies which have attempted across-profession attitude measurement (Strauss 1964) have not included a control group phase in their experimental design, to measure degree of homogeneity of ideological content when measuring ideological differences. Thus the degree of ideological difference which has been found to exist may have been exaggerated. A single overall measure on a continuum of ideological homogeneity may have shown insignificant differences on overall ideological content across professional groups in these studies.

Whilst considerable differences between the professions may be anticipated in the cognitions of practitioners from each profession, it is reasonable to suppose that ideological views of practitioners in mental health care will at least have some shared attributes despite the psychiatry/psychology dichotomy. This supposition that real differences (in training etc.) as well as real common attributes (as mental health professionals) exist, defines a further proposition of this research.

One theme that appears throughout the ideology literature points to the close relationship between prevalent social values and their effect on the nature of mental health practice. A final proposition coming out of this section of the research, is that a compromise model which governs and mediates between the values and expectations

of the professions under study and those of the larger society does exist at both the ideological and practical levels. It is this assumption which suggested the locus of inquiry for this study.

The present research will investigate the propositions about professional ideology generated in this introductory chapter. The study will also include direct response by practitioners to probing about ideological content suggested by the literature. The analysis of crucial ideological issues in mental health practice within this framework will make it possible to isolate the presence of ideologically based professional attitudes. With reference to within-profession differences in ideological content, the researcher will attempt to narrow the areas of overlap by identifying within-profession schools of thought. (eg. Somatic-Psychoanalytic group in Psychiatry, Existential-Analytic group in Psychology, etc.).

Two general propositions which come out of this study will be synthesized to guide the theoretical issues raised in Chapters 2-5. Further, five specific testable hypotheses will be subjected to empirical analysis in the sixth chapter using an instrument designed to measure ideological content.

The first proposition is:

That ideological differences will be shown to exist at each level of analysis in this study. Different assumptions will be shown to be held by mental health professionals in accordance with personal, occupational (organizational) and professional ideological systems.

The second proposition is:

That occupational ideological rivalry will be demonstrated between the two professions under study. This proposition reinforces the notion that to the extent that such rivalry exists, the establishment of ideological hegemony by a single occupational group is precluded, and that ideological hegemony by both groups as a shared professional sector will not be demonstrated.

Hypotheses 1 states:

That ideological separation along the dimensions of such domains as degree of custodialism/humanism, community, somato/psycho therapeutic orientation, etc. will be significantly linked with particular personal, occupational and professional ideological systems.

Hypotheses 2 states:

That a higher level of ideological flexibility will be evident in the psychology rather than the psychiatric sample. Within the psychology sample, the higher the score on the humanism scale, the lower will be the score on the behavioral test scale.

Hypotheses 3 states:

That high scores on traditional ideological domains such as somatotherapy for the psychiatric sample will be related to a high score on the Psychiatric Hegemony Scale and a low score on the Psychology Hegemony Scale.

Hypotheses 4 states:

That within the psychiatric sample the higher the scores on criteria such as humanism, sociotherapy, community, etc., the lower will

be the scores on dimensions of custodialism or somatotherapeutism.

Hypotheses 5 states:

That high scores among the psychology sample on the behavioral scale will be related to a higher score on psychological hegemony and a low score on psychiatric hegemony, and humanism scales.

The specific objectives of this research then, are:

1. To investigate the ideological evolution of each profession in a socio-historic context.

2. To investigate ideological content as it is reflected by the nature of choices of treatment and professional attitudes towards the outcome of intervention in each profession.

3. To draw on diverse sources of primary and secondary data which provide "ideological" information.

4. To provide an empirical analysis of professional ideology in each test-group.

The section dealing with the socio-historic evolution of mental health ideologies is provided in the following chapter.

Chapter II

A SOCIO-HISTORY OF THE MENTAL HEALTH IDEOLOGIES

THE EVOLUTION OF PSYCHIATRIC IDEOLOGIES:

The evolution of treatment forms has been historically linked to the social concerns of the larger society at every point of its development. Primitive man used a simple belief system to expalin mental illness. When the cause of mental disorder was not obvious, man sought to explain it on the basis of some influence that another human being or spirit exercised over him. To the extent that there was commonality of experience among pre-historic men, super-natural phenomena were held to account for disturbance in behavior. The magical-religious system evident in this philosophy suggests that an attempt was being made to meet the need for some form of behavioral cohesion in an essentially chaotic realm of psychological experience. (Zax and Cowen 1972)

Early Egyptian culture provided a relatively sophisticated integration of physical and psychic process and the first moral therapy modality. Normal behavior was viewed as the product of a "life-model" which suggested a balance between man and his relationship with the universe. Biblical references to the phenomenon of mental illness (the Talmud) considered epilepsy and insanity to be diseases but prescribed treatment by charms and symbols rather than drugs.

The Hellenist and Roman cultures assumed that the task of treating mental illness was more metaphysical and philosophical than medical. Anti-social behavior was viewed as "punishment" by the gods,

relieving the mentally-ill individual of criminal responsibility. The insane individual was exiled from his city or forced to undergo purification rites. In the Platonic dialogues, there is the suggestion that violation of moral internalized principles would result in punishment by the gods. (Plato's "daemon" was viewed as the equivalent of what was later called by Freud the functioning super-ego.) Heraclitus (535 B.C. - 475 B.C.) and Empedocles (490 B.C. - 430 B.C.) advanced the first scientific bases for mental illness. Cicero (106 B.C. - 43 B.C.) called on men to participate in their own cure through "philosophy;" in a sense he was calling for what evolved into "insight" therapies.

While Plato had attempted to explain irrational behavior as an inevitable part of human life, Aristotle, (383 B.C. - 322 B.C.) provided the first empirical analysis of human behavior. His paradigm was not much different from the experimental methodology of today's psychology. Aristotle was the first to postulate the "cathartic" effects of music therapy as an effective treatment base. His viewpoint was to evolve into the basic rationale of moral treatment for mental illness in the 19th century.

The earliest humanistic orientation to mental illness was recorded by travellers returning to Europe from the Arabian countries. They recorded the relaxed atmosphere, special diets, baths, drugs and perfumes that constituted the enlightened treatment afforded to mental patients in these countries. The roots of this early enlightenment was the Moslem religion, which held that the insane were the beloved

of God and were chosen by him to speak the truth in their suffering. In 13th century Europe, the mentally ill were not held legally accountable for their actions. Albert the Great and Thomas Aquinas believed that cause and treatment of mental illness depended largely on astrological influences on the psyche and on the evil power of demons.

> Consequently mental illness remained untreated for the most part. Mental patients were regarded as freaks or, more kindly, as unfortunates, which seems to indicate a more tolerant attitude than is evident in some segments of modern society. (Freedman and Kaplan 1972 p 6)

The church of the middle ages deprecated the "worldly" condition of man, making it subservient to a life in the hereafter. Man's existence was viewed as one of moral weakness (his fall from grace) and intervention was vested in the therapeutic power of the religious symbol. Since the devil was viewed as the culprit responsible for deviant behavior, demonology was the ideological backdrop for treatment procedures. Incantations and exorcism were the tools used to "remove the devil from men's minds." Church sanctioned abuses in witch-hunting and torture led to new ideological bases for treatment.

Renaissance thinking brought some enlightenment to the treatment of mental illness. Jean Luis Vives (1492 - 1540) advocated the establishment of hospitals for treating the mentally ill, stressing that "the mentally sick are first and last, men, human beings, individuals to be saved and to be treated with utmost humaneness." (Freedman and Kaplan 1972 p 9) Vives can be seen as the precursor of the humanist tradition which evolved in the psychological profession.

Sixteenth century practice introduced the scientific method,

when Montaigne (1533 - 1592) developed methods of direct observation, case descriptions and a classificatory scheme for treating the mentally ill. Machiavelli (writing as an observer of human behavior) subsequently distinguished between "behavior" and "morals," and from his distinction came an important contribution to the growth of ideas about human behavior.

The Renaissance provided the first scientific psychiatric procedures. In "De Praestigiis Daemonum" published in 1563, Johann Weyer adamantly rejected witchcraft and demon-possession as the causes of observable disturbed behavior. He strongly condemned those members of the clergy who advocated this position. Where he was unable to account for disturbed behavior on the basis of pure medical knowledge, he attributed the cause of this behavior to a combination of natural and supernatural forces. Weyer recognized the importance of the therapeutic relationship, but postulated that to be truly effective, this benevolent attitude had to be based on scientific principles. Weyer was responsible for laying the ground-work for the initial ideological premise upon which the "medical model" was to be built.

The basic principles laid down by Weyer were further reinforced by Paola Zacchia. (1584 - 1659) He wrote that only a physician was competent to judge the mental condition of a person. Examination of suspect behavior was to be based on language, actions, ability to exercise sound judgment and emotional state. These criteria established in the 16th century constitute the core assessment material in present day standard psychiatric interviews. In "Anatomy of Melancholia"

Richard Burton (1577 - 1640) proposed that additional variables be included in psychiatric assessment. He suggested that the psychological and social causes of insanity were attributable to jealousy, solitude, fear, poverty, unrequited love or excessive religiosity.

Seventeenth century social thought and philosophy brought an emphasis on the rational processes operating in human behavior. John Locke (1632 - 1704) and Thomas Hobbs (1588 - 1679) developed associational psychology and the "tabula rasa" concept of man as a blank slate at birth. As a result of the emphasis placed on "reason" during the Renaissance, "madness" was confined to the realm of the absurd. The lack of tolerance for the irrational culminated in the complete rejection of the mentally ill from a philosophical viewpoint. The 18th century provided a marked contradiction in attitudes towards mental illness.

> On the one hand, the mentally ill were rejected by medical and other professional societies. On the other hand, the impressive scientific and social accomplishments during this period led to the establishment of modern science. (Freedman and Kaplan 1972 p 8)

In Europe, even in the most progressive institutions, strong controversies ranged between those physicians who believed that treatment had some value and those who believed that mental illness was incurable. Institutions which housed these people combined the characteristics of a penal institution, an insane asylum, a sheltered workshop and a hospital. Out of these institutions evolved many of the centralized functions of the larger mental hospitals of the present, along with some of the warehousing and custodial properties which have characterized them up to the present time. (Wolman 1971)

Early humanist and radical psychiatric practice can be traced back to Vincenzo Chiarugi. (1759 - 1820) He was the first medically trained psychiatrist to emphasize the need for humane treatment forms.

> It is a supreme moral duty and medical obligation to respect the insane individual as a person. (Freedman & Kaplan 1972 p 9)

This statement defined the philosophy behind the policy of the Hospital Bonifacio under Chiarugi's supervision. The regulations binding hospital-staff to abstention from the use of physical force and cruelty, as well as additional safeguards of hygiene and safety, represented a radical shift in orientation toward treatment of the mentally ill.

Under the leadership of William Tuke, the York Retreat was opened in 1796. Patients were treated as guests with kindness and understanding in a friendly atmosphere, free from any mechanical restraint and also from any direct medical influence. The "benevolent" nature of psychiatry was further reinforced in Phillippe Pinels (1745 - 1826) thesis on moral treatment based upon the Aristotelian concept of mental health as dependent on the balance of passions. Pinel's doctrine made evident that the psychiatric ethos had developed into a mature ideological position which now included all of the characteristics of the medical model.

> Therapeutically, the doctor had to exert the greatest firmness in his approach to the patient: he had to hold the patient's attention and control his will with his eyes. Once the patient was subdued and had been completely dominated by the doctor, treatment consisted of a combination of kindness, firmness and coercion. (Freedman and Kaplan 1972 p 10)

Psychiatric philosophies (they had not yet developed into full-blown ideological assumptions) could be seen to be taking different paths according to differing national trends. In France, psychiatrists stressed the clinical study of the patient. An effort was made to improve the institutions and the quality of care for the mentally ill. German psychiatry had been strongly influenced by the Romantic movement and theological principles. Clinical experience was limited and lacking in scientific objectivity. There is evidence that good insights in German psychiatry often fell prey to sentimental pathos and metaphysical accountings for disturbed behavior.

British psychiatry of that period, was largely characterized by a practical orientation in accordance with the respect for the individual that was emphasized in English philosophical works of that period. Patriarchic features were also evident in early American psychiatry. Thomas Kirkbride (1809 - 1883) wanted small hospital populations so that the hospital superintendent could function as a father figure to the patients and facilitate the implementation of moral treatments. Kirkbride's optimistic treatment modalities (the so-called "cult of curability") was strongly opposed by other practitioners in America, particularly by Pliny Earle of the Bloomingdale Asylum. (Deutsch 1948)

By the late 19th century, the organic content of mental illness was receiving much more attention. Wilhelm Griesinger (1817 - 1868) maintained that mental diseases could only be explained on the basis of physical changes in the nervous system. This organic approach

was adopted by leading German psychiatrists, providing the core of what was to evolve into the somatotherapy school of psychiatry. In the U.S.A., moral treatment was discarded almost completely. The treatment of psychiatric patients became increasingly impersonal. Mental illness was considered to be physiological in origin and independent of personal and social factors. "Hospitals" were built to replace "asylums," but the medical staff of these hospitals had no contact with medical schools, nor were they interested as a general rule in the conduct of research. (Alexander 1966)

During the 19th century, interest in the unconscious forces of personality had been evident, largely through the influence of the romantic movement. Charcot (1825 - 1893) described the hysteric reaction and demonstrated its cure by means of hypnosis, acquiring a substantial following and also a vocal set of opponents within the medical profession.

It is of some interest to the ideological background of Freudian theory to note the source from which he drew in establishing his theories of personality and neurosis. The notion of "catharsis" had already been entertained by the ancient Greeks and was effectively used in drama of that period. The unconscious had been a central facet of 18th and 19th century study of self-knowledge and philosophy. Theories of sexual development and their behavioral effects were present in the thought of Goethe and Darwin. Plato too, had made reference to the "instinct for survival" in his concept of immutability. The Freudian notion of "cure through insight" was in the Platonic and

Orphic tradition. (Freedman and Kaplan 1972 p 18)

The traditionally conservative nature of Freudian psychiatry stemmed largely from the factors that influenced his view of man and society. Freud interpreted politics, religion and culture in terms of the inner life of the individual and his immediate family experiences.

Reisman (1954) suggests that Freud posited the Protestant work ethic as a professionally correct stand, and that he adopted his therapeutic techniques to fit his outlook on cultural and class dimensions. Freud's view of work as the "tragic and inescapable necessity" as well as man's "inherent laziness and the futility of socialism" can be understood from his view of a world dominated by scarcity, economic uncertainty and Malthusian fears. The overall pessimism of his view of man was revealed in Civilization and its' Discontents. (Stacey 1961) Freud constructed an ideological model from which he drew inferences about the nature and conduct of psychiatric practice.

> I can offer them (my fellow men) no consolation.... The fateful question for the human species seems to me to be whether and to what extent their cultural development will succeed in mastering the disturbance of their communal life by the human instinct of aggression and self-destruction.... (Freud in Stacey 1961)

Although Freud was pessimistic about social change, later members of the psychoanalytic movement, (the Neo-Freudians) while accepting basic psychoanalytic theory, were more aware of the shortcomings of some of Freud's social pronouncements. Freud's traditional view had been largely patriarchal. His clinical findings reflected these stereotypic and sometimes discriminatory assertions about womens'

destiny and their biological limitations.

He incorporated his assumptions about social facts into his clinical practice. Freud's theory of "hysterical neurosis" evolved out of restricted case studies, from a population consisting almost exclusively of female, upper-middle class, Jewish persons, displaying symptoms of sexual repression. Hence, it was from the social values of his day that Freud constructed his theory of "sex-appropriate behaviors." These contributed to the conservative social stance which he advocated. Freud's model of behavior was defined as "biological determinism" (Hall and Lindzey 1970) even though he viewed the individual as being able to free himself (psychologically) to some extent through insight about his unconscious thought.

A succint account of the political-ideological content which flowed from Freudian theory is to be found in Anna Freud's presentation of the psychological dynamics which underly "protest" movements, particularly among the young and the socially-alienated. What emerges from this position is that the status quo might only be challenged under threat of having one's behaviors interpreted as "inadequate, immature, or neurotic." The patriarchal nature of psychoanalysis, and its conservative properties are evident in her statement:

> If a radical learns that his desire to restructure society and overthrow its' leaders is but a displacement of his desire to restructure his childhood family constellation and overthrow his father, the implication is that he should abandon his revolution since it is but a symptom of his neurosis. (Freud A., in Roman and Harrison 1974 p 13)

Anna Freud interpreted the psychology of the protest movement among today's youth as not so much an interest in solving social ills, but

as a mask for concealing personal inadequacies.

Full acceptance of Freudian theory would have discounted the value of social change in influencing individual behavior. The nature of Freudian ideology had laid much of the groundwork for the conservative attitudes towards social activism which remained relatively constant among psychoanalytic practitioners until the advent of the radical movement among mental-health professionals. More "radical" interpretations of Freudian theory were not advanced until late in the twentieth century. Most notable among these were the "political" treatises on the psychoanalytic school advanced by Fromm (1947) Laing (1968) and Szasz (1961).

The psychiatric profession underwent a rapid ideological transition over a relatively brief period. The neo-Freudian movement (Erich Fromm, Harry Stack Sullivan, Karen Horney, and Erik Erikson) made some attempt to apply classic psychoanalytic concepts to modern social and cultural problems. (See Figure 3). Focus shifted from Freud's biological determinism to include questions such as alienation, poverty, automation, individuality and "the search for identity." (Erikson 1966) The questions posed by twentieth century psychiatry led to some radical shifts in ideological positions; among some practitioners, to an "anti-psychiatry" front within the profession. (eg., Laing, Szasz, etc.) (To be discussed in more detail in Chapter III).

THE EVOLUTION OF PSYCHOLOGICAL IDEOLOGIES:

Freudian thinking had reflected nineteenth century mechanistic

Figure 3

Post-Freudian Development in Psychiatry

Table 1.3

Other Post-Freudian Workers

Name and Area of Emphasis	Some Contributions
Culturalist psychoanalysts	
Karen Horney	Basic anxiety and basic hostility, feelings of helplessness and isolation
Erich Fromm	Role of culture in mental disease; social conformity--loss of freedom, neurosis
Harry Stack Sullivan	Interpersonal theory of development; coined new language of psychiatry, e.g., ergasiz-schizophrenia, consensual validation
Ego psychoanalysts	
Anna Freud, Heinz Hartmann, Ernest Kris, David Rapaport, Erik Erikson	Role of ego rather than id in personality development; emphasis on mechanisms of defense
Psychoanalysts	
Melanie Klein	Infantile development and aggression
W.R.D. Fairbairn	Ego analysis emphasizing infantile strivings for object relations
Husserl, Binswanger, Boss, Jaspers	Existential philosophy applied to psychoanalysis

Source: Freedman, A. M. Kaplan, H. I. and Sadock, B. J.

Modern Synopsis of Comprehensive Textbook of Psychiatry, Williams and Wilkins 1972, Table 1:3 p. 20.

physics, by stressing the physical boundaries governing and limiting the range of psychological functions. The discovery of the principle of "indeterminacy" in twentieth century physics led to a marked shift in psychological thinking, in the perception that objective forces were very much related to subjective states. This view accounted for the emergence of psychological views which reflected only part or sometimes none of Freud's principles of biological determinism. The historical evolution of the "philosophy" of clinical psychology apart from psychiatric practice is pertinent at this point since it accounts for the emergence of the phenomenological and behavioral schools of psychology and their separation from Freudian psychiatry.

This period also triggered the emergence of a number of "schools" of academic psychology, structuralism, associationism and behaviorism. Later evolutions within the field led to the split into the behaviorist-humanist dichotomy within psychology. (To be discussed in more detail in Chapter IV). Existential therapy forms were initially a product of European thought, but were taken up in North America predominantly by psychologists in the "humanist" camp within the profession of clinical psychology. (R. May, J. Bugental, S. Jourard, and C. Rogers.)

With each emergent philosophy of psychology, there evolved an accompanying methodology. Figure 4 illustrates the underlying philosophical and methodological assumptions of the "schools" of academic psychology which came out of the non psychoanalytic tradition. In some cases certain psycho-dynamic views were incorporated into those "schools."

Figure 4

Table 1.2

Schools of Academic Psychology (1870-1930)

School of Psychological Thought	Workers	Specific Emphasis
Structuralism	Wundt, Titchener	The study of conscious experience through introspective experimentation. images, feelings, consciousness, observed and analyzed
Functionalism	Titchener, Dewey, Angell	Like structuralism, functionalism emphasizes the study of consciousness but in relation to environmental adaptation, through application to education (education psychology) and people (clinical psychology)
Associationism	17th century, philosophers such as Hobbes, Berkeley, Locke, Mills, 19th century, Herbart 20th century, Ebbinghaus, Pavlov, Thorndike, Skinner	The study of learning and memory, as exemplified by Thorndike's law of effect, Pavlov's law of reinforcement, and Skinner's learning in animals and humans
Behaviorism	Watson, Meyer, Weiss, Hunter, Lashley, Tolman, Hull, Skinner	The objective study of human and animal behavior. Concepts of stimulus, response. Study of consciousness is avoided.
Gestalt psychology	Wertheimer, Koffka, Kohler, Lewin	The total perceptual configuration and the interrelation of its parts are studied, represents more than the sum of its parts. Studied through introspection and observation
Purposive or homeric psychology	McDougall	The study of goal-seeking behavior of social psychology
Organismic pshchology	Coghill, Goldstein, Kantor	The holistic, biological study of the individual
Personalistic psychology	Calkins, Stern	The holistic, social study of the individual

Source: Freedman, A. M., Kaplan, H. I., and Sadock, B. J. Modern Synopsis of Comprehensive Textbook of Psychiatry, Williams and Wilkins, 1972, Table 1.2 p. 19.

In contrast to their role as academicians and researchers, when psychologists began to provide direct services to the public in clinical practice, the various schools of thought to which they subscribed led to applied methods of intervention from differing ideological perspectives. For example,. . . . central to the notion of Gestalt therapy was the holistic notion that "man" was greater than the sum of his parts as he perceived his world in shifting gestalts of ground and figure. This ability of man to "transcend" his immediate environment made all of man's actions greater than that accounted for by Freud's biological paradigm or Skinner's mechanistic view of man.

The focus of humanistic and "growth" factors operating in human behavior led to the formation of a humanistic underground (The third force) at a time when the discipline of psychology was operating within a relatively narrow and structured paradigm. Some degree of disharmony; eg., between humanists and behaviorists still exists among practitioners at present, according to the philosophy of science to which they adhere, (i.e. the intellectual ideology). These philisophical differences determine the selection of research-areas and the nature of applied clinical practice at the present time. (Martin D. 1971)

Current psychological vocabulary emphasizes regularity, uniformity and predictability to a lesser degree than that proposed earlier by the more narrow laboratory-controlled experimental paradigm. The term "growth" in humanistic psychology addresses itself to positive behavioral sets such as creativity, autonomy and spontaneity,

unlike the medical model which dealt with all non-normative human behavior in negatively toned terms i.e. Psychopathology. This positive perspective led to an increasing number of practitioners in both the professions under study defining themselves as ideologically committed to the "existential analytic conduct of psychotherapy."

Ideological components of the humanist movement evolved out of a reaction to the psychiatric and behavioral models. While behaviorism often presented itself as a purely "methodological" system, the ideological assumptions of that paradigm became explicit when they were employed as clinical techniques. (See Chapter IV)

The humanists or third force in the profession of psychology have been described by the behavioral school as employing "pure metaphysics" in their conduct of clinical practice. (Eysenk 1972) Their stance has incorporated into its ideological framework, a position which is inconsistent with the intellectualism/scientism with which the humanists identify the behavioral position. The humanist brand of eclecticism has shown an affinity for Eastern philosophy, techniques and music, and has enunciated a moral position which holds man-kind responsible for his life-conditions and the assuming of a better life for himself. (Kopp 1972)

Encounter and growth therapies (Wesley 1969) which evolved, have been described as "therapy for the man who has everything." However, in keeping with the ideological assumption that medicine (and hence psychiatry) deals only with "pathology" in its various forms, the psychiatric profession has resisted such "growth oriented" therapies

which have not been geared to the classical nosology of mental illness and its treatment. "Marathon" therapy groups have been strongly resisted by traditional psychiatrists in keeping with procedural criteria that preclude the possibility of therapeutic gains as a consequence of a single extended period of therapy. (eg. a weekend)

The evolution of psychology as a discipline is most significant in its change from a purely research-oriented to a service-delivery occupational group, at least in the clinical area. The breakdown of research versus direct service-delivery components inherent in the role of the clinical psychologist has been one of the major areas of contention between the two groups in this study. The roles of psychiatrists and clinical psychologists as primary health care providers and intervention agents (therapists) will be discussed in the following chapters in relation to the ideological conflicts within their professions and between them.

THE EVOLUTION OF "MENTAL-HEALTH PROFESSIONAL IDEOLOGIES:"

London (1964) has observed that mental health professionals have often been irresponsible in their insistence on denying responsibility for social change that they have fostered. The "potential for social engineering" by mental health experts, as well as their reluctance to assume responsibility for such change was held to detract from the value of such interventions. He also noted the lack of concern with social values and society outside of the narrow behavioral context in which many mental health professionals have worked. Seeley (1953) drew an analogy between the function of mental health

professionals of the 20th century and the priests of the middle ages. He described the mental health movement of the present as occupying the "socio-religious" vacumn caused by the passing of the traditional sway of organized religion.

Folta and Schatzman (1968) suggest that the minimum care model afforded to mental patients in the last century reflected the prevalent ideology of Social Darwinism. New treatment forms which made services available to any and all groups were viewed by Strauss (1964) as a reflection of changed social awareness stemming out of the "New Deal" and "Great Society" aspirations of mid 20th century social and political thought. A further factor deemed to be relevant to changing treatment orientations, was the increased use of mental health professionals other than those produced by the medical-psychiatric profession, particularly the increasing numbers of socially oriented medical sociologists, social workers and clinical psychologists.

Some research has focused on the dangers of potentially "value laden" professional mental health ideologies. The imprecision of psychiatric theory, particularly in evaluative statements such as "normalcy," "disturbed," "adjusted," "deprived," etc., have made the ideological components of psychiatric diagnosis a major area of contention.

Ideological factors inherent in diagnosis have been shown to accomodate the moral preferences of the mental health professional in the guise of scientific descriptions of fact. Parsons (1951) considered the functional structure of institutionalised psychotherapy to be:

> The case in our society where those fundamental elements of the processes of social control have been most explicitly brought to light. For certain purposes they can serve as the prototype of the mechanisms of social control.

and Laing (1961) declared:

> Psychiatry could be and some psychiatrists are on the side of transcendence, of genuine freedom, and of true human growth. But psychiatry can so easily be a technique of brain-washing, of including behavior that is adjusted, by (preferably non-injurious) torture. In the best places where straight-jackets are abolished, doors unlocked, leucotomies largely foregone, these can be replaced by more subtle lobotomies and tranquilizers that place the bars of bedlam and the locked doors inside the patient.

Psychotherapy in the service of social control has been described by Szasz (1961) as "the forerunner of increased chains on human freedom and dignity in the future." This attack has been leveled largely at the ideological base of the mental health professions as psychological watchdog for the status quo. Current political information has revealed extensive documentation of Soviet psychiatric use of incarceration in mental hospitals for political dissent. Commitment of individuals for psychiatric care because of deviant political views has not been confined to the Soviet Union. It has been suggested by Lemert (1962) and others that coercive principles have operated to some degree in mental health structures in a relatively constant fashion across varying political regimes. Conservative ideological content (in the service of superordinate political groups, mostly governments) has mirrored the degree of social status and protection from external sanctions provided by the social-structure which mental health professionals have served:

> Attempts to commit for care individuals with deviant political stances, has not been confined to Totalitarian regimes.

> The invoking of psychiatric vocabularies to discredit behavior and attitudes with which one disagrees not only enables one to ignore the issues that are raised in the argument but makes unnecessary a search for structural factors conducive to such behavior and attitudes. (Lemert 1962 p 37)

Mental health workers from the ideological schools which subscribed to professional activism, (See Appendix 3) considered their work function (as "change" agents) as a tool for building the "good Society." Government financing eventually provided funds to translate some of those ideological goals into social psychiatric practice. Increased use was made of community mental health clinics and community-oriented mental health workers from varying disciplines (Psychiatry, Sociology, Psychology, Social Work, Nursing etc..) as well as non-professional input from voluntary community organizations and individuals. More attention was paid to mental health prophylaxis via education of the public about the mental health movement.

The new locus of attention in the treatment of mental illness largely displaced the psychiatric hospital with its centralized functions, as well as the orthodox hierarchical structures of mental health services. At the present time the "custodial" ideology appears to have been largely replaced by an upsurge in the "humanistic" orientation to treatment. (Schulberg and Baker 1975)

Ideological "shift" has thus resulted in innovative therapy forms which stress increased awareness about the social structure as part of the insight to be sought in therapy, i.e., increased social awareness leads to better social contingency management. New research areas have also developed which include both biological and socio-psychological models of mental illness, and which stress the role of the

family, the hospital and the community in mental illness.

Duhl (1963) focused on the post-world-war trend of psychiatric practitioners to restrict their roles to that of "office therapists" and "cream-puff psychiatrists," to the neglect of environmental factors as well as the socio-economic determinants of mental illness. He noted a shift toward "community values" in both psychology and psychiatry, though the more conservative psychiatric wing displayed some resistance to these changes. Particularly among "activist" mental health professionals, he suggests that greater emphasis was now being placed on the interactional effects of social and personal systems in diagnosis and treatment.

The ideological assumptions of Duhl's "community mental health workers," were that in order to change the behavior of individuals, social institutions also had to be changed. Some examples of these ideological shifts were reflected in the creation of "storefront" psychiatric services, the break-down of the traditional fifty minute interview, home visits, and the use of laymen in mediation between mental health professionals and the community. Race and poverty were recognized as increasingly relevant variables in shaping and socially determining the acquisition of particular labels of mental illness. (Goffman 1963, Duhl 1967)

Coles (1967) considered changes in psychiatric thinking to be a reflection of world and national events and the changing social order. Rieff (1955) suggested that the whole "therapeutic process" was becoming more democratic. The changing social order of society

(and the family) was reflected in the changed nature of the interactional process between therapist and patient. Yablonski (1967) considered the very presence of a "professional" in the helping professions to be unnecessary and possibly damaging, due to the hierarchical structure of expert and supplicant inherent in therapeutic dyads.

Some self help groups from the community took up the social function of "caring" for individuals suffering from psychological dysfunction, and displayed a marked aversion to making members of their community available to professional intervention agents. While this alienation from mental health professionals remained largely among marginal social groups, the degree of ideological alienation (and concomitant distrust of the profession) tended also to exist to some degree within the larger society. As a reaction to traditional professional intervention that had been offered, whole societies have sprung up solely to displace the use of established mental health facilities.

> The Diggers creative society, a hippie group, consider it their function to take care of individuals on "bad trips". According to an informant, the worst thing to do with a person like that is to take him to a doctor or a hospital. (Roman 1974 p 137)

Evidence of this reaction to professional abuse is also evident in the heroic qualities ascribed to Ken Kesey's Patrick McMurphy (1962), and his portrayal of the mental health establishment as punitive, insensitive and inauthentic. The popular literature of the present suggests that the social control aspects of the mental health professions have become increasingly more apparent and

more vigorously resisted by the lay public. (See Williams 1956, Burroughs 1959, Kesey 1962) The degree of homogeneity in the images presented and shared by numerous literary figures, suggests that more than mere "literary fantasy" accounts for the intense fear of ideological abuses and arbitrariness coming out of mental health practice up to the present time.

A further example of psychotherapeutic populisms increasing stature, is evident among the women's movements "consciousness raising" groups. Much research has been generated in reaction to ideological formulations about sex-role appropriateness, particularly regarding Freudian notions of "hysteria" and female sexuality. Women have become increasingly rejecting of the psychological attributes, associated with female sexuality which came out of Freudian theory.

> The vows of celibacy which were imposed on monks and nuns of the middle ages were not sufficient to inhibit erotic drives. Threats to the status quo demanded a cause around which the focus of orthodoxy could rally their flocks, and that cause became the female witch-hunt. Since women stimulated man's licentiousness, it was "logical" to lay the blame for sinful erotic behavior at her feet. In terminology Freud developed later, the unsavoury impulses of men were projected onto women. They were presumed to be the devil's agents. Given such an atmosphere, women who openly expressed erotic fantasies and who blasphemed against the church became easy targets. (Zax and Cowen 1972 p 38)

Ideological stances had been incorporated into professional psychiatry out of a system which dealt with female sexuality initially in terms of witch-craft and then as psychopathology; an historical derivative it would seem, of Medieval morality.

In the profession of psychology, female stereotyping has

also been demonstrated. The ideological component of sex-role stereotyping was shown to be present in a study designed to test "healthy standards of psychological functioning." (Broverman 1970) In this study, a questionnaire was distributed to active mental-health professionals (psychiatrists and clinical psychologists) soliciting their professional opinions about the nature of a healthy personality. The experimental hypothesis was that behaviors and characteristics deemed healthy for an adult, reflecting an ideal standard would resemble behaviors judged healthy for males only. The hypothesis was confirmed. (Broverman 1970)

Among professionals in the mental health field, publications and interchange of information has resulted in radical views about mental health enjoying some popularity. The unlikely propositions of theorists such as R. D. Laing, which posit "that insanity is a sane response to an insane world" have attracted a substantial and controversial following within the profession.

"The Radical Therapist," a current publication which includes articles critical of the medical model of mental illness and of many of the principles of psychological manipulation, provides a sharp focus on the nature of sexism in psychotherapy. This publication has suggested alternative models of life style and therapeutic technique. A sub-culture of mainly clinical psychologists and social workers has attempted to translate this philosophy into professional practice, by breaking down the traditional barriers between patient and "expert" in psychotherapy. They have evolved into a group called

"the guerilla therapy collective."

"Therapy," for some groups has evolved into a full blown social movement complete with "true believers" while others have continued to regard it as a speculative last resort device to deal with the mentally ill. (Yablonsky 1967) The "growth" aspects of psychotherapy have been particularly emphasized by groups attempting to fuse the principles of social psychiatry, radical intervention and humanistic psychology. Whole professional communities have evolved with a professional manifesto to actualize the growth-function of practitioners themselves. (eg. The Kiro's Mental Health Spa, Esalen Institute etc.)

FUTURE IDEOLOGIES:

Current views about the direction in which the professions will move (and what will determine any shifts that occur) have been offered by practitioners from both disciplines. Bensman and Vidich (1957) suggest that in the future, the impact of psychoanalysis will largely be in the direction of greater social awareness rather than a form of treatment for individual problems. Greenblatt and Sharaf (1971) advocate training programs for psychiatrists and clinical psychologists that will include greater exposure to the patient populations which they will be treating in the future. They support a reduction in the prevalence of "cream-puff psychiatry, by men and women who are content to live out their professional lives dedicated to the welfare of a thin layer of well-heeled patients at the top of the economic heap." (Greenblatt and Sharaf 1971, p 114).

The future direction for clinical psychology seems to entail further separation of practitioners into private and public

service mental health agents, (already in effect in California, Florida and other parts of the U.S.A.) increased involvement in the community (preventive) mental health movement and the research sector. Much research has also been focused on the delivery of mental health services to rural and urban areas out of different methodological and ideological frameworks.

The ideological assumptions guiding futurist models in clinical psychology have been largely those of the past (behavioral versus humanistic criteria) subject to the same shortcomings of earlier models. There has been a marked impact on the profession by statistical and systems theorists who have suggested various strategies for behavioral change in individuals, family units and communities. Many of the ideological premises of these new models while already in effect have not yet proven their clinical or social utility. (Haly 1972, Wiener 1975)

The literature has suggested that professional pre-occupation with intra psychic factors has made psychiatry an essentially conservative force in society. Similarly, psychology's preoccupation with the prediction and control of human behavior without an adequate analysis of the clinical impact of intervention has tended to detract from the social impact of many of their treatment modalities. Changes now evident in the professional ideologies of both groups reflect trends similar to those in other segments of society in the direction of:

a) Further democratization of interpersonal relationships.

b) Economic supports (by government) which guide the direction and outcome of therapy.

c) Further inclusion of non-medical personnel in a modified hierarchy of work relationships.

d) Greater awareness of the problems resulting from strictly social concerns, eg., poverty and racism.

Some questions with regard to clinical practice have been generated from the socio-historical account of ideological evolution provided in this chapter. These questions will be pursued empirically later in this study.

Chapter III

THE PSYCHIATRIC IDEOLOGIES

IDENTIFYING PSYCHIATRIC IDEOLOGY:

The only recorded study which has been directed at the comparative distribution and interrelationship of psychiatric ideologies, is that of Gilbert and Levinson (1956). This study provided the first empirical examination of the nature of therapeutic ideologies and the problems associated with their measurement. Treatment orientations were measured by means of a bi-polar attitude scale expressing a continuum of ideological positions with a range from purely psychotherapeutic to purely sociotherapeutic positions. The extreme ideological polarity between the two views in that study posed some doubts about the exact relationship between the two positions.

Strauss, (1964) in a subsequent study, concluded that the correlations found by Gilbert and Levinson were spurious, since the cluster of items which supported the psychotherapeutic position and those which supported the sociotherapeutic pole provided a negative correlation which was directly attributable to the test instrument. Strauss concluded that the nature of the items and the scoring procedure provided biased results.

Strauss held that each orientation should have been studied and measured independently and the empirical relationships determined consequently. He also concluded that the analytic-psychotherapeutic (A-P) and directive-organic (D-O) poles of the Gilbert and Levinson study did not provide a sufficiently exhaustive range of psychiatric

positions.

The Strauss study provided an integration and elaboration of the Gilbert and Levinson findings. In order to off-set differences of opinion within each orientation he defined each ideology from the viewpoint of a "purist" within a given position. The major psychiatric ideologies which he identified consisted of the following three groups:

a) The Psychotherapeutic Position: assumes that intrapsychic systems are impaired by internal or external trauma which suffice to constitute a state of mental illness. Social and biological factors are not held to be of primary importance. Psychological dynamic "structure" is evident in the language and theoretical constructs used eg. ego states regression, etc. Treatment involves a specific therapy over a fixed period of time. The treatment is designed to effect a "cure" and has more than palliative value. The nature of the relationship between the professional and the patient is viewed primarily in terms of the changes which occur in the intrapsychic processes of the patient.

b) The Somatotherapeutic Position: assumes that mental illness involves malfunction of the central nervous system, as a consequence of physiological, neuropsychological, biochemical or physical-chemical dysfunction. Genetic and biological processes interact to determine the propensity towards mental illness. A general assumption of this position is that where "hard science" does not presently provide specific answers, these answers will be forthcoming in the future and will provide a much more acceptable account

than any other position.

c) The Sociotherapeutic Position: assumes a "tabula rosa" in the individual at birth upon whom mental illnes is subsequently imposed. Social variables are the essential contributing factors, particularly early need deprivation, social stress, family interaction patterns and sub-cultural affiliations. Treatment is conducted in social and interpersonal terms, using no particular treatment modality other than "effective communication," and making extensive use of all available social agencies. This position is the least structured with regard to professional roles. It encourages role diffusion and blurring of professional distinctions. The mental health "team" and "community mental-health worker" are products of this orientation.

Strauss' data provided more information about the nature of "measured" psychiatric ideologies. The study suggested that as a general rule, medical psychiatric practitioners tended chiefly to support a psychotherapeutic or somatotherapeutic position. Strauss found that the psychotherapeutic and somatotherapeutic positions were viewed as polar opposites regardless of the orientation to which the respondent belonged. Psychiatrists who scored high on the somatotherapeutic dimension scored low on both the psychotherapeutic and sociotherapeutic dimensions. Somatically oriented psychiatrists also viewed both of the other groups as more similar than the individuals in those groups perceived themselves to be.

A further significant finding of the Strauss study was its' confirmation that the somatotherapeutic point of view constituted a

significant and separate psychiatric position. Many psychiatrists saw it as antithetical to any "therapeutic" orientation and as unrelated in any way to the practice of psychotherapy. The nature of this finding is the more startling since significant differences were found to exist between the ideological position presented by these psychiatrists and their actual conduct of psychiatric practice. One example of this discrepancy was the high endorsement of psychodynamic views by strictly somatotherapeutic practitioners.

Strauss' study proposes the following generalizations:

a) Organically oriented psychiatrists view ideological conflict as existing particularly between medical and non-medical views, and are less aware of the differences between the two non-somatic orientations.

b) Psychotherapeutically oriented psychiatrists, while drawing a clear line between medical and psychological approaches to mental illness, have even less uniform perceptions of the sociotherapeutic position than do the somatic-oriented practitioners.

c) Sociotherapeutically oriented psychiatrists best distinguish the sociotherapeutic position from other positions, but view the "dominant" psychiatric ideology as revolving around the psychotherapeutic and somatotherapeutic positions.

This study tends to reinforce the notion that psychiatric ideological differences are much more sharply defined than in other professions. Though other professional groups have split along ideological lines, the dimensions of ideological split are not as evident

or well measured as those of the psychiatric profession with regard to their stand on treatment strategies.

In the field of psychology for example, polarization with regard to medical-model ideological issues has been secondary to the "humanist-behaviorist" ideological divisions. It may not be of major consequence to a practising clinical psychologist to identify with a major "psychiatric" ideology, since the medical content of applied clinical work is often minimal, providing for a more eclectic position on purely medical dimensions. As Strauss states:

> A more parsimonious explanation is that, while the non medical professions may be aware that various somatic tenets, for instance, are logically inconsistent with endorsement of certain tenets of psychotherapy, their passions are much less stirred by the distinction than are those of the psychiatrists. (Strauss 1964 p 237)

In the Strauss study, he had invited practitioners of psychiatry in Chicago to describe the local professional setting along strictly ideological dimensions. Respondents were asked to make ideological distinctions based on treatment philosophies and underlying theoretical differences. Differences in practice were accounted for in terms of polarities, the central polarity in practitioner ideologies being between the dynamic and organic treatment modalities. One respondent stated:

> My own concept of this had been pretty well formed before the Hollingshead and Redlich material came out. I already had essentially the same kind of stuff that they expressed with regard to this rather strong dichotomy between what--in very simple language--might be called the "shocking psychiatrist and the talking psychiatrist." I think that in a sense the community has a pretty strong orientation for these two areas. There are relatively few people that bridge the gap. (Strauss 1964 p 47)

Strauss found that despite the polarity of views, the analytic pole was far more clearly defined than the somatic position. The "centre" of psychiatry was clearly perceived as lying in the psychoanalytic position even among the somatotherapeutic psychiatrists, who did not have a "centre" position. The typography of practitioners in that study, included "talking, shocking, analytic, organic, dynamic and non dynamic" psychiatrists. Responses to the interview material also provided mention of such psychiatric practices as milieu therapy, community programs and hospital psychiatry.

Practitioners from the psychoanalytic position identified themselves as in the process of "entering" that community, as occupying the middle-ground, or as representing some extreme along a continuum of psycho-dynamic views. The analytic orbit represented a clear world view with well-defined career lines inside that perspective. Their orientation was "analytic," and their professional title "analyst." In comparison to this orientation, other local psychiatric orbits were skewed so as to be almost invisible.

When questioned about the relationship between psychoanalysis and the practice of psychiatry, the analytic community divided along two response patterns:

1) that the only useful psychiatric theory was analytic or derived from it.

2) that psychoanalysis is "separate from" psychiatry, overlapping in part in the practice of general psychiatry. (It represented a specialized segment of psychiatry, dealing with a particular type of

patient population, entailing a special type of practice.)

Strauss experienced some difficulty in finding respondents who would typify the non-analytic or somatic position. Even those practitioners whose treatment modality was exclusively somatically oriented described themselves as "in between the analytic and somatic" poles. The somatic oriented practitioners did not provide a middle position in the form of an organized set of ideas (ideology) but tended to define their orientation in terms of what they "were not."

The reluctance of practitioners to present themselves as solely committed to the somatic ideology provided an interesting observation. Since the purist definition of that ideology implies that it is a more "scientific" and potentially more adequate position than any of the other professional orientations, one would have anticipated a higher level of identification with that position. Strauss proposes that one reason for the low visibility of the somatotherapeutic position may be that "the somatotherapeutics do not identify themselves as psychiatrists." (Strauss 1964 p 123) Emphases in training for those practitioners may have been in the field of "neurology," and psychiatric practice may be merely an over-lap function in their case.

The position held by the author of this research however, differs from that of Strauss on the question of visibility of the somatic position. From the literature, particularly that representing the radical psychiatric stance, the ideological features of the somatic position have been presented as "tainted" and distinctly unfavourable in a psychotherapeutic sense. The stereotypic fears of the lay public

(echoed to some degree by the profession itself) have been directed almost exclusively at psychiatric practice within the somatotherapy domain. The most evident examples of the unsavory aspects of somatic ideology which have been presented are:

1) The use of "shock therapy."

2) Lobotomy and other psychosurgical procedures.

3) The extensive use of drugs to control behavior.

4) The impersonal and dehumanizing aspects of somatic treatment forms.

It is a proposition of this research that the reluctance of practitioners to present themselves as ideologically committed to this orientation (despite its "practical" soundness) was due to the undesirable properties associated with these treatment modalities, rather than being due to the absence of a clearly-definable set of principles which define this position.

The methodological problem which arises out of identifying a "somatic" group within the psychiatric profession stems from the mixed role of the psychiatrist as physician-psychotherapist. While the overwhelming majority of psychiatrists interviewed in the Strauss study described themselves as "using psychoanalysis" as their major treatment form, there was also reliance on drug-therapy as part of treatment by those professionals who described themselves as "psycho-analytically oriented." In ascribing an ideological base to any psychiatric group, consideration must be given to the degree to which reliance on somatic therapy forms contradicts the respondents' identification with some other

professional orientation.

IDEOLOGY AND DIAGNOSIS:

The problems inherent in the diagnostic and classificatory systems of psychiatry have been alluded to earlier in this research. However, the ideological content which goes into the formulation of diagnostic procedures is dealt with at greater length in this section.

Terms such as "schizophrenia, psychosis, or immature personality" have been shown to contain ideological and evaluative components as well as serving a classificatory purpose. The effects of being labelled with such a term have been well documented, particularly within the sociological literature. (Goffman 1961, Spitzer and Denzin 1968, Scheff 1967)

Some valuable research came out of Lemert's (1951, 1968) treatment of the crude empiricism marking the formal classification systems of insanity. Lemert attempted to construct a sociological formulation of paranoia which included social/cultural determinants of the illness. "Paranoia" was shown to occur within an interactional model, where the observed behavior (i.e. acting out in a paranoid fashion) could not possibly occur without the consent and active participation of the individuals interacting with the person displaying the pathological behavior. Lemert in fact suggested that "conspiracy, fear, and coalition formation" were more evident among the individuals with whom the paranoid individual interacted than in the behavior of the disturbed individual. (Lemert 1961)

Lemert was suggesting that a more adequate accounting be

made of the variables precipitating any psychological dysfunction, in order to protect a patient from diagnosis made in a social vacuum. He considered that sex, age, ethnicity, acculturation, urbanization, economic-status and intelligence all should be used in determining treatment selection on social-variable scales, alongside medical diagnostic criteria.

Diagnosis becomes less arbitrary in a context where reference to critical social situations and their relationship to the onset of symptoms is part of that diagnosis. Lemert's research can thus be viewed as an attempt to question the reliability of inconsistent psychiatric diagnosis. He states:

> Anyone who has ever sat in a diagnostic staff meeting of a mental hospital will appreciate the disagreements continually arising over the appropriate diagnosis for a patient and also the fortuitous factors often determining what diagnosis is finally chosen. In some hospitals the superintendent more or less arbitrarily settles such controversies; in others, a sort of supreme court procedure rules with 5 - 4 decisions no less common than in that great tribunal. Such things as the patient's economic status, whether a pension is at stake as in the case of war veterans--all of these as well as the special biases of staff physicians may give directional prejudice to the cumulative diagnostic picture of hospital mental cases. (Lemert 1951 p 117)

One example of ideological content being present in psychiatric diagnosis is evident in the classification of the "character disorders." Individuals so classified, are categorized not as persons labouring under some form of psychological dysfunction, but rather as a set of social pathology statistics. Wertham (1963) pointed to the weakness in making a diagnosis of "problem personality."

> By and large, current diagnostic designations of problem personalities are more presumptive than clinical, more administrative than psychiatric, more moralistic than analytic. (Wertham 1963, p 14)

He suggested that conscious and unconscious biases were present in psychiatric practice due to the imprecise nature of diagnosis. Terms used by psychiatrists arose from their disapproval, resentment, or annoyance, resulting in prejudicial and discriminatory diagnosis. Some of the terms Wertham identified as having these qualities within psychiatric practice were "unstable," "inadequate," "egocentric," "perverse," "aggressive," "hedonistic." The terminology employed by the diagnostician was relevant, because it underlined the ideological position of the practitioner making these statements. (i.e. It reflected the social reality and moral values of that professional.) Figure 5 illustrates the use of psychiatric nosology in terms of ideological rather than clinical-medical terms. The social factor is clearly evident as the division of diseases treatable in hospital vs. "office" settings.

Wertham accounted for the ideological content of psychiatric diagnosis as a product of the development of clinical practice. Careful clinical examination which had been part of Freudian psychiatry was viewed by Wertham, as having been displaced by "psychodynamic cliches." Franz Alexander's description of neurotic character as "an underlying revolt against public authority" was held by Wertham to be a socially dangerous concept. With regard to psychiatric attitudes to sociopathy as presented in the Diagnostic and Statistical Manual for Mental Disorders (DSM, 1956) Wertham demonstrates the social control aspects of that diagnostic group.

The section on "sociopathic personality disturbance," in current teaching textbooks sounds more like a policeman's manual than a physicians guide: Those who fail to "conform to

Figure 5

Psychiatric Nosology and its Social Functions

SOCIAL FUNCTION	DISEASE	SIMILARITY TO A PRECEDING CATEGORY	DIFFERENCE FROM A PRECEDING CATEGORY
Medical Practice	1. Medical disease	****	****
Hospital Psychiatry	2. Organic brain disease	Caused by bodily disorder	Psychological symptoms prominent
	3. Psychosis	Disabling psychological symptoms requiring hospitalization	No organic basis
Office Practice (Psychoanalysis and psychotherapy)	4. Conversion hysteria	Resembles bodily disease	No actual bodily disease
	5. Other psychoneurosis	Discrete "symptoms"; psychological conflict; undesirable	No resemblance to physical disease
Social Psychiatry	6. Character neurosis; behavioral maladjustments	Psychological conflict; undesirable	Patterned behavior rather than discrete symptoms

Source: Leifer, R., In the Name of Mental Health, Science House, 1969, Figure 7, p. 109.

the rules of prevailing cultural milieu" are suspect. (Wertham 1963, p 17)

THE "POLITICS" OF PSYCHIATRIC IDEOLOGIES:

Wertham held that the early humanist content which was evident in Freud's work has been largely vitiated by "scholasticism" in the subsequent development of psychoanalysis. Modern psychology has provided information about the diverse range of normal human personality. Psychiatrists, however, tended to deal with the social aspects of personality in the manner with which psychology had dealt with it in Pre-Freudian times.

Society was equated with culture as if it was a single homogenous mass without diversity and change. Psychiatrists have dodged the issue of "class" by referring to class differences as quantitative rather than qualitative strata differences. The psychological impact of "class" rather than cultural differences has frequently been downgraded in psychiatric theory. Equally, psychiatrist's perceptions of themselves as members of a privileged group in relation to the rest of society (in terms of economic and social power) have served to provide a protective barrier from sub-cultural affiliation with their patient populations.

Of the three sub-groups within Strauss' psychiatric sample, this view could be said to most closely approximate the position of the "classical analysts" (psychodynamicists) in their essentially conservative social perspective. The high level of "custodial" thinking associated with the somatotherapeutic position suggests that there too, a relatively high conservative ideological set might be present. Most

ideological flexibility, as well as higher levels of tolerance and ideological liberalism should theoretically be found in the socio-therapeutic sector of the psychiatric profession. The author initially anticipated a high correlation between the community oriented psychiatrists and high liberal (non custodial) thinking, but as the later chapters show, this expectancy was not borne out in the extant literature.

Wertham has suggested that despite personal analysis (or perhaps because of it) more and more psychiatrists are developing an "organization man" mentality. Ideological "shift" has thus been precluded, because professional barriers have prevented the levels of interaction between psychiatrist and patient necessary to cause psychological "change." In this sense, psychiatry has demonstrated that it is still a static and closed system, since "feedback" from the client population is viewed as incompatible with the therapeutic process involving expert-supplicant interaction.

Haley illustrates this dynamic at work in The Art of Being a Failure as a Therapist. (Haley 1969) "Resolution" in psychiatric terms, is seen by Haley as occurring when the issue of control in therapy has been adequately worked through. Acceptance of submission to the directives of the psychiatrist defines what Haley views as the psychiatric notion of "therapeutic gains."

Fromm (1955) claimed that as a basic tenet of social psychiatry, a widely held assumption that the "masses" as such were always inferior to the individual, was held. A second basic tenet of psychiatric ideology was that the social system was superior to the individual. Synthesis

of these two assumptions, however, reveals that two strongly contradictory ideologies have in fact been advocated by the psychiatric profession.

One position it would seem, was designed to promote the occupational interests of the practitioners, the other to pay lip-service to the notion of service to the individual as the most important unit of society. The negative aspects attributed to the "masses" by the profession were shown to be both prejudicial and unsound, since the masses were made up of the average of those "individuals" which the profession claimed to prize so highly. (Fromm 1955)

In current psychiatric practice, social process is reduced by and large to the "inner conflicts of the individual." The autonomic biological boundaries which were enunciated by Freud are still generally viewed as governing human behavior. Psychiatry has not sought to deal with the individual outside of his intra-psychic components or as part of a social "whole." In this respect ideological and practical demands have prevented the profession from dealing with objective social phenomena (such as socioeconomic class) which are not completely reducable to intra-psychic processes.

Restriction of social process to such "mini-units" as the family has not adequately mirrored developments in the larger society. Freud and Marx both mistakenly assumed that the fundamental unit of division of labour was familial rather than tribal. Freud never reviewed that mistaken position, despite his subsequent focus on "Society and its Discontents." The weakness of that position is currently being

revealed in the changes which are occurring with regard to current economic role performance in the nuclear family.

Some ambivalance and paradoxic qualities of psychiatric ideology have been suggested in this research. It is, however, in the area of clinical practice that manifest ideological problems have become explicit. On the one hand, psychiatrists have advocated "self-expression" and individual mental health as an ultimate social and ethical value. In practice, (particularly in the sphere of hospital psychiatry) individual conformity to the status quo has been defined as the criterion by which mental health is achieved.

The need for the psychiatric profession to function as social critic was resisted by Freud himself, since he viewed his social role as that of physician only. The scope of current psychiatric practice and influence however, has clearly gone beyond the field of conventional medicine. Psychiatry today plays a role in the laws governing mental health, the dispensation of the property of the insane, and the "policy-decisions" governing the administration of mental hospitals. These social functions involve psychiatry in much more than the provision of purely medical services, and demand a more rigorous examination by the profession of its socio-medical function.

PSYCHIATRIC IDEOLOGY AND THE LAW:

The nature of the relationship between psychiatric and legal practice is central to many of the ideological positions which have evolved in the area of mental health. An account of the interaction between legal and psychiatric ideology has been provided by Jerome Hall. (1966) Figure 6 demonstrates the adversarial nature of the

Figure 6

The Effect of Legal Counsel upon the Admission of a Civil Commitment Process in a Mental Hospital

	Admitted	Not Admitted	Total
Legal Counsel	4	11	15
No Legal Counsel	61	5	66
TOTAL	65	16	81

Source: Wenger, D. and C. R. Fletcher, "The Effect of Legal Counsel on Admissions to a State Hospital: A confrontation of professions." Journal of Health and Social Behavior, 10, March, 1969. (Table 9, p. 152).

interaction between the courts and the mental health professions. In cases where only psychiatric views were present, the commitment vote was much higher than when legal counsel had input into such civil commitments. (The table does not address itself to the legal systems' separation of counsel and civil commitment procedures).

While the two were seen to have complemented each other in the past, Hall suggests that at the present time, psychiatric ideology has produced an "attack" on the law, in a power struggle for the greater support of government. The attack comes not against inhuman aspects of the legal system, but in order to make law subservient to psychiatric demands for greater control over human behavior. He states:

> The vaunted "humanitarianism" of psychiatrists demands in the name of science control of the lives of hundreds of thousands who have violated no law or have committed only petty offenses. (Hall 1966 p 117)

In psychoanalytic theory, criminal behavior was not differentiated from mental illness in terms of causality. Whitlock (1963) suggests that "determinism" was stressed far more in forensic psychiatry than by legal practitioners, when ascribing reasons for the commission of a particular act. The ideological battle between psychiatric determinism and the legal professions advocacy of the "free will" position led to growing friction between these groups. Each profession sought to impose its' view on the conduct of jurisprudence. (Alexander and Staub 1962)

The classic McNaughten rule of 1843 limited the options which were available to the psychiatric profession in their dealings with the

courts. The plea of insanity had not of itself proved sufficient to constitute a total defense. When strictly interpreted, the law protected only the acts of the most severly disturbed individuals. In 1896 the New Hampshire Rule provided precedent for an expanded role by the psychiatric profession in dealing with all criminal behavior which was an "off-shoot of a mental disease." Psychiatric determinism was further reinforced in Alabama in 1886 under the Irresistible Impulse Test, giving the profession a stronger foot-hold in the legal system.

The final victory of psychiatry came with the Durham rule of 1950 which stated that a defendent was to be found not guilty if his act "was the product of mental illness." The scope of the Durham rule expanded psychiatric input into the courts to such an extent that reasonably liberal interpretation of this rule would have given psychiatry priority over the legal profession in many decisions. While strict interpretation has been associated with the Durham rule until the present, the psychiatric invasion of the legal system has aroused strong antagonism from the legal profession. (Hall 1966)

The psychiatric position with regard to criminal liability has emphasized the value of subjective liability rather than the rigid objective position of the criminal code. However, as Katz (1970) points out, where the Durham rule has resulted in hard core criminals being remanded for psychiatric treatment, the profession has been reluctant to accept them, since they constitute a population that is harder to rehabilitate and hence are at variance with the interests of the psychiatric

profession, but not with its ideological hegemony over diverse areas of human behavior.

SOCIAL CLASS AND PSYCHIATRIC TREATMENT MODALITIES:

The ideological variables which shape the nature of client-selection and treatment have been researched within several disciplines. One study which investigated the ideological dynamics underlying psychiatric practice was a sociological analysis of the relationship between social class and the selection and treatment of patients at a psychiatric out-patient clinic (Meyers and Schaffer 1954).

Meyers' study focused on the availability of a single treatment modality (psychotherapy) for people from differing social classes with a single disorder (neurosis). The study dealt with the argument that psychotherapy is expensive and is administered only in private practice. This was the reason advanced by psychiatrists for the failure of lower social class individuals to receive psychotherapy. In this study, potential patients were divided into five groups designating particular class-levels, Class I representing the highest social class group, Class V the lowest group. Of the lowest class, two thirds were not accepted for psychotherapy at the intake conference. One tenth of classes I and II were not accepted.

The study showed that significant differences were also present among the personnel who administered treatment to those who had been accepted. Trained staff psychiatrists treated class I and class II patients. Resident psychiatrists in training treated class III and IV type patients. Type V patients were treated by medical

students taking a four week course. (See Figure 7)

The selection procedure employed by the psychiatric practitioners in this study, presented an ideologically discriminatory position. Even where the economic factor and form of illness were held constant, acceptance into therapy, the nature of clinical treatment, and the duration of therapy were all significantly linked to the patients' social class.

An earlier study by Redlich and Hollingshead (1953) had also found a significant relationship between social-class background of patients and the type of psychiatric treatment they received. A distinctly higher percentage of patients from upper social classes had received some form of psychotherapy, while the percentage of persons receiving custodial care or some form of organic therapy was found to be much greater in the lower social classes. More recent studies of the same area have tended to replicate the Hollingshead and Redlich studies. Figure 8 demonstrates the therapy modality by social class distribution found in the original study.

HAS "IDEOLOGY" BEEN INVOKED TO MAINTAIN HEGEMONY OVER PRACTITIONERS THEMSELVES?

Dibble had suggested that in a given occupational group, the extent to which practitioners collectively interact with a variety of other groups, determines their perceptions about the nature of their work and the services they provide. "Ideological" choice to devote the majority of research, and service to the least rather than the most urgent problem areas has done more damage to psychiatric

Figure 7

Type of Treatment, Duration of Contact, and Acceptance into Therapy as a Function of Social Class at a Psychiatric Clinic

Table 1. Percentage Distribution of Patients by Social Class and Intake Conference Desicion

Conference Decision	Social Class II	III	IV	V
No treatment recommended	11.8	9.6	22.2	64.3
Assigned to staff	35.3	17.3	2.8	.0
Assigned to resident psychiatrist	29.4	38.5	30.6	2.4
Assigned to medical student	.0	9.6	26.4	23.3
Assigned to other therapist (social workers, psychology students)	5.9	7.7	9.7	7.1
Referred to other agencies	11.8	17.3	4.2	2.4
Unknown*	5.9	.0	4.2	.0
	100.1	100.0	100.1	100.0

Chi-square = 81.7924, p less than .001.N = 183.

*Unknown cases were not included in the chi-square computation.

Source: Myers and Schaffer. Social Stratification and Psychiatric Practice. A study of an Outpatient Clinic. American Sociological Review, 19, 307-313.

Figure 7 (continued)

Type of Treatment, Duration of Contact, and Acceptance into Therapy as a Function of Social Class at a Psychiatric Clinic

Table 2. Percentage Distribution of Patients by Social Class and Duration of Contact with Clinic

Length of Contact	Social Class II	III	IV	V
Less than one week	11.8	26.9	37.5	47.6
1-9 weeks	29.4	26.9	33.3	38.1
10 or more weeks	58.8	46.2	29.2	14.3
	100.0	100.0	100.0	100.0

Chi-square = 17.5029, p less than .01. N = 183.

Table 3. Percentage Distribution of Patients by Social Class and Total Number of Times Seen in Clinic

Times Seen	Social Class II	III	IV	V
One	17.6	23.1	38.9	45.2
2-9	29.4	28.8	40.3	42.9
10 or more	52.9	48.1	20.9	11.9
	99.9	100.0	100.1	100.0

Chi-square = 22.5410, p less than .001. N = 183.

Source: Myers and Schaffer. Social Stratification and Psychiatric Practice. A study of an Outpatient Clinic. American Sociological Review, 19, 307-313.

Figure 7 (continued)

Type of Treatment, Duration of Contact, and Acceptance into Therapy as a Function of Social Class at a Psychiatric Clinic

Table 4. Percentage Distribution of Patients Accepted at Intake Conference by Social Class and Duration of Therapy

Times Seen	Social Class II	III	IV	V
1-9	25.0	36.8	70.0	71.4
10 or more	75.0	63.2	30.0	28.6
	100.0	100.0	100.0	100.0

Chi-square = 15.4446, p less than .01. N = 114.

Source: Myers and Schaffer. Social Stratification and Psychiatric Practice. A study of an Outpatient Clinic. American Sociological Review, 19, 307-313.

Figure 8

Distribution of the Principal Types of Therapy by Social Class

Social Class	Psychotherapy		Organic therapy		No treatment	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
1	14	73.7	2	10.5	3	15.8
2	107	81.7	15	11.4	9	6.9
3	136	52.7	74	28.7	48	18.6
4	237	31.1	288	37.1	242	31.8
5	115	16.1	234	32.7	367	51.2

*Class 1 is the highest class, Class 5 is the lowest class

Source: A. B. Hollingshead and F. C. Redlich, Social Class and Mental Illness: A Community Study, Wiley, 1958. (Figure 7, p. 51).

practice than any theoretical shortcomings. Philosophical inconsistency has at times made psychiatric practice and ecumenic ideals uncomfortable partners. As Wertham suggests:

> It is my thesis, based on many years of experience that in its overall effect in our present-day society psychiatry serves a praetorian function. The praetorian guard in ancient Rome guarded the leaders of government and became more and more a general influence supporting the old and established and preventing social changes toward the new. Some atomic scientists who have done their duty to science and to government now feel guilty at the consequences. Psychiatrists do not seem to have any such guilt feelings. I would like to arouse them. The greatest task of our society is to adjust its structure to the enormous advances of modern technology. What was right at the time of the Vienna fiacre is reactionary in the time of rockets and atomic power. (Wertham 1963 p 413)

Modern psychiatry fosters the illusion (Whyte 1956) that since Freud, internal reforms in theory and practice have prevented the evolution of a praetorian profession. However, by upholding power and privilege, the psychiatric establishment (as opposed to individuals and groups within the profession who have resisted it) has sought (with some success) to promote an ecumenic image which is very different from its actual role.

Practitioners with "lower-class" clientele have enjoyed least prestige within the profession in the same fashion that those with the greatest need of psychiatric help have benefited least from what psychiatry has had to offer (Myers and Schaffer 1954, Roman 1974, Schulberg and Baker 1975). In order to minimize the discomfort of being identified with this position, some "activist" professionals have tended to minimize their contacts with socially elitist psychiatric principles. This ideological fragmentation has resulted in dismemberment from the larger psychiatric body, laying the foundation for

the maverick "radical therapist" movement within psychiatry.

Ideological fragmentation has in turn served to weaken the ideological hegemony of the psychiatric profession, allowing other mental health professionals to "take up the slack" and fill the vacuum created by these ideological splits. Moreover, ideological conflict has served to slow down psychiatric domination of the mental health professions in the absence of a unified professional ideology.

Psychiatry, however, has not been blind to public reaction to increasing social control in other sectors of society, such as the schools, the prisons and other total institutions. Psychiatric attention has more recently been directed towards "socially relevant" ideological domains. The profession has become increasingly involved in the practice of "community psychiatry" to achieve social and political change through the community psychiatric movement. (Halleck 1971) In order to ensure that the administration of these programs remained under the direction of the psychiatric profession, new training paradigms such as Public Health Administration have emerged in the universities and medical schools, alongside the community psychological movements.

Despite the "shifts" in ideology which have been demonstrated in psychiatric practice, some features of earlier psychiatric practice remain evident. This research will address itself to examining those areas of psychiatric practice where "residual" ideological properties may still be present. Some psychiatric principles which are associated with traditional medical-model psychiatry will be investigated in an attempt to measure their presence among the practitioners included in this study. Examples of residual ideology in psychiatry are as follows:

1) Expert-Supplicant Interaction

2) Downward flow of ideas

3) Locus of change resting in the individual

4) Failures in therapy attributable to the motivational failures of the patient

5) Delegitimization of the experiental domain of psychiatrically labelled individuals.

In this chapter, the social concerns of the larger society have been shown to be very much affected by the type of "change" that occurs in the hospital, or on the office-couch. Acknowledgement of the vital social function which psychiatry is called upon to play is potentially its most ecumenic and far-reaching task. Yet the limited visibility of the profession on social issues and the conservative nature of its practice until the present, suggest that mainly "occupational" ideological interests have been stressed in psychiatric professional positions to this time.

Chapter IV

THE PSYCHOLOGY IDEOLOGIES

IDENTIFYING PSYCHOLOGICAL IDEOLOGIES:

Within the psychological profession much discord and controversy has divided the ranks of practising psychologists into two groups, loosely defined as "humanistic" and "behavioristic" in orientation. This division has its evolutionary roots in theoretical differences of opinion about the philosophy of science and methods of inquiry. (The division into two ideological camps parallels the dialogue between humanism/idealism and rationalism in the development of the social sciences.) At the practical level, however, clinicians from these opposing schools of thought have fought over ideological concerns as they apply to the provision and content of mental health services. An exchange of views on these philosophical and methodological differences is to be found in the symposium between B. F. Skinner and Carl Rogers. (1956)

The behavioral-psychological tradition reflects the antithesis of "self-actualizing" notions of therapy. It is deterministic rather than spontaneous, based on an impersonal theoretical framework, (learning theory) and holds particularized views about human nature and society. Behaviorism relies strongly on rationalization of the dictum "all men control and are controlled," (Skinner 1956) on dehumanization, and scientism.

Behavior modification therapy, the clinical off-shoot of behaviorism has been defined as consistent with the tradition of therapy

as social control. (Jourard 1961, Rogers 1956, Kopp 1972) These therapy forms are based on present observable behaviors rather than unconscious factors, and are designed to remove symptoms causing discomfort without "tampering with selves and souls or even personalities." (London 1964) The most frequent accusation made by the humanist school and equally by psychiatrists who adhere to the medical model, is that at the level of professional services, what the behavioral therapist is doing, is merely covering one form of pathology and creating a new one. This effect has been called symptom substitution.

Behaviorism rejects the Freudian assumption that insight leads to changed behavior. For behavioral therapists the converse would appear to be true; i.e., that changes in overt behavior lead to more adequate living, and hence greater insight. Behaviorism equally rejects humanist psychology as "sentimental and muddle-headed." (Eysenk 1972) It is much more concerned with technical facets of behavior such as "efficiency," prediction and control. The behavioral literature reflects a starkly mechanistic orientation to therapy. (Example - the therapist as social-reinforcement machine, Krazner 1961)

The ideology of behaviorism is widely associated with the work of B. F. Skinner. The social philosophy underlying his work is that of social determinism. The methodological procedures to be employed are an extension of that philosophy. (Walden II 1962, Brave New World 1967, Beyond Freedom and Dignity 1970) In contrast to existential or self-actualizing theories of behavior, Skinner believes that people behave in certain ways not because of any innate goodness

or evil but because they are reinforced for doing so. (Rogers and Skinner 1956)

Ideological differences have been evident among professional psychologists in the same manner that they have polarized psychiatrists. Professional differences have tended to be much more clearly defined in terms of "philosophies of psychology" rather than in the nature of services provided by the profession.[2] The dynamic-organic dichotomy which has separated psychiatric ideological positions, has been secondary to philosophical perceptions regarding the investigation of human behavior in psychology. This conflict has focused on the "humanist" and "behaviorist" theories of behavior and intervention. As a single professional group, both schools of psychology have also presented ideological positions which stand in opposition to the "psychiatric ideologies" discussed in the last chapter.

The ideology of the psychological profession has often tended to down-grade the value of Freudian theory, though professional

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[2]The author was unable to trace any studies which dealt with "professional psychological ideologies" per se. No studies were evident which attempted to "measure" psychological ideological content in the sense that psychiatric ideological content has been measured, e.g. the PSI scale. The author suggests that the failure to find psychological "professional" ideologies similar to those of psychiatry, rests on the fact that the "training paradigm" for psychologists has stressed a "research" rather than a "professional" orientation. The literature suggests that the various orientations of psychology have emerged as academic "schools of thought" rather than formalized ideologies, at least until the recent past.

usage of Freudian terminology has ranged from the most "far out" existential psychological theorists, to hard core Skinnerian theoreticians. Social Darwinism too, has served to shape the evolution of the discipline's theory, perceptions of man, and ideological principles. On the "reinforcement" principle Miller states:

> Between men, reinforcement is usually a mutual relation and each person controls the other to some extent. What we (as psychologists) have tried to do is to describe its' psychological basis and its' limits in terms sufficiently general to hold across different species, and to suggest how the technique might be extended to educational, rehabilitative, therapeutic, or even political situations in which economic rewards and punishments would not normally be appropriate. (Miller 1969)

Dominant paradigms which have emerged in psychology have been based on largely ideological perspectives. The ideology of "control" often associated with behaviorism has made it not dissimilar from other social ideologies which reflected a view of social order based on coercion, punishment and retribution. The "humanist" model conformed to a second popular ideological position held by the larger society, (approximating the political criteria of "liberalism" in some respects) based as it was on principles of flexibility, autonomy and constructiveness. (Miller 1969) The third dominant ideology which was identified in this study, was the "corporate" ideology (governing large group organizations) referred to in this research as the "establishment" ideology in psychology.

Hudson (1970) studied the attitude formation of students of psychology as they passed through the ideological socialization process of "becoming psychologists." He concluded that success within the discipline was often a function of conformity to the ideological

prejudices of the implicit norms governing the politics of a particular training institution. Recognition of the norms governing ideological socialization, has also been observed in the training paradigm of the medical profession. (Becker 1961, Freidson 1973)

Hudson added that "academic socialization" in the discipline of psychology also tended to arouse an "artist-scientist" polarization and ideological conflict among the student body.

> These students were alert to the social and cultural processes; not only in 'society,' but within systems of knowledge..... And they take it for granted that the credo on which I myself was weaned - psychology as the science of behavior - is either at the descriptive level a mistake, or an utterance of covert ideology..... that both linguistic philosophy and behavioral psychology are part of a capitalist plot designed to prevent students from asking searching questions, not merely about the nature of their own discipline, but about the roots of power in the society in which they find themselves. (Hudson 1970)

Hudson's remarks, while sounding somewhat accusatory and overly-generalized, do tend to point to the roots of social control, where the base of power in society is governed by a particular economic/political control over "knowledge."

"ESTABLISHMENT" IDEOLOGY:

At the present time the ideological premises which govern the conduct of mainstream psychology are to be found in the positions advocated by its professional associations, particularly the American Psychological Association. (A.P.A.) In many respects this body espouses the same professional attitudes, as those put forward by its Psychiatric counterpart. In this respect it is also subject to the same degree of ideological fallibility as the psychiatric group. However, to the degree that "ideological" hegemony over mental

health is identified with the psychiatric profession, the ideological stance of the psychological association may be seen as still moving "in the direction of" control of some of the areas which had previously been in the jurisdiction of psychiatry only. Psychology's attempts to move toward greater control over such areas and to exercise territorial hegemony over them is demonstrated in Appendix I.

"Psychotherapy" and "community mental health" are the most visible areas in which the profession has sought to gain a foot-hold equal to that of psychiatry. Evidence of psychological "inroads" into hospital administration, ward programs, sex therapy and private practice have also been noted. (Schulberg and Baker 1975)

The official stance of the profession regarding social activism can best be observed from the presidential address to the American Psychological Association of 1969. In his address, Miller summarized the professional view as follows:

> There is nothing in the definition of psychology that dedicates our science to the solution of social problems. Our inability to solve the pressing problems of the day cannot be interpreted as an indictment of the scientific validity of psychological theories. As scientists we are obliged to communicate what we know, but we have no special obligation to solve social problems.

Demands from within that the profession be used as an instrument for social action have often been resisted, causing strain and disharmony among the professional membership. (Ladd 1969) The professional association's response to demands for social action by psychology (as voiced in the presidential address) were to decline, on the grounds that "expressed issues involving the promotion of human welfare, were likely to be at variance with the scientific and

professional interests of the membership." (Miller 1969) This statement, reflecting the ideological position of the profession on social issues fits Dibble's model of professional interests as displacing other ideological concerns.

The first article of the By-laws of the A.P.A. however, suggests something quite different from Miller's position:

> that the Association shall have as its' object to promote human welfare, a goal that is echoed in our statement of the "Ethical Standards of Psychologists. (A.P.A. By-laws 1968)

Thus, in accordance with Whyte's definition of the organizational mentality (1956) the psychological professional association may be seen as having moved in the direction of "occupational" parochial rather than "professional" interests. Certainly the nature of the professional association tended to reinforce Dibble's propositions about the self-enhancing and protective qualities associated with occupational ideologies, as evident in Miller's address to the A.P.A.

> Responsible spokesmen for psychology seldom emphasize the revolutionary possibilities of scientific psychology. One reason is that the general public is all too ready to believe it, and public resistance to psychology would be all too easy to mobilize. Faced with the possibility that revolutionary pronouncements might easily do more harm than good, a prudent spokesman finds other drums to march to. (Miller 1969)

The "official" view of the profession about its social role was to be found in its philosophic separation of the natural and the social sciences. The position of psychology was that it was not bound by either discipline, and that it represented a radical shift in <u>the methodology</u> of studying human behavior, (Kuhn 1962) by tampering with the adaptive processes of human evolution. The "revolutionary" aspects

of the psychological paradigm lost much of its validity, however, because of the parochial content associated with its professional goals. To the extent that the "ecumenic" properties of psychological ideologies were neglected by the behavioral sciences, the parochial nature of their investigation precluded the attainment of the professional goals which A.P.A. enunciated.

Mainstream psychology's parochial occupational interests short-circuited its claim to be engaged in a process of "radical transformation of knowledge," as a consequence of its self-confessed ideological ego-centricity. One way of interpreting the posture of A.P.A. vis a vis the understanding of human behavior is to view it as a defensive reaction to what it perceived as the domination of the behavioral sciences by the psychiatric profession. (The analogy to be drawn here might be defined as professional "sibling rivalry." This point will be pursued in more detail in Chapter V.

In presenting the psychological professional ideology, (Miller 1969) the fears of the lay public (shared by many social scientists including some psychologists) about the abuses related to the control of human behavior, were down-graded and discredited but never completely disproved. The control features which psychology has associated with psychiatric ideology, produced a remarkably similar defensive and selfjustifying response from the profession of psychology when confronted with these features in own professional ideology.

The "establishment" position in psychology has been that the understanding of diagnostic principles involving personal and social

problems is only possible if the "controlling" aspects of behavior are understood. (Miller 1969). However, this premise stands in marked contradiction to an earlier professional position which stated that psychology in its occupational role should have no direct involvement in social issues other than those which were directly associated with the interests of psychology. (Miller 1969) What could be more socially relevant than a science which addresses itself to research based on the need to uncover the principles which govern social behavior? Disclaimers notwithstanding, Miller's position suggests a clear ideological commitment to a view of behavior based on "control."

> All we want is to discover how the controls work. Once we understand that, society can use the knowledge in whatever manner seems socially advantageous. Our critics on the other hand want to know who will diagnose our problems, who will set our social goals, and who will administer the rewards and punishments. (Miller 1969)

Mainstream psychology in its ideological and professional stance, provided models which have not served the ecumenic ends providing for wide-spread acceptability. Indeed, the focus on purely professional interests has led to substantial criticism of the type to which Miller refers in the previous paragraph.

Unlike the psychiatric profession, the position of psychology on "holding on to specialized forms of knowledge" has been far less parochial in this respect. In terms of professional hegemony (at least at the higher levels of professional psychological organization) a more ecumenic stand regarding the implementation of psychological principles has come from the psychologists. Their willingness to share their brand of knowledge with the larger public may be interpreted in a

number of ways:

a) It promotes the aims and interests of psychology in a truly ecumenic fashion.

or,

b) It may reflect psychology's less-prestigious position in the hierarchy of mental health professionals, providing an example of psychology's under-evaluation of its product when compared with that of psychiatry, rather than a bona fide desire to "give psychology to the people."

Miller's position (reflecting the establishment view of the profession) suggests that psychology is indeed currently still at the stage of tying to gain wider acceptance among the larger society. Dibble's model suggests that the level of ideological occupational evolution in psychiatry has already passed through this phase, addressing itself to issues of greater ideological complexity and structure. Psychology's willingness (even eagerness) to share its findings with the public are evident from Miller's proposals.

> Part of the answer is that psychology must be practiced by non psychologists. We are not physicians; the secrets of our trade are not to be reserved for highly trained specialists. Psychological facts should be passed out freely to all who need and can use them. And from successful applications of psychological principles the public may gain a better appreciation for the power of the new conception of man that is emerging from our science. (Miller 1969)

Mainstream psychology has offered some level of commitment to interaction with other social institutions, in dealing with issues of social change. As mentioned earlier, it has demonstrated a more visible presence in such social institutions as the schools, the justice system, industry and the public health system . In many cases the

profession has had to provide new definitions and methods for dealing with issues which the more traditional medical model could not deal with.

Unlike the medical model, it acknowledges the increasing alienation of society's members from its institutions, and the breakdown of the social system based on punishment and retribution. While denying a commitment to any particular form of social activism, psychology even in the "established" paradigm has provided a more inclusive and flexible model than the psychiatric medical model. The "social awareness" aspects of psychological professional ideology, by comparison, show the positions of psychiatry on such issues as social dissent, political activism and discrimination to be conservative by nature.

> Vested interests will oppose these changes, of course but as someone once said, vested interests however powerful, cannot withstand the gradual encroachment of new ideas. If we psychologists are ready for it, we may be able to contribute a coherent and workable philosophy based on the science of psychology that will make this general agitation less negative, that will make it a positive search for something new. (Miller 1969)

The author of this research accepts as a working hypothesis that the nature of psychological ideologies make them less resistant to change than the more developed psychiatric ideologies. This proposition is in agreement with the literature presented in this research and with several of the hypotheses from the earlier sections. A consequence of accepting this position is that the researcher must seek to account for the manner in which these psychological ideologies shape the nature of research, intervention and "outcome" in applied clinical

settings in a manner that is substantively "different" from that of the psychiatric ideologies. Hence, it is vital to this research to identify the axis upon which the major ideological positions in professional psychology tend to polarize. In Chapter II a socio-historic account of the evolution of psychological ideologies was provided. In this section, the research provides a description of both ideological positions ("humanist" versus "behaviorist") by explaining some of their basic assumptions.[3]

HUMANISTIC IDEOLOGY:

This school or system of psychology has been historically linked to Western Philosophical thinking, but has come to include components of Eastern mysticism and European Existential thought. Clinical applicability has evolved out of its philosophical bases. The major cause for the rise of this movement in psychology was attributable to a perceived need among some psychologists "to do justice to healthy human functioning, modes of living, and goals of life." (Maslow 1962) It was felt that these goals were not central to other psychological orientations. (i.e. Behaviorism and psychoanalysis) Collectively, adherents of these ideological tenets in psychology came to be known as "the 3rd Force."

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[3]A 3rd major ideological force in psychology exists among "psychoanalytic psychologists." Their ideological positions have not been reported in this study, since the ideological variables attributed to this group have not been shown to differ significantly from the psychoanalytic psychiatric group. Within psychology, views held by some colleagues have described this group as performing the role of "mini-shrinks," accepting the dominant ideology in mental health as being the medical model, and tailoring the practice of clinical psychology to fit that ideology.

For the purpose of collective description, the common attributes along the spectrum of practitioners in this group are emphasized in this research. Different areas of emphasis among them, have tended to create an emergent "system" within psychology rather than a particular school of thought. Some have emphasized understanding the human being as a whole (Gestalt), others the need for deep analysis of the experiential qualities of life (the Existential Analysts), still others, the "growth" and actualization drives in human behavior. (Maslow etc.) Briefly, the humanists represent an open system of emerging orientations within the profession.

The scientific study of human behavior has frequently looked at the individual as a member of a group. Observations about behavior involved the study of specific functions and role structure in that context. The humanist ideology however, has been concerned with "the individual" as the most logical and desirable unit of analysis. It has emphasized the uniqueness of each person as a repository for whole ranges of potential behaviors. Unlike the single-organism design of the laboratory-controlled psychological paradigm, the methodology of the humanist tradition has been to differentiate among "existential" layers (i.e. qualitative differences) associated with the life processes of every person.

In order to deal with this form of psychological experience, the evaluative components of behavior have in some ways been replaced by attempts to understand rather than explain in absolute links of causality or predictability. This form of understanding behavior was

suggested in Max Weber's notion of "Verstehen" and espoused by modern theorists such as Buber, Kierkegaard and Bugental. The thrust of this position has been that levels of "knowing" a person were dependent upon perceptions of him as a "whole entity within a system of meaningful relations."

Criticism of this orientation within the profession has often been voiced on methodological grounds. It has been suggested (Allport 1937) that making the scientist a part of the process which he is studying, imbues the ideographic method with subjective and non-scientific qualities. The response of the phenomenological humanist school of science has been that:

> Comprehension on the basis of personal participation, is neither an arbitrary act nor a passive experience, but a responsible act claiming universal validity. (Polanyi 1958 p 83)

What separates the humanist movement from the behavioral school in methodological concerns, (and in the ideological sphere) is in the issue of predictability. Even the behavioral school itself has concluded that to assume that behavioral psychology (in the experimental paradigm) can be validated at this point in time would be a form of self-deception. (Yates 1970)

The importance of a cumulative account of individual life-histories has been central to the humanist clinical tradition and to the profession of psychiatry. The central ideological difference between the humanist school and psychiatric practice, however, has been that psychiatry seldom sought to relate the patient to the course of "his life as a whole," while for the humanists, the existential elements

of an individual's "beingness" have been intricately related with his life experiences as a centralizing, unifying and core aspect of the total human being. (Buhler 1973)

The existential component has been a pre-requisite for humanistic clinical thought in every facet of the conduct of humanistic psychotherapy. It has served as the "barricade" against the biological determinism of Freud and the behavioral determinism of Skinner. The essence of the humanist ideology, has been the notions of intentionality and responsibility in human behavior. These precepts have caused both the medical and behavioral models some difficulty in accounting for such behavioral phenomena as novelty, curiosity, spontaneity and "play" behavior. The humanists sought to proclaim the autonomy of the individual, and to promote rather than suppress human freedom and dignity.

Rollo May (1969) conceived of "intentionality" as the human experience of self. Unlike the psychoanalytic position which conceived of self as an object which merely reflected the human mind, May's existential self constituted the "inner-core of identity," the only authentic goal-setting mechanism which was present in every person.

In the social sciences, teleological assumptions about causality plagued the research methodology which was employed. In opposition to this model of inquiry, Kuhn proposed his radical shift in the paradigm of learning. Kuhn's position seems to have been taken up by the phenomenologist methodology and incorporated into the humanist position. (Ryan 1970) The fallacy of the teleological position of causality it was suggested, lay with its overriding assumption that

homeostasis was the end goal of the human organism. It was assumed that human behavior conformed to the empirical models of the natural sciences.

The psychoanalytic thesis was that the healthy person would fit the model of homeostasis; having an alternating need for action and relaxation. This model was subsequently negated by the Humanist position. Eiduson's (1962) study of chemists supported the humanist contention that the creative persons predilection towards problem-solving moved him in the direction of resolution rather than avoidance, so that homeostasis was not the inevitable drive-state guiding human behavior.

Goldstein and Buhler (1959) suggested that only a "sickness" paradigm, conformed to the homeostasis model of organisms, so that any "healthy" organism would not have an homeostatic drive, but to the contrary, would be an active, goal-seeking, "emerging" and growing organism. In terms of human behavior, Maslow used this model to describe psychological growth as a positive, non-normative force which he called "self-actualization." (Maslow 1962)

The growth or actualizing view of human behavior did not conceive of everyone as consistently moving in the direction of growth in a linear fashion. A feature of the growth ideology, was that it constituted a "struggle" paradigm which included side-stepping, slowing down, peaking and periods of rapid acceleration and stagnation. The humanist model was in many ways as ideologically-bound as the Freudian model with its emphasis on "psychopathology" and the "control" features

of the behavioral model. Indeed, for the humanists, psychopathology was not conceived of as occurring where "non-normative" behaviors were presented, (Behavior may be non-normative and positive) but where drives toward actualization and growth were frustrated. As Buhler states:

> In psychoanalysis, Freud the great discoverer of the process of repression of conflicts and guilts into the unconscious, theorized that all human conflicts resulted from the clashes of the individual's wishes with reality's obstacles and society's demands. The new version in humanistic psychology is that guilt feelings arise in an individual who squanders his life and does not live up to or does not develop his own best potentials. (Buhler 1973 p 11)

Buhler further suggested that the conflict between Freud's "pleasure principle" and Maslow's "actualization principle" was not the core ideological issue. Unlike the gloomy prognosis on youthful dissent voiced by Anna Freud, (cited in Chapter II) Buhler viewed conflict as existing between a complacent and secure self-adaptation to life circumstances and the daring creative struggle <u>against</u> such a view as the central humanist/existentialist position. The support for this struggle was one of the criteria by which he defined the humanist position. The humanist ideology defined conflict as a creative and adaptive renewal in the struggle for human development.

> Struggle toward what? Toward something which this new youth is not yet able to formulate properly, something which has to do with new but as yet unclear visions of life, something valuable that will improve and enrich the world. (Buhler 1973 p 14)

The ideological premises of humanist psychology have had a great deal of input into shaping the models and strategies of intervention within the mental health professions. Despite the "unscientific" principles with which it has been identified by its adverserial colleagues, it was one of the "humanist" practitioners who established the

procedures by which the conduct of psychotherapy could be objectively studied and evaluated. (Rogers 1957) His methodology served to detract from the mystique associated with pre-Rogerian psychoanalysis. The nature of the client-therapist relationship was changed from that of pure "transference" between patient and therapist to one which demanded congruence, authenticity and personal involvement by the therapist in the exchange process.

The humanist ideology also served to shape a change in the larger society's attitudes toward the mentally ill. Phraseology which had contained discriminatory, perjorative or "loaded" evaluative statements about individuals were replaced by such terms as "emotional problems, problems-in living and existential crises."

Unlike the behavioral or mainstream position in psychology, the humanist movement often found itself in an adversarial position with regard to "technical proficiency." In the sense that Marx addressed himself to "false-consciousness," the humanist movement sought to free creative social forces from some of the crippling effects of modern technology, not least of which were the dubious rewards of "behavioral" engineering. Emphasis in the ideological framework of the humanist sector of the profession has been in the direction of spontaneity, actualization and the "transcendence" of behavioral problems.

THE BEHAVIORAL IDEOLOGY:

The contention of most adherents to the behaviorist position is that theirs is a purely methodological stance divorced from the ambiguity of metaphysics or from any ideological concerns. That claim is best substantiated by Eysenk (1972) and Bandura (1969). Their

description of behaviorism is that it precludes the use of "unscientific methods without generating an instrumental ideology."

> Out of all this, behaviorism emerges as something really quite colourless, and without any distinct doctrine. What it has to say is simply that psychology is a scientific discipline; that as such it has the right to pick the concepts which it finds most useful in carrying out its task; and that like other scientific disciplines it has only one request to make of metaphysics - get off my back! Behaviorism is not really a "school" of psychology, in the sense that its teaching has some specific content (as in the case with psychoanalysis, for instance, or the Gestalt school); under its umbrella there are gathered extremely varied groups of psychologists with little in common other than an urgent desire to get on with the experimental work necessary to give a firm basis to the building up of a modern psychology worthy to be called "scientific." What is there in all this that causes people to wrinkle up their noses and give vent to their spleen? (Eysenk 1972)

Behavioral approaches to psychopathology involve a "learning" paradigm for interpreting the mechanisms which underlie behavior. Causal properties of behavior are seen as being present in the reinforcement patterns which govern that behavior rather than from hypothetical internal drives which are associated with other theories, particularly psychoanalysis. In the case of deviant behavior, the behavioral perspective is quite similar to the sociological position of "labelling theory" as advanced by Becker. (1963)

Psychopathology is not viewed solely as behaviors which are detrimental to the individual or as symptoms of underlying pathology, but as ways in which a person has learned to cope with environmental and individual stress. "Deviance" is not a property of a particular behavior, but a reflection of the responses of societal agents to actions that violate prescribed codes of behavior.

Subjective forces which provide the labelling content of

Psychopathology as it is viewed by behaviorists include, the aversiveness of the behavior itself, the social attributes of the violator, the normative standards of the evaluator and the social context in which the behavior is performed.

Social learning theory (the basis of behaviorism) regards both pro-social and deviant behaviors as being "learned" from three distinct regulatory systems, which form the nucleus of the social reinforcement paradigm. "Control" over behavior can thus be examined in these three domains, external stimulus control, response feedback processes, and central mediation processes. (Bandura 1969)

The conceptual scheme of behavior-modification can thus be seen as involving an active process which seeks to establish control over all response patterns; to replace those behaviors which are deemed "inappropriate" with more salutory behaviors, or simply to extinguish unwanted behaviors. The essence of this treatment modality is "control," hence the question that is posed in this research is whether such a system can be regarded as having a "control-oriented ideology," or whether (as suggested by Bandura and Eysenk) it is merely a methodological system which has no ideological basis or properties.

In terms of clinical practice, behaviorists view themselves as unconcerned with the notion of "power" in the therapeutic relationship. This is one of the ideological criteria which they have employed in their critique of the other models presented in this research. Their contention, while making for good image management and providing a sound ecumenic function in furthering the behaviorist

position, does not stand up in terms of theory or practice. As a strategic tactic, the specific objectives of behavioral therapy are frequently left unspecified, in order to avoid acknowledging the value judgments and social influences involved in behavior modification.

In applied clinical practice, the literature suggests that behaviorism has indeed made a commitment to "selling its ideology" despite claims to the contrary. Martin (1971) suggests that behavior-modifiers have frequently violated their purported purely methodological paradigm, by moving toward a variety of strategies which are quite similar to traditional approaches to therapy.

He cites a particular study (Klein, Dittmann, Parloff and Gill 1969) which substantiates that behavioral therapy does not occur in an ideological vacuum. The behavioral procedures employed in that study were found to include a significant level of "indoctrination, teaching, and exhortation." Further, that study also revealed that some form of "therapeutic relationship" existed between therapist and client, so that therapeutic gains could not be attributed to purely methodological functions. (Berger and McGaugh 1965).

Out of Skinnerian philosophy it becomes increasingly obvious that the issues of "power" and "control" are not only present in behavioral thinking, but are essential features of the behavioral ideology. Despite its freedom from metaphysical concerns and the benign nature of behaviorism as it is depicted by Eysenk and Bandura, the social philosophical treatise of Skinner ties up the methodological practice of behaviorism with its ideological implications.

The behaviorist position advocates a stance that cannot be interpreted in an ideological vacuum. The implications which come out of the behavioral position indicate greater rather than lesser commitment to a specific ideology (control) than any other psychological position. "Behaviorism" then, goes much further than a methodological or scientific principle.

Science has often sought to explain human behavior in terms of causality and external conditions which account for various phenomena. The philosophical premise of behaviorist thought is that particular forms of behavior which are deemed "suitable, appropriate or normal" should be producible if the proper conditions to support those behaviors are met. By the correct manipulation of purely environmental conditions, the assumption is that new behaviors may be created or maintained, or that a tendency to engage in "undesirable" behaviors may be reduced or extinguished.

Skinner (1956) suggested that attempts to provide a "better world" have often provided foolish and unworkable propositions. He also claimed that any great change in society had been attributable to some perfectionistic philosophy, linked to changes in man's physical or cultural environment. Since man was viewed as being in control of his environment, Skinner suggested that this control paradigm was generalizable and appropriate to the area of human behavior as well.

> The simple fact is that man is able, and now as never before, to lift himself by his own bootstraps. In achieving control of the world of which he is a part, he may learn at last to control himself. (Skinner 1956)

Though it is evident that a "control" ideology was not deemed an appropriate manner of dealing with human behavior by other social scientists, Skinner attempted to equate the social philosophy of behaviorism with the interests of mankind. While performing an admirable ecumenic function (according to Dibble's criteria) his theoretical tenets of behaviorism were not easily integrated or accepted by the lay public or by other mental health professionals, since they frequently provided mechanistic reasoning for what were "human" problems. (Jourard 1971, Rogers and Skinner 1956)

Skinner's premise was clearly at odds with traditional democratic conceptions of man, but he attributed the penchant for democratic principles to mankind's "philosophical" need to be responsible for the conditions which shape his behavior. For Skinner, the increasing complexity involved in accounting for man's behavior made the human factor almost insignificant, hence the need for democratic principles was regarded as "unnecessary"and no longer relevant in a world of technological complexity.

The behavioral philosophy negated the value of free will under conditions of stress, since even the reactive component of man's behavior was interpreted as being determined by external conditions over which man had no control. Skinner, however, did not account for the fact that human behavior does not correspond to the paradigm of the natural sciences in every respect; that there is diversity and flux in human behavior. Behaviorism has thus far failed to produce perfect prediction about human behavior, even though this would have

enhanced the validity of its ideological position. While this is true for all the professionals discussed in the research, the behavioral position has been the one most invested in the prediction and control of human behavior.

Skinner attributed the democratic philosophy of social action to "political exigencies and techniques" and not to the goals of democracy: The ideological assumption being that democratic process is not the "intent" of "free" men, but the consequence of social goal-oriented behaviors. This ideological assertion however, did not gain credence, from the variety of political systems among which different societies have chosen to live. Skinner attempted a fusion of the ideological and political arenas in order to apply behavioral philosophy to a system of government in line with his political ideology.

> No matter how effective we judge current democratic practices to be, how highly we value them or how long we expect them to survive, they are almost certainly not the final form of government. (Skinner 1955)

One facet of behavioral ideology which was employed with great effect was Skinner's emphasis on the need to understand the nature of control, so that only "judicious" use can be made of this tool. Skinner assumed that by man's very nature he was both "controlled and controlling." He equated negation of this position with weakness, since according to his proposition, failure to assume benevolent positions of control would leave the field of control open to tyrannical or exploitive others.

A weakness in Skinner's proposition lay in his omission

of a single and vital point; namely, that it would not be possible to "control" (at least in the perceptual field) if the "other" toward whom control tactics were directed, did not react to those control-tactics. Skinner suggested a whole system of control and counter-control while ignoring the possibility that a "non-control" paradigm could exist. The behavioral position lost much of its credibility from that assumption, since Skinner was espousing a position which claimed validity out of an ideological rather than an objective statement. This had been the major target of behaviorism's attack on the "ideological" assumptions of other psychological theories.

Skinner derided the chaotic nature of anti-scientism as espoused by the humanist position. He saw no value in the "happy accidents" which shaped the nature of man's development. Since technical efficiency was central to the behaviorist position, fear about "the exercising of control over man's thinking" (Krutch 1954) was not held to be too great a price for an engineered culture. Certainly the technological arguments in favour of the behaviorist ideology were enticing, and in a simplistic form, they posed some provocative questions!

> Suppose that someday we possess such effective educational techniques that every student will in fact be put in possession of all the behavior specified in the syllabus. Should we reject such a system on the grounds that in making all students excellent it has made them all alike? (Skinner 1955)

Skinner was advocating that through control over social contingencies, perfection in behavior could be approximated. In terms of the social benefits which might accrue from a system of education such

as he proposed, he did not acknowledge the deleterious consequences which would accompany "conditioned education." It is exactly that conditioning factor which would be present in a behavioral educational system which would short-circuit the very reasoning faculties which education attempts to instill.

Equally, in terms of moral development, Skinner's model failed to provide a system for "shaping" ethical standards of behavior. Because of its mechanistic orientation behavioral ideology must be seen as postulating the development of "amoral" thinking. In Skinner's proposed "automatically good" society (as a product of shaped social behaviors) he failed to define the criteria that would make particular behaviors "automatically good." Thus, the depth of ideological (even idealistic) content in the behavioral position is self-evident despite its presentation as a purely instrumental or pragmatic approach. Even Skinner himself was aware that its major weakness was that no matter how sophisticated behavioral technology became, it could never control for random or chance effects in nature.

> It is reasonable to look forward to a time when man will seldom "have" to do anything, although he may show interest, energy, imagination and productivity far beyond the level seen under the present system (except for rare eruptions of the unplanned). (Skinner 1955)

IDEOLOGICAL INPUT INTO PROFESSIONAL PRACTICE:

The practice of clinical psychology has been shown to be differentiated more in terms of philosophy of psychology to which practitioners subscribe than in terms of differences in "training paradigms." A high level of commonality and eclecticism, however, is

evident in the training paradigms and clinical procedures employed across all the ideological positions, which sometimes tend to mask the differences in orientation to the practice of psychology. This eclecticism has even included some psychiatric principles in clinical psychology.

Even the "hardest" behaviorist positions make use of psychiatric terminology in describing their work, and use psychiatric classificatory systems to distinguish the types of behavior with which they are concerned. eg. Schizophrenia, autism, neurosis, etc. Equally, learning principles particularly "reinforcement" and "control" are present to some degree in every therapy modality, regardless of the ideological position of the practitioner. (The psychiatrist who merely nods his head when he is in agreement with a particular client-response is "shaping" a response repertoire in accordance with behavioral theory.)

This chapter has attempted to describe the "philosophy" of each orientation found among professional psychologists in order to account for the presence of ideological content in their treatment forms. Since the philosophical base of the practitioner determines the methodology with which he works, it constitutes the central indicant of the "type" of therapeutic intervention that will be provided.

Finally, with regard to the question of ideological hegemony within the profession of clinical psychology, the following points appear to emerge from the discussion in this chapter.

a) From the behavioral position, the notion of "control" has

been shown to be a central principle guiding research and practice. The trend appears to be in the direction of displacing the other positions in psychology and psychiatry by presenting a position which is ideologically and methodologically at variance with other proposed clinical theories.

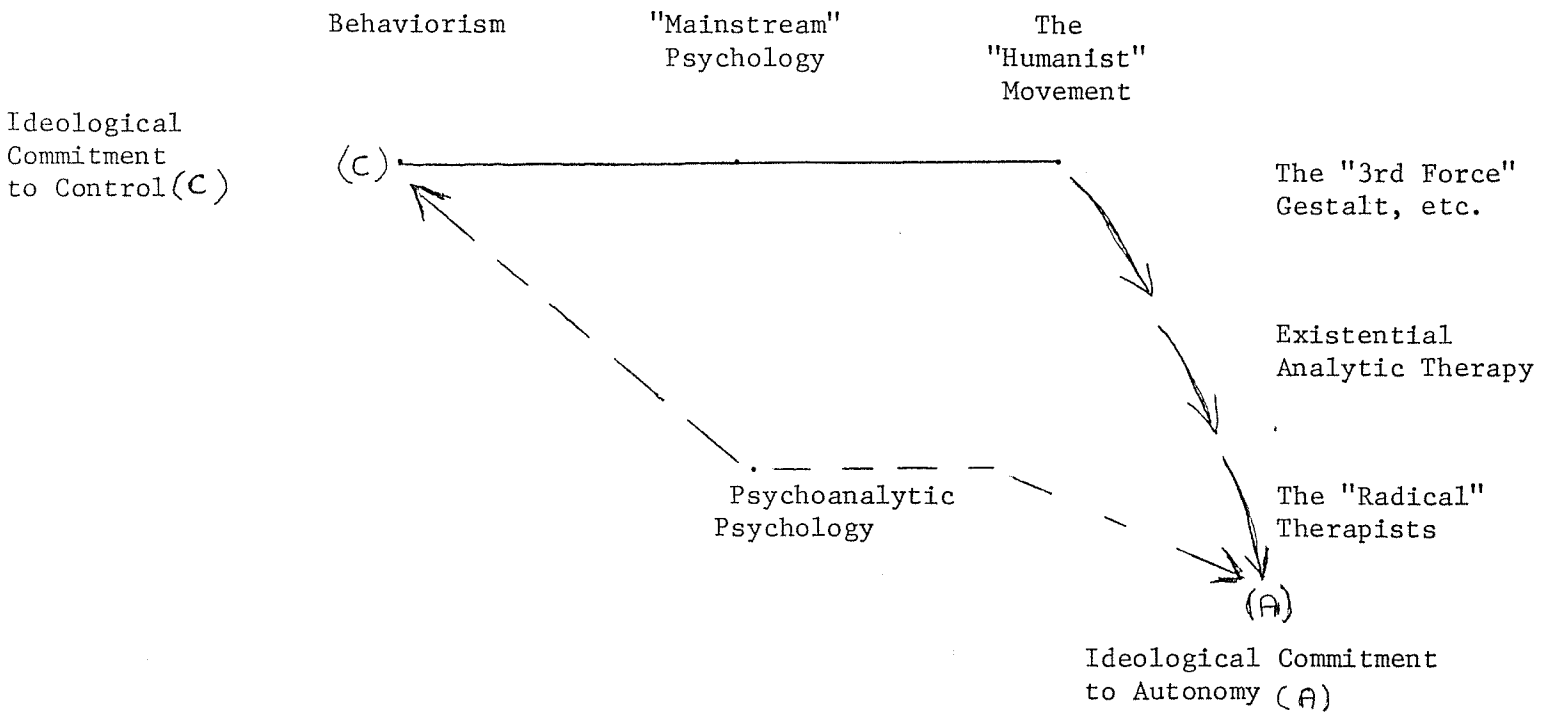
b) Mainstream psychology (which theoretically represents the whole spectrum of ideological thought within the profession as its organizational body, (C.P.A.) still appears to be engaged in a form of "sibling rivalry" with the psychiatric profession. The use of the professional organization appears to have been effective in consolidating and in some areas in advancing the position of psychology in mental health work. (See Appendix I) Ideological and professional rivalry with other mental health professionals (eg. social workers, psychiatric nurses) has also been evident (Strauss 1964) but these differences have not been included in the scope of this study.

c) The "humanist" movement within the profession appears to have displayed the least commitment both philosophically and in practice to the aim of ideological hegemony in mental health. The highly fragmented ideological positions within this group (see Figure 9) as well as their opposition to the "control" features of therapy have tended to reinforce their lack of committment to ideological hegemony or social control. They have stressed "growth" and individual autonomy as the only legitimate goals of therapy, and among their extreme adherents (the radical front) have equated "change" with therapeutic success.

Figure 9

A Theoretical Presentation of the "Spectrum" of Psychological Ideologies

Reflecting Degrees of Commitment to Ideological Hegemony (control)



The notion of ideological hegemony has been central to the positions of both the behavioral and humanistic positions but from diametrically opposing points of view. One has displayed a position which is philosophically committed to "scientific control." The other is a position aimed at ridding the therapist of any power over the patient population or of ideological hegemony over the structure of the mental health professions.

Both positions present strong arguments in the direction of their world-view and in so doing have provided an expanded "ecumenic" role in furthering the complexity and generalizability of psychology's positions viz-a-viz the lay-public and the larger society. What is clear from the discussion in this chapter is that ideological content is very much a part of psychological theory and practice even though it has not generally been dealt with from that perspective in the literature and research on clinical psychology.

In terms of the "professional" aspects of clinical psychology, the criteria governing occupational functions were found to exist along the same dimensions to those present in the psychiatric sector. This was particularly evident in the overall ecumenic function provided by the professional associations of both occupational groups, though the psychiatric profession was viewed as coming within the larger umbrella of the American Medical Association as well as the psychiatric professional organization.

The following chapter will explore the interaction of the similarities and differences between the two groups. It will examine

the way in which both professions deal with one another in terms of complementarity of roles as well as areas of conflict over territoriality and other issues.

Chapter V

INTERACTION OF THE MENTAL HEALTH PROFESSIONAL IDEOLOGIES IDENTIFYING "MENTAL HEALTH PROFESSIONALS:"

The disciplines of psychiatry and clinical psychology have produced differing models, from which their practitioners draw their theoretical and practical assumptions. Despite major areas of difference between the disciplines as a group, they represent the occupational sector known as "mental health professionals." A tacit area of consensus which may be assumed from their occupational role is that all of these professionals subscribe to the notion that the entity, "mental illness," exists, despite differences of terminology or areas of emphasis in treatment. Psychiatrists refer to "symptoms," existential analysts to "life crises," and behavior modifiers to "inappropriate behaviors." Hence, the "professional" aspect of their work is that they are involved in changing certain patterns of behavior as a service to a client population.

In-the-field regulation, joint use of social agencies and referral systems, and shared input into the formulation of clinical diagnoses attest to the joint enterprises undertaken by the amorphous group called "mental health professionals." Ideological concerns of each profession relate to that group's attitudes to such questions as their view of "man," their conceptualization of "society," and their assumptions about the cause and effect of social change. Differences which emerge from each profession's worldview serve as indicants of differing "ideological" perspectives. These ideological perspectives, in turn, determine the assumptions held by members of each profession

about the nature of mental illness and its treatment.

The traditional psychiatric view had been that only people holding medical degrees were qualified to both train and work professionally as "psychiatrists." That assumption served to exclude from the mental health professions such groups as individuals who did not have the financial resources to pay for training, and as a result, reflected a skewed population distribution having access to mental health training. Practicing psychiatrists came from upper middle class backgrounds with a high degree of success in upward mobility. This background, from an ideological perspective, shaped their image of man from the viewpoint of a group who were "making it in society." (Hollingshead and Redlich 1958)

Psychology, in the "professional" sense, came to the mental health domain from rather different orientations. The training backgrounds of psychologists were academic rather than practical, but they were more likely to have had exposure to the social and behavioral sciences, since their learning base did not conform to the narrow limits of the "medical model." Psychologists fought a running battle for a lengthy period of time in order to attain the right to treat clients. Their lower status in the hierarchy of professional mental health workers was (and to a degree, still is) reflected in lower fees for their services, and, in the Province of Manitoba, cannot be viewed as competing for clients with the psychiatric profession since their services are not covered by "Medicare."

PROFESSIONAL IDEOLOGICAL RIVALRY:

The range of theoretical and ideological positions which have been held by mental health professionals tends to suggest a general confusion in attempting to classify them strictly according to professional disciplines, philosophies, or work situations. Vast differences in their techniques and theory make ideological "fusion" by these practitioners seem most unlikely. Despite these apparent conflicts, however, the actual working consensus which has been achieved by the different professions suggests that some level of agreement as to the purpose and structure of mental health intervention has been attained. The level of "scientific" as opposed to "ideological" consensus that has been achieved is as yet unclear.

In order to account for ideological conflict and its effect on the mental health professions, the focus of this research must return to the general propositions regarding the impact of ideologies on occupational functions. It was suggested earlier (in Chapter I) that the level of effectiveness of any occupational group in a given ideological domain was highly correlated with its ability to espouse ecumenic goals, without alienating other occupational groups in the same ideological domain. (Dibble 1962)

Dibble (1962) and Caplow (1957) suggested that inter-occupational rivalry was the major factor in the erection of attitudinal barriers between each occupational ideology and the larger public to which it was directed. In Caplow's view, ideological content in the high-ranking occupations reached such levels of occupational rivalry

in the effort to convince the diffuse and heterogeneous public, that "mild paranoia" was demonstrated in the images which the professions had of each other.

> Because of the rivalries and suspicions between higher ranking occupations, the outlook of one will not be accepted by others. And, if high-ranking groups are split off from one another ideologically then there is less likelihood that lower ranking groups will take over ideas from the ideology of any single high-ranking occupation. For they will receive contradictory, or at least different, messages from on high. Those in the higher ranks may agree on the basic outlines of the society, on morality, motherhood and the American way. But since they do not coalesce around any set of ideas outside of specifically occupational ideologies, lower ranking groups are beyond their influence so far as these kinds of ideas are concerned. (Dibble 1962 p 47)

Dibble's statement went to the heart of the mental health profession's failure to "get their message across" to the larger public. While public attitudes at the present time to the general and ecumenically espoused notion of "mental health" may be viewed as quite favorable, the ideological aspersions cast by mental health professionals on each other's ideological premises did much to prevent the attainment of ideological hegemony by either occupational group.

The rivalry that exists between the two professions has been described by Brody (1956) as analogous to the phenomenon of sibling rivalry in the nuclear family. Inter-professional relations have been marked by a degree of "self-consciousness" on the part of both the psychiatric and psychological professions. The general trend among the psychiatric practitioners has been to regard the more professionally assertive clinical psychologists as "Young Turks." Their attitude has been viewed at least by some members of the psychiatric profession as displaying the uneasiness associated with the

strivings and self-appraisal of an emerging profession, when compared with the professionalism of traditional psychiatric practice.

> These preliminary remarks are not intended to identify psychiatrists as wise, experienced, or grey-bearded. They are intended to indicate the presence of a conflict, in which psychiatry seems to represent the established order, and clinical psychology the force which seeks to change it. (Brody 1956 p 106)

The "uneasiness" which writers such as Brody have ascribed to the emergent professionalization process in clinical psychology has been demonstrated in the relative discomfort with which psychologists have embraced their new status. Some growing pains associated with making the transition form a laboratory-oriented to a people-oriented service have typified psychology's uneasiness with regard to particular job-roles. This discomfort has been most evident in the "healing" properties associated with the conduct of psychotherapy.

The role of healer has traditionally been endowed with a certain level of mystique. Among mental health professionals, the mystery surrounding therapeutic practice often forced the role of shaman or "healer by rituals" on professionals who would have preferred to remain more firmly within the objective realms of science. (Kiev 1964) The healer role was thus frequently externally imposed upon the mental health professional as a consequence of the characteristics attributed to him by the client. As physicians, the psychiatrists adapted more easily to that role due to the direct service delivery aspects of their earlier training as physicians.

Ideological inconsistency about the appropriate form of response to this role has been shown among the two groups under study.

As Freidson (1973) suggested, the psychiatrist (as a consequence of the medical training paradigm) was more likely to deal with the client from a "sick role" perspective particularly in his discussion of medicine as a consulting rather than an academic profession.

Brody (1956) suggested that interprofessional conflict was often reflected in the intrapersonal conflict which accompanied the assignation of the "healing" role. He claimed that the medical training which the psychiatrist underwent facilitated a defensive posture by the psychiatric practitioner in his role as healer.

Since psychiatrists did not employ conventional "medical" treatments, Brody suggests that as an occupational group they had a great need for reassurance that their talking and listening functions were real and legitimate forms of medical practice. Psychologists, who had even less familiarity with the healing role would thus have even greater difficulty. Brody saw the discomfort associated with this role function as being expressed in the form of interprofessional conflict.

In the field rivalry has also been shown to exist between the professions where clinical psychologists have assertively made inroads into the conduct of psychotherapy; a function which had previously been strictly within the domain of psychiatric practice. In many cases, clinical psychologists expressed a need to explicitly <u>disassociate</u> themselves from the "medical" connotations of psychological intervention, out of ambivalence about their own role as "healers." This has been evident in the professional "reaction formation" that so

many clinical psychologists display with regard to the medical model as the basis of diagnosis and treatment.

At the level of educational input into professional ideology, clinical psychologists frequently emerge from a liberal arts (or as is increasingly evident, from a natural sciences) and humanistic program of education. The psychiatric professional, by contrast, has been trained in "medicine," having had limited exposure to any reformist or academic approaches to the social sciences. The "shaping" of psychiatric thinking is largely a result of exposure to an orthodox, formalized corpus of knowledge.

In terms of dealing with patients, possession of an M.D. degree still seems to provide feelings of a higher level of personal competence to deal with the healing role than does the Ph.D. degree. Brody claims that as a consequence of this perceived inadequacy, many clinical psychologists adopt a defensive professional stance in relation to the psychiatric profession.

In substantive terms, the training phase has much to do with the ideological productions of the two professions. Most important to the neophyte psychologist's ideological conditioning is the stress placed on academic (specifically research-oriented) goals. The psychiatrist-in-training, however, passes through a variety of levels of responsibility in what is essentially a client-centered profession.

The job-dynamics which underlie respective levels of responsibility determine part of the professional ideological climate. The psychologist who works from nine to five can be expected to have differing

perceptions of his job-role than the psychiatric practitioner who often assumes central administrative functions which define his higher levels of responsibility.

Some stereotypic assumptions about the nature of training in clinical psychology are evident among psychiatric practitioners. (Brody 1956) The overall image of what clinicians "ought" to be in order to fit the model that is ascribed to them is often at variance with the diverse and fragmented orientations which emerge from the ranks of practising clinical psychologists. Brody, a psychiatrist, makes such assumptions of homogeneity and uniformity about emerging clinical psychologists. He states:

> The young psychologist's experience with research techniques and the literature of his own field is great. His experience with people and their problems and in the assumption of responsibility is slight. (Brody 1956 p 107).

Such assumptions held by the psychiatric profession about clinical psychologists have provoked an identity crisis among clinical psychologists. This crisis has stimulated psychologists' demands upon themselves in pursuance of greater professionalism and autonomy, often "in defiance of the psychiatric edict."

Another area of professional rivalry surfaced out of the relative breadth and flexibility that was afforded to the psychology graduate with regard to the job-roles which he might assume. ("Clinical" training may serve as preparation for work in fields as unrelated to psychology as industry, politics or technological consultation) The psychiatric training paradigm by contrast, is much narrower since it teaches a type of expertise which is limited to the mental-health

services sector according to a pre-defined set of criteria, hence offering a more limited variability of job-roles for the psychiatric graduate.

The literature (Schulberg and Baker 1975, Strauss 1964) suggests that some shift in orientation has taken place with regard to occupational role flexibility. More psychiatrically trained persons have moved into roles which are outside purely psychiatric or psychotherapeutic functions, eg., consultation, hospital-administration and "pure" research, which indicates that some shifts in psychiatric job-roles has occurred.

In the conduct of psychotherapy which is deemed to be the central area of activity shared by psychiatrists and clinical psychologists, a number of issues about the nature of the interaction between the professions emerge from the research:

a) Some "confounding" of the purest ideological biases of both disciplines has tended to occur as a result of the eclectic demands of everyday practice. eg. the team concept of "diagnosis" in which both psychiatrist and psychologist have input, has become a common feature of the clinical case conference.

b) Similar problems in dealing with the counter-transference by the professional seems to have been encountered by young practitioners from both professions.

Brody (1956) suggests that the discipline out of which the young professional emerges determines the nature of his response to the anxieties encountered in the counter transference. Psychiatrists

were viewed as resorting to greater authoritarian activity, by becoming more directive and offering "interpretation" of behavior prematurely. Psychologists, by contrast, reacted to the same anxiety by engaging in excessive passivity and withdrawal into the role of "detached scientific observer." (Brody 1956)

Despite the fact that the transference is the psychiatrists stock-in-trade, Brody claimed that extensive reliance on the dynamics of this phenomenon sometimes caused the young psychiatrist to "use" the transference without seeking to "understand it." This professional stance was attributed to psychiatric training in the use of psychological technique without stressing its social ramifications. The opposite was held to be true for psychologists. Brody felt that, as a group, they tended to intellectualize their therapeutic goals, and to be more locked into predetermined therapeutic strategies, regardless of the idiosyncratic nature of the interaction with each client.

Ideological and interpersonal conflict has also been present in the selection of research material by both professions. The psychiatric brand of research was often a direct consequence of clinical case studies, while for the clinical psychologist, much of his research was generated out of laboratory experimental studies, eg., "the experimental neurosis." (Levison, Zax, and Cowan 1961)

Differences in research strategies, as well as the high level of personal investment in clinical research, thus created an ideological adversarial system in accordance with the conflict properties associated with that term from its early usage. The defensive

operations mounted by mental health professionals in defense of their system attest to this ideological confrontation:

> It has been suggested that unconscious guilt and anxiety are more prominant in investigations of human behavior than in other fields. Behavior reflecting defensive needs may include, for example, ascribing great importance to one's own contribution and belittling the contribution of others; feeling misunderstood by colleagues, insistence on one's own methodological bias; emphasis on the uniqueness and complexity of one's own professional training; overt aggression directed downward in the hierarchy of a project, and the need to placate authority figures in the project and so forth. (Brody 1956 p 110)

Ideological rivalry between the professions has thus been shown to perform a dual function in this research. When it has been invoked to support an "occupational" priority, (i.e. in the line of interest of only one of the two groups of mental health professionals) it has caused tension and strained interprofessional relations. When ideology has been associated with the whole diverse group of "mental health professionals" without regard to "occupational" ideology, it has served to strengthen shared professional goals in furthering their collective hegemony over the field of mental health.

In terms of formal hierarchical distinctions, psychiatry appears to have retained the dominant position among professionals who deal with the mentally ill. Psychiatrists currently serve as administrative heads of hospitals and enjoy extensive legal mandates to shape the direction of treatment in their field. Clinical psychologists, on the contemporary scene, viewed their skills as "equally appropriate" to the management of mental illness, thus becoming locked into a battle for territoriality with psychiatry.

The psychiatric profession was perceived by psychologists as

enjoying a "monopoly" of the mental health field, having no competition or critics of their trade practices. Their position was viewed (enviously it would seem) by psychology as having cornered the market in a situation not unlike the power vested in the giant corporations of the business sector. In jockeying for position with psychiatry, the clinical psychologists were creating a conflict situation which involved ideological strains regarding occupational rather than theoretical concerns.

An alternative explanation can be posited about the nature of interprofessional rivalry in "mental health." This theoretical position suggests that higher levels of ideological hegemony among mental health professionals emerge out of the limited conflict in their ideologies without creating intolerable strain on the provision of mental health services in the interim. This view, espoused by Coser (1956), rationalized the conflict model as serving an essentially integrative function for both professions. From the model provided by Coser, the strains between the two groups should serve to enhance the quality of care given to the consumer of mental health services, since both groups of professionals should theoretically be constantly honing their skills in order to make their profession more attractive to the client market.

PROFESSIONAL COALITION FORMATION

Ideological differences which separate within--profession practitioners have shown an effect on the nature of their interaction with practitioners from other disciplines in the mental health field

(The psychiatrist who works from a sociotherapeutic orientation maintains a far closer relationship with his "social services team" than the psychiatrist who adheres to neuropsychiatric principles). It is thus at the level of occupational interaction that ideological and theoretical positions served to determine "the divisions of labor" in those institutions in which professionals were studied:

> In short, the specialists in one field and psychiatry is no exception--frequently find more in common and work more closely with certain specialists from allied fields than with many of their professional colleagues. In fact, they usually regard many of the latter as doing less good and quite possibly more harm than the allied specialists. (Strauss et al 1964 p 7)

Strauss attempted a descriptive analysis of the ideological interaction between psychologists and psychiatrists in an applied hospital setting. Occupational interaction effects that were recorded in that study showed some reluctance on the part of clinical psychologists to regard the psychiatric professionals as "the" experts. Many psychologists saw themselves as having more input into (non-medical) intervention procedures than the psychiatric staff. Psychologists in that study perceived themselves as being more experienced than psychiatrists in the field of "milieutherapy" and tended to form coalitions with the social services staff to make it part of hospital policy. Coalition formation between social services and psychology staff in that study tended to display stronger ideological homogeneity, leadership and the ability to articulate their operational ideology than the nursing and medical staff.

The point of focus of interprofessional ideological conflict in the mental hospital was examined in terms of the dynamics which

underlie the "mental health team" concept. This usually consists of psychiatric director, psychologist, social service member, nursing staff, and possibly a representative of the hospital administration. Strauss's study showed that congruence of professional ideology and operational philosophy were highly contingent upon whether a "team" ideology or a hierarchical occupational structure constituted the dominant hospital ideology. Social workers and psychologists involved in treatment services had much in common and generally supported each other on "team" issues. Rather than competing with each other for positions, they were united by their opposition to traditional custodialism in the hospital as a whole, and to traditional medical hegemony in psychiatric treatment in particular. (Strauss 1966 p 144)

In wards with patient and representative government, psychology staff were seen as enjoying a high level of therapeutic autonomy. On medical and psychiatric authority wards, there was a much lower level of therapeutic input by psychologists. Equally, on the psychiatric "authority" wards, nursing staff were shown to enjoy a high level of satisfaction in implementing psychiatric hierarchic principles, while suffering considerable "task-stripping" and role uncertainty in the patient-government wards. Thus, ideological polarization appears to have occurred between social services and psychology and between nurses and physicians on the issue of monopoly of power by the medical practitioners.

Traditionally, the mental hospital has been described as being strongly hierarchical and having very centralized positions of

power. In the Strauss study, they found that only those professionals who were seeking maximum role-change (the clinical psychologists) in the hospital structure were able to exploit the professional potentialities of a "decentralized" team concept. These professionals were described as having "blossomed" in their new-won equality, while the most successful psychiatric and nursing staff were seen as being those who made the greatest accommodation to these ideological shifts.

TERRITORIALITY IN PSYCHOTHERAPY:

In the Strauss (1964) study, the data revealed some very important assumptions held by each profession about itself and other mental health professions. This was particularly evident in their positions with regard to the conduct of psychotherapy. Figure 10 illustrates the level of endorsement of psychologists as psychotherapists by medical (psychiatric) staff as well as by their own and other non-medical therapeutic staff. Figure 11 provides the level of endorsement of psychiatrists as psychotherapists by their own profession as well as the non-medical therapeutic staff.

Psychologists were viewed as totally committed to the position that they be empowered to conduct psychotherapy both within a hospital setting or as private practitioners. The psychiatric sample was the professional group least in favor of an "expanded" therapeutic role for psychologists. Some spread in the range of opinions of psychiatrists about psychologists' role in therapy was evident. While 83 per cent were in favor of psychologists "doing therapy" in a hospital setting, only 23 per cent thought psychologists could do

Figure 10

Table 8--Psychologists as Therapists[a]

Item	As Seen by NONMEDICAL PRACTITIONERS: Psychologists (N=52)	Social Workers (N=53)	Nurses (N=38)	As Seen by MEDICAL PSYCHIATRIC PRACTITIONERS: All (N=339)	High Psychos[b] (N=82)	High Somatos[b] (N=106)	High Socios[b] (N=102)	Low Socios[b] (N=100)
30. Clinical psychologists who show interest in doing psychotherapy should be permitted to do so in a hospital setting.	100%	92%	87%	83%	80%	74%	92%	70%[c]
58. A child psychologist is usually more qualified to practice psychotherapy with children than is a generally trained psychiatrist.	87	77	68	60	70	48	67	59
79. Clinical psychologists should be permitted to engage in psychotherapy in private practice.	98	92	58	40	41	33	49	29[c]
96. Most clinical psychologists are qualified to work with patients who have adjustment or marital problems.	83	58	79	52	38	57[c]	59	38[c]
103. No clinical psychologist should be allowed to engage in private practice without medical supervision.	92	60	34	33	34	25	36	24
115. Clinical psychologists do not need medical supervision to practice good psychotherapy.	85	51	29	23	22	15	31	14[c]
157. Psychiatrists should help clinical psychologists to secure legal certification.	92	72	74	52	54	42	66	42[c]

[a]Figures are the proportions of individuals in each group that agreed with the statements, except for Item 103; the figures are the proportions of those who disagreed.

[b]Only the differences for the "high psychos vs High somatos" and "High socios vs Low socios" were evaluated statistically--by chi square test.

[c]This proportion is significantly different from the proportion for the immediately preceding group at the .01 level.

Figure 11

Table 9--Psychiatrists as Therapists[a]

Item	As Seen by NONMEDICAL PRACTITIONERS: Psychologists (N=52)	Social Workers (N=53)	Nurses (N=38)	As Seen by MEDICAL PSYCHIATRIC PRACTITIONERS: All (N=339)	High Psychos[b] (N=82)	High Somatos[b] (N=106)	High Socios[b] (N=102)	Low Socios[b] (N=100)
127. A medical degree should be the major criterion for evaluating an individual's qualifications to practice psychotherapy.	0%	0%	39%	30%	21%	47%[c]	20%	39%[c]
131. Only psychiatrists should treat neurotic patients.	2	2	34	32	28	40	22	48[c]
136. A medical degree should always be one of the criteria for evaluating an individual's qualifications for practicing psychotherapy.	4	15	55	64	56	74[c]	54	80[c]

[a]The figures are the proportions of individuals in each group that agreed with the statements.

[b]Only the differences for the "High psychos vs High somatos" and "High socios vs Low socios" were evaluated statistically--by chi square test.

[c]This proportion is significantly different from the proportion for the immediately preceding group at the .01 level.

Source: Strauss A. L. et al. Psychiatric Ideologies and Institutions

New York Free Press, 1964, (p. 81, Table 9).

"good therapy" in a private setting without medical supervision. On this point ideological conflict between the psychiatric and psychological groups was most focused.

The Strauss study also revealed a high level of ideological confrontation among psychiatrists themselves (along the dimensions discussed in Chapter III) with regard to their own conduct of psychotherapy. Only 64 per cent of the medical (psychiatric) practitioners agreed that a medical degree should be a relevant criterion for conducting psychotherapy. Only 30 per cent thought that a medical degree should be the major criterion. Interestingly, the Strauss study did not provide an opportunity to examine the views of the psychologists with regard to the legitimacy or competence of psychiatrists to conduct psychotherapy, except in presenting the reasons why they (psychologists) were equally qualified to do so.

"Within-profession" differences among psychiatric ideologies were also shown to have some effect on psychiatrists' attitude to the psychotherapeutic functions of clinical psychologists. Psychiatrists who were higher on the psychoanalytic pole of psychiatry were shown to be more supportive of an increase in the psychotherapeutic activities of clinical psychologists than psychiatrists who were high on the somatotherapy scales. However, the tendency to view the therapeutic role of psychologists in a positive direction was not so prominent among psychoanalytic practitioners as to promote this position at the expense of psychiatric hegemony.

Although there is some tendency for psycho-therapeutically oriented practitioners to be more favorable toward psychologists as psychotherapists, it does not overshadow the basic belief in medical authority, which both groups of practitioners (the psychoanalytic

and somato-therapeutic psychiatrists) seem to share. (Strauss 1964 p 83)

Strauss suggested that both ideological groups in the psychiatric sample were more favorable to a therapeutic function for psychologists than for psychiatric social workers. He proposed that the psychology profession had at least tentatively been accepted by the psychiatric profession as having some claim to professional automony and recognition. He attributed psychiatric recognition of "some level of autonomy" for clinical psychologists to be partially as a consequence of their training, and partially because of their defined professional intent to be a part of the delivery of mental health services.

While the whole range of psychiatrists in that study retained a homogeneous commitment to retention of professional prerogative by their profession, they were equally homogeneous in their perception of clinical psychologists as the most serious threat to retention of that privilege. (Strauss 1964 p 241)

The concern of the current research is with <u>the effects</u> that the ideological components of professional thought have on the nature of services that are provided. The ideological propositions of the "sociotherapeutically oriented psychiatrists" in Strauss's study provide some relevant information in this regard. Their general position advocated a higher blanket endorsement of psychotherapeutic functions for all mental-health professionals than either the psychoanalytic or somato-therapeutic psychiatrists. While Strauss does not provide an

explicit interpretation of those results, it can be reasonably inferred that the high level of endorsement by the sociotherapeutic group is consistent with a position which favors greater division of labour in the mental health field, more team and community work and a lower level of subscription to professional dominance or hegemony.

IDEOLOGICAL HEGEMONY AND THE MENTAL HEALTH PROFESSIONS:

Since the early 20th century, psychiatry enjoyed a period of almost universal acceptance with regard to its professional position. This was most pronounced in the ease with which Freudian theory and psychoanalysis were received by Western society, particularly in the United States. The position of psychiatry became strongly entrenched in organized medicine. In 1937, the American Psychiatric Association (with the approval of the American Medical Association) broke away from the international Psychoanalytic Association on the issue of ideological hegemony. Their contention at that time was that psychotherapy was solely within the domain of medicine and was to be practiced by physicians only. (Leifer 1969)

Clinical psychologists were subsequently allowed to engage in therapy under medical supervision. This issue remained in contention and is currently unresolved among mental health professionals. The psychoanalytic "center" of psychiatry was perceived by professionals and the lay public as moving toward elitist criteria in terms of the type of people they would treat, the conditions under which they saw patients (office-couches rather than hospital wards) and the type of therapy they would undertake. The general assumption in

psychoanalytic therapy was that patients with "good prognosis" would generally tend to be young, attractive, wealthy, educated and verbally skilled.

The nature of hospital psychiatry provided a different orientation to treatment of patients. Generally they were perceived as not meeting the criteria of office-management intervention. Hospital psychiatry was associated with reliance on somatic therapies, minimal contact with patients, and psychiatric diagnosis based frequently on the social standing of the patient population. (Rosenhan 1973, Becker 1963, Goffman 1961) The move by psychiatry to dichotomize its function into "private practice" and "hospital psychiatry" left the middle ground of mental health work open to other disciplines.

The direction of psychiatric "politics" had been noted by professionals from different disciplines who shared similar concerns. Despite the unconventional methodology which he employed, Ronald Laing's treatise on mental illness attracted a substantial following of radical psychologists and psychiatrists, such as Timothy Leary and Richard Alpert. Their experimental models which initially seemed unscientific and bizarre were later to be employed by the role theorists and interactional theorists in scientific research.

Much of the present research on family processes and therapy may be directly traceable to (or reactions to) the early work of Laing on the pathogenic nature of the nuclear family, the schizophregenic mother, and coalition formation and scape-goating in the nuclear family. Ironically, it was from the ranks of "alienated psychiatry" that professionalized clinical psychology got its early start.

Laing and his associates among the radical psychotherapists presented some unorthodox views about mental illness. Where traditional psychiatry (particularly psychoanalysis) had viewed most of the psychoses as "unreachable," Laing and his associates contended that psychotherapy for these populations was both possible and essential. Development of interactional models of psychotherapy such as "family systems, communications theory, and role-interchange" were largely an outcome of these unconventional mental health investigations. (Ram Das 1974) The occupational sector responsible for these changes lay outside the role of traditional psychiatry, representing a new brand of "therapists" who did not use the ongoing psychiatric system to implement change.

The provision of services to the "Third World" of the mentally ill became increasingly linked with the research and practice of clinical psychology. This transition became increasingly apparent in the greater "visibility" of psychology in the social institutions dealing with deviant behavior (the prisons, clinics and mental hospitals). This new visibility was evident in the proliferation of psychological research and therapy models of the recent past. Qualitative superiority in the nature of services provided by psychiatry became more difficult to point to, particularly since a number of psychiatrically trained therapists were making use of psychology-generated treatment modalities. In ascribing a purely "technical" role to the psychological (as opposed to psychiatric) conduct of therapy, psychiatry was clearly on the defensive, and unable to assert earlier levels of professional hegemony. (Eyesenk 1970)

Psychiatry was thus increasingly forced to rely on social-status supports (the M.D. degree and their professional organization), for substantiation of their claim to be at the helm of the mental health professions. Their success in this respect has not been overwhelming. Nummably and Kiltrous (1968) suggest that the public generally makes no distinction between the services provided by psychiatrists and clinical psychologists.

Psychiatric professional ideology had clearly promoted a view about the competency of psychology which was at variance with psychologists' views of themselves. Their rapid movement toward greater visibility in the professional community may be seen as a reaction to statements about their professional status from within the psychiatric profession, such as the following:

> It is to be hoped that the number and calibre of clinical psychologists will continue to advance, just like the rapid advances of technicians whose aid to physicians cannot be overestimated. (Brody 1954 p 178)

The typical response of clinical psychology to the ideological assumptions held by psychiatric practitioners was to negate Brody's contention that their function was that of "technical physicians-aides." The form that their response took has included ideological unmasking of the psychiatric profession, and defensive regrouping of their own position. Psychologists presented counter-claims about the psychiatric use of "the healing mystique" and have gone so far as to discount the total validity of psychoanalysis. (Eyesenk 1970) Psychologists have tightened up their own training programs to prove the adequacy of their "professional" competence.

The move toward occupational autonomy by psychologists may be seen as partly conditioned by the paternalistic (at times interpreted as patronizing) position of the psychiatric profession. The defensive posture of many clinical psychologists vis-a-vis their professional relationship with psychiatry may be interpreted in that context. Psychiatric claims to a "better brand of knowledge" shaped much of the ideological stance of professional psychology.

Acceptance by psychology of the medical model would have meant acceptance of the medical component of disordered behavior, hence, many psychological practitioners sought to build a model of mental illness which could be explained and treated outside of purely physiological determinants of behavior. Much of the reaction by psychologists to the medical model came, surprisingly, from the "scientific" behavioral school. The learning theory and reinforcement models of behavior (both normal and pathological) were heavily weighted in the direction of psychological rather than physiological theories of causality. (Bandura 1968, Lovaas 1968, Wolpe 1958)

Due largely to their organizational efforts, the position of psychology today is that it is vying for the "first-spot" among mental health professionals. In terms of research and innovative behavioral theories, psychology has indeed provided great input into mainstream clinical practice. Theoretical claims about "psychotherapy" from psychology have been given more serious consideration by the psychiatric profession. Strategies and theory in such psychological domains as behavior modification are now a requirement in the training of many

psychiatric practitioners.

While some level of "eclecticism" is evident among "all mental health professionals," theoretical and academic fusion of theory and practice (Praxis) has still not crossed occupational and professional ideological lines. The conflict which has (and still does) separated practitioners from both disciplines, suggests that "hegemony" by the mental health professionals (as a homogeneous rather than a fragmented entity) does not exist. Alternatively, at the level that professional ideological lines have been crossed by the whole group (as "mental health workers") a strong ecumenic base has been provided for both professions.

Reference to the term "mental health," and association of that term with the functions of psychologists and psychistrists attests to some level of hegemony enjoyed by both professions at the present time. To the extent that the mental health professions enjoy a greater acceptance of their theories of human behavior than disciplines such as anthropology, history or sociology, some level of hegemony over the "mental health sector" may be attributed to both professions.

With regard to the level of hegemony exercised by both professional groups, the mental health enterprise to which they belong represents a status-quo to which both groups subscribe as a primary goal. Despite interprofessional rivalry, expansion of the mental health market provides greater opportunity for hegemony for all mental health practitioners. In this respect, ideological consensus may be deemed to exist in the promotion of the "mental health movement" (sans occupational rivalry) for the benefit of all professionals engaged in that area of work.

To the extent that hegemony by these mental health professionals is held to account, a commonality of purpose and a common front may be attributed to both groups of professionals. Thus, mental health professionals have, as a group, established a great deal of protection from accountability to the lay public for the nature of their practice and even more so for the ideological positions from which they work, by virtue of their "professional prerogative."

The professional associations of both groups have been effectively employed to prevent concerted attack by any outside group on the ideological assumptions of each profession. Information about ideological concerns has often been jealously guarded to withstand ideological confrontation.

Even in those cases where limited coalition formation has occured, eg. between psychologists and social workers (Strauss 1964), these have proven inadequate to challenge the cumulative hegemony of the psychiatric and psychological professions.

> The mental health power structure, committed primarily to its own preservation, is alertly opposed to any events that might change it. Thus when innovation intrudes, the structure responds with various strategies to deal with the threat; it might incorporate the new event, alter it to fit the pre-existing structure so that, in effect nothing is really changed. It might deal with it also by active rejection, calling upon all of its resources to starve out the innovator by insuring a lack of support. (Giaziano 1969 p 43)

"COMMUNITY:" THE END OF PROFESSIONAL HEGEMONY?

Although each of the "psychiatric" and "psychological" ideologies has served as a powerful determinant of clinical practice during its peak, each has also faced some level of criticism or rejection as a

consequence of shifting social influences on mental health practice. The movement which appears to have taken up the slack in mental health work is the "community mental health ideology."

The level of acceptance of this movement has not been uniform across both professions. In the original study, out of which the community mental health scale was developed, significant differences were found in its level of acceptance by psychiatrists and psychologists. Data provided by Langston (1970) showed psychiatrists to be less favorable to that ideology than any of the non-medical professions in mental health. In a study of hospital psychiatry, Kotin and Sharaf (1967) showed that a community ideological position held by a new hospital superintendent resulted in ideological polarization on a psychodynamic-sociotherapeutic dichotomy among the hospital staff.

A second intensive study of community ideology among various professionals in a hospital setting was conducted by Schulberg and Baker (1967). In this study, the CMHI scale was administered to psychiatrists and clinical psychologists as well as other mental health professionals. On the first administration of the test instrument, psychologists, nurses and social workers were highest on the community ideology scale, and physicians (including psychiatrists) were lowest. On the second administration, psychologists were found to be highest and psychiatrists lowest in terms of commitment to the community ideology. The mean scores for "young psychiatrists in that study were not shown to be significantly different from the scores of senior psychiatric staff. Psychiatric reluctance to accept the onset of this new

ideology in mental health work was also noted by Langston (1970) and Breeskin (1972).

"Non-medical (psychologists) hospital staff have consistently favored change in the direction of further implementation of community programs (Schulberg and Baker 1967) This support has been associated with the fact that, despite numerical superiority, the non-medical professions had not been able to displace psychiatric hegemony in the structure of mental health care systems. (See Figure 12). The "community" philosophy assisted the profession of psychology to claim more "input" into the delivery of mental health services.

> This is perhaps one of the reasons why community mental health ideology finds relatively greater acceptance among non-medical professionals; it emphasizes skills which are not directly dependent upon the usual training of medical professionals. Non-professionals in particular stand to gain in status if the ideas of the ideology are implemented. (Schulberg and Baker 1975 p 195)

With the advent of the "community ideology," a radical shift in the nature of interaction between the professions occurred. The hierarchic advantages which were traditionally associated with psychiatry in mental hospitals were challenged with regard to their legitimacy in a work philosophy which stressed "team" participation (Rushing 1964) Shift in the social ideologies of the sixties contributed to the complexity surrounding the interpersonal relations between the two professions. The "model" which emerged for mental health workers demanded a higher level of self-critical functioning on the part of any professional, scrutiny of his roles and skills, and of the relationship which he cultivated with mental health professionals from another discipline.

Figure 12

Relative Increases of Selected Professionals in all Mental Institutions of Canada, 1960-70*

Year	Total Medical staff**	Total Non-medical professions***	Psychologists	Therapists****	Social Workers
1960	1015	1494	140	465	213
1961	1083	1609	154	551	234
1962	1141	1846	177	637	271
1963	1203	2004	194	715	309
1964	1299	2414	212	835	389
1965	1361	2840	224	948	425
1966	1296	2899	243	1080	427
1967	1587	3534	308	1336	547
1968	1614	4431	416	1349	706
1969	1671	4591	421	1451	731
1970	1925	4850	443	1423	753
% Increase 1960-70	89.7	224.6	216.4	206.0	253.5

* Source: Mental Health Statistics, Dominion Bureau of Statistics, Ottawa, 1960-70.
** Total medical staffs include all M.D., full time and part time.
*** Total non-medical professions include all affiliated professions and technicians except nursing staff.
**** Therapists include occupational therapists, physiotherapists and all other therapists.

For the duration of the period marked by ideological domination of the medical model, the role-functions of psychiatrists and psychologists had been clearly defined. The organic and somatic poles of the psychiatric ideologies had delineated an autonomous region for psychology in the area of "behavioral research" which was not a direct function of medical pathology. This defined area had been the only "legitimate" area of psychology which psychiatry had recognized. The advent of "community" and "team" concepts in mental health changed the interprofessional system of relationships to a significant degree.

Overlap in role functions, role-blurring and "total-treatment strategies" involving a team approach, had both salutory and negative consequences. The dominant assumption of the community ideology had been that the potential for achieving change would be maximized when arbitrary disciplinary barriers were brought down. The effect of enacting those assumptions has in some cases realized some of the fears expressed by the psychiatric profession. In some cases, abuse of the "team" orientation led to self-appropriation of higher status tasks where the required degree of professional competence was not present. This model also enhanced the potential for "buck-passing" where particular professionals found certain tasks to be incompatible with their "occupational" ideologies, or where they perceived them as "low value tasks."

Schulberg and Baker (1975) have suggested an axiom which proposes that the more "novel" the interprofessional model turns out to be, the higher will be the level of resistance generated by the more

conservative, established standards of the profession. They advocate that professional accountability be standardized in terms of productivity in the work situation rather than from a predetermined hierarchy of leadership. They viewed psychiatric hegemony over intervention as encountering greater demands for accountability in the future, with regard to proven administrative skills, patterns of functioning and discrepancies in salary.

Hirschowitz (1973) has claimed that the pre-community mental health era had already made use of the concept of the mental health "team." He suggested that many of the functions associated with the usage of that term were in fact misleading or mythical (i.e., they conformed to ideological rather than objective criteria). The mythical elements of the mental health team which he identified were in regard to the notion that "democratic process" could operate in a psychiatric setting. He viewed the decision-making process as being skewed in the direction of higher-ranking professionals (psychiatrists) at the expense of input from lower status staff (psychologists).

Hirschowitz proposed that the same communication network was in operation between psychiatrists and lower-ranking mental health professionals as the communication system employed by psychiatrists in therapy (i.e., exploitation of the "one-up/one-down" positions in therapy).[4] Challenging the assumptions of "one-up" members of the

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[4]For a more elaborate description of the dynamics of "one-up/one-down" psychotherapy forms, see Jay Haley's, The Art of Being a Failure as a Therapist, in, The Power Tactics of Jesus Christ and Other Essays. Haley's humorous description of psychoanalytic ploys and counter-ploys belies the concern with which he views psychiatric use of "power tactics" to establish control in the therapeutic relationship.

team (psychiatrists) posed the threat of sanctions for insubordination by the "one-down" team members (psychologists).

The community ideology proposed a "continuation" of specialized areas of expertise in applied areas of practice. Clinical psychologists were still expected to know more about the administration and theory of psychological tests, while psychiatrists were expected to retain expertise in dealing with organic features of disordered behavior. The "shifts" in practice associated with this ideology were to be more extensively directed at the nature of the interaction between the professionals and the client populations which they served. As mental health professionals they would be increasingly called upon to act as "generalists" (rather than being limited to narrow areas of expertise) in meeting the total range of mental health needs of their communities.

Many clinical psychologists had turned to universities as a consequence of their perceptions that the professional mental health sector had been subsumed within the realm of psychiatric hegemony. Their views were now able to be expressed more emphatically with regard to their ideological assumptions about the nature of professional practice.

The "community" ideology resulted in a growing number of psychologists aspiring to positions of leadership in mental health practice by returning to the service rather than the research sector of mental health work. Training institutions which supported this philosophy were established to train practitioners in clinical psychology to meet demands in both areas. The legitimacy of psychological

attempts to displace psychiatric hegemony were clearly stated in the rules and goals governing the ideology of the community movement:

> Nowhere in the federal regulations about community mental health centers was it suggested that administrative leadership be limited to psychiatrists. (Yolles 1966)

In hospital studies conducted to observe the changes in intervention which accompanied implementation of the community ideology (Schulberg and Wojcik 1971), the data showed that "activity" oriented treatments peaked in the early 1960's but showed a major decline (from 32 per cent to 22 per cent) with the onset of the community program. Further, the emphasis on direct patient services resulted in a great reduction in the number of patients who had been receiving (custodial care) no treatment, from 37 to 13 per cent by 1968. The major increase in intervention modality was in the use of somatic therapies, mainly medication. (See Figures 13 and 14).

From the Schulberg studies of the sixties, it is evident that the "community" ideology was undoing many of the basic premises that were originally associated with its creation in the early sixties. The psychoanalytic "center" that had been associated with mainstream psychiatry had indeed been challenged by the "community" ideology... only to result in the increased dependence on drug therapies within hospital psychiatry. Schulberg reports that by 1968, at the Boston State Hospital, between 75 and 90 per cent of the patients were receiving drug medication. Extensive use of somato-therapy in "community" based institutions provided a paradoxical situation. The initial proponents of the "community" ideology had been the social

Figure 13

Table 10-3

Percentage of Inpatients Receiving Various Types of Therapies in 1963, 1965, and 1968

	1963*	1965	1968
Nothing specific	37	18	13
Verbal alone	4	5	3
Activity alone	11	6	2
Somatic alone	24	34	46
Verbal and activity	3	3	2
Verbal and somatic	4	11	16
Somatic and activity	10	14	9
Verbal, activity and somatic	7	9	9
Any verbal	18	28	30
Any activity	31	32	22
Any somatic	45	69	80

*Based upon data assembled by Dr. Ralph Notman, Boston University School of Medicine

Source: Schulberg, H. and Baker F.
The Mental Hospital and Human Services, Behavioral Publications, New York, 1975, (Table 10-3 p. 286).

Figure 14

Table 10-5

Percentage of Inpatients Receiving Treatment in 1965 and 1968 by Age

	Any verbal	Any activity	Any somatic	Nothing specific
15-24 years				
1965(N=84)	62	52	71	12
1968(N=98)	59	49	77	12
25-39 years				
1965(N=282)	45	44	85	7
1968(N=200)	43	37	85	8
40-59 years				
1965(N=652)	27	43	79	9
1968(N=366)	27	28	82	10
60 and over				
1965(N=860)	19	13	55	31
1968(N=549)	22	9	77	7

Source: Schulberg, H. and Baker, F.

The Mental Hospital and Human Services. Behavioral Publications, New York, 1975, (Table 10-5 p. 286).

activists; the ideological position most at odds with the ideological stance of the somato-therapy group (Strauss 1964)

The ideological properties of the somato-therapeutic position have been identified earlier in this research. The "non-therapeutic" social orientation of that ideology was demonstrated in the properties of custodialism, impersonality and dehumanization associated with its use (Strauss 1964). In its haste to make "mental health services" available to "everyone," the community movement reinforced the very ideology with which it had presented itself as being least compatible.

In the profession of psychology, an ideological view associated with instrumental or administrative goals appears to have evolved in the wake of the "community" movement. In the "total institutions" of society, the mental hospitals, the prisons and the military, the same paradigm appears to have emerged as that of "community" psychology. Programs which have been implemented in schools, clinics and total institutions were largely grounded in the "behaviorist" tradition. An upsurge in "token-economies" in the hospitals, "implosive" interventions in the prisons, the increasing use of dubious psychological evaluative instruments such as I.Q. performance tests and programmed learning in education, all attest to the fact that the "community" is more than ever under the hegemony of the mental health "experts."

The following chapter will attempt to test empirically the hypotheses derived from the propositions generated by the discussion in the preceding chapters. An attempt will be made to obtain an empirical validation of the ideological positions of mental health professionals in the province of Manitoba, as posited in this research.

Chapter VI

AN EMPIRICAL TEST OF THE IDEOLOGICAL POSITIONS OF MENTAL HEALTH PROFESSIONALS IN THE PROVINCE OF MANITOBA

CONSTRUCTION OF THE TEST INSTRUMENT:

This research addressed itself to questions concerning professional attitudes to changing social conditions and to the ideological content which determines professional practice. The research attempts to ascertain the degree to which ideological factors serve to shape the nature of thought about mental health practice from a sociology of knowledge perspective.

Information to investigate the propositions suggested in this research (see Chapter 1) was gathered via a "paper and pencil test" constructed in order to measure respondents' attitudes to particular ideological domains. The test-instrument was based on scales constructed to test mental health ideologies in earlier research. The instrument constituted a "hybrid" model, making use of some of the ideological scales discussed earlier in this research. Examples of the scales from which the author drew items were the Community Mental Health Ideology Scale (CMHI) (Schulberg and Baker 1956), the Psychiatric Ideologies Scale (PSI) (Strauss 1964), and the Occupational and Job Characteristic scales developed by Robinson et al. (Robinson 1969) The format of the questions is that of declarative statements pertaining to professional ideologies.

The levels of response were deliberately varied with regard to attitudinal intensity (agree strongly, agree, disagree, strongly disagree) in order to aid the researcher in gauging the differences

between respondents in terms of levels of commitment to particular attitudinal sets. Some items in the questionnaire were more "controversial" than others, to delineate further ideological differences and to lay the groundwork for subsequent questions in the interview phase conducted with each respondent. While an evaluative component was present in every item, some items were explicitly phrased in a judgemental form to provide heightened focus on each ideological dimension, so that respondents' statements would reflect their ideological positions.

The test instrument was administered to two faculty members of the department of sociology and one member of the department of psychology (non-clinical) in order to establish whether each item in each domain was in fact gathering information about the ideological domain it purported to be testing. The researcher avoided using members of the groups to be tested in the item selection phase, in order to prevent bias in the selection of items used in the test instrument. Where any particular rater indicated that items were ambiguous or needed further clarification, adjustments in the test items (deletions, inclusions, changes in use of language, etc.) were made in accordance with the view of the rating-individuals. A final consensus between raters was established on the item-selection of the test instrument.

The ideological material tested in this research consisted of 100 questions which were addressed to ten ideological domains. The items broke down according to the following ideological content areas:

1) Somatotherapeutism
2) Behaviorism
3) Psychiatric Hegemonism
4) Community Orientation
5) Psychodynamicism
6) Humanism
7) Custodialism
8) Radicalism
9) Sociotherapeutism
10) Psychology Hegemonism

All test items were scattered throughout the test instrument to prevent identification of domains by the respondents. To assist the researcher in coding and scoring procedures, the format of scatter was according to digit endings in the list provided above, i.e., all items ending in 1 (e.g. items 1, 11, 21, etc.) were somatotherapy items, all items ending in 2 were behaviorial items etc.

Scales (3) and (10), the scales measuring professional hegemony, provided mirror questions which recorded responses in the direction of hegemony by psychology and psychiatry as professional groups. In the group of questions on hegemony by psychiatry, items 3, 43, and 53 were negatively scored items. In the psychology hegemony series, items 30, 50, and 60 were also negatively scored items (i.e. responses on these items were inversely scored since a response of "agree" constituted a non-hegemony reply).

Examples of the types of question items drawn from the original ideological test instruments were of the following type:

- A mental health program should direct particular ~~attention~~ attention to groups of people who are potentially vulnerable to upsetting pressures.
- The locus of mental illness must be viewed as extending beyond the individual and into the family, the community and

society.

- The responsible mental health professional should become an agent for social change (CMHI, Schulberg and Baker 1956).
- In a mental hospital, frequent changes in administrative policy on the ward tend to interfere with the patient's recovery.
- There are unnecessary risks in keeping hospitalized patients who are undergoing intensive individual psychotherapy on open wards.
- Clinical psychologists who show interest in doing psychotherapy should be permitted to do so in a hospital setting (PSI, Strauss 1964).[5]

THE INTERVIEW AND "PROBE" PHASE:

Interviews and "probing" with each respondent from the test sample were conducted subsequent to administration of the test instrument in order to gain access to information which was not forthcoming from the structured questionnaire items. The schedule of interview questions (Appendix IV) which supplemented questionnaire items provided supportive and in-depth data on the facts, opinions, attitudes and reasons for the responses of both professional groups. This involved sifting through the literature to find the most salient questions which allowed for the construction of "professional ideological profiles."

The researcher worked from a basic assumption that the

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[5] For the whole test instrument used to test all ideological domains, see Appendix 11.

respondent groups were verbally skilled in enunciating their desires, values and needs in order to construct models representative of their professional ideologies. Responses to test items which were deemed evasive or ambiguous were followed by probes in the interview phase using the "funnel effect" of moving from simple to in-depth questions to alleviate this problem.

> Although fixed-alternative items have the decided advantage of achieving greater uniformity of measurement and thus greater reliability, of forming the respondent to answer in a way that fits the response categories previously set up, and of being easily coded, they have certain disadvantages. The major disadvantage is their superficiality. Without probes they do not ordinarily get beneath the response surface. (Kerlinger 1973)

Hence, the methodological format of this research attempted to obtain data from three sources:

a) Behavioral referents by responses to the questionnaires.

b) Direct interviews without probing.

c) Probing involving the "funnel procedure" to obtain elaboration and greater reliability of response to the category being examined.

The probe methodology was also used to obtain information where no adequate test item had been provided to cover a particular ideological domain. The questions and probes thus concentrated on one facet of practitioner responses, i.e. professional ideological content.

THE SAMPLE:

The study use of samples has aided in off-setting the difficulty and expense (time and money) involved in attempting to interview large populations, e.g. "all professional mental health workers in

Manitoba."

In this study, a sample of 20 respondents was drawn from two groups of mental health professionals. The study was limited to active practitioners of psychiatry and clinical psychology. An equal number (10) of practitioners was obtained from each group. An attempt was made to draw on practitioners who operate in similar, if not identical professional milieux. There was some methodological difficulty in obtaining practising clinical psychologists who do "private consultation" only in line with their psychiatric counterparts.

In order to off-set differences due to work settings, only psychiatrists who had an affiliation with a hospital or clinic, and who had treatment input into those institutions were used for the psychiatric sample. In order to ensure greater respondent homogeneity in terms of work milieux, an attempt was made to draw members of each profession from the same work localities (i.e. psychiatrists and psychologists were drawn from the same hospital or clinic wherever possible).

To minimize regional differences (the scope of the study encompasses "practitioners in Manitoba"), respondents were drawn from Mental Health facilities in the Winnipeg area as well as from centers in Brandon and Selkirk. Contact with the respondents was made through their professional associations.

To control for greater homogeneity of the "professionalization" variable, the researcher confined the scope of subjects to those practitioners who had already completed the basic educational phase of

professional socialization. It was considered important (in meeting the criterion of "having been professionalized" with regard to the impact of ideologizing forces on professionalization) that each respondent in the sample have had sufficient experience in the field, to constitute a state of having acquired a professional ideology, rather than still being "in the process of acquiring" that ideology.

For the psychology sample, the criteria to be met were the Ph.D. degree, a clinical internship and subsequent experience in the field of mental health. For the psychiatric sample, the criteria were a medical degree, psychiatric postgraduate training and experience in the mental health field. All psychology respondents met their criteria. In the psychiatric sample, some respondents had not yet completed their Psychiatric Board examination, but were deemed to have met the "professional" criteria by virtue of the extent of their exposure to "in the field" professional activity.

DATA COLLECTION AND ANALYSIS

The researcher used a standard recording and scoring procedure for the test questionnaire. Responses to the test instrument were hand-scored for both individual and group-responses. The "raw" responses were then subjected to statistical analysis. The interview phase responses were recorded by the researcher during the question-session and were subsequently condensed in order to supply supportive in-depth information.

The scoring procedure for the test instrument involved a range of "a priori" assigned values of -4 to 4, with scores of 2 and -2 being

assigned to the intermediate range of responses. All items were scored in a positive direction, so that a "strongly agree" was worth a score of 4, and a "strongly disagree" worth -4. The negatively scored sub-items on the hegemony scales were transformed to positive scores from the raw data, and subsequently recorded in a fashion consistent with the rest of the test instrument.

In rare cases, where no response was made or where agree and disagree responses were presented, a separate category with a value of 0 (zero) was recorded as the no-response category. The instrument was designed to alleviate this effect as much as possible by not providing a "no response" category in the questionnaire, but the researcher was not able to preclude this response entirely. The total scale score of each individual was obtained by summing all item scores on a particular dimension and transforming the responses to numerical values provided in the "a priore" scoring procedure. Any item thus had a possible value of 4, 2, 0, -2 or -4. Any respondents' total score on a given ideological domain (consisting of ten test-items) had a maximum positive score of 40, or minimum score of -40.

The test instrument was designed as a means of determining whether an internally consistent range of beliefs held by mental health professions could be measured. The basic question regarding this instrument is whether the items in each scale (and the scales themselves) effectively isolate the same attributes, orientation and individual response styles, despite some dissimilarity in the manifest content between items and across scales. In order to avoid any bias in

reporting statistical relationships, only the means by profession and for the whole group were provided.

A second statistical procedure was applied to provide the levels of significance of differences found on the questionnaire subscales. The means (by profession and for the whole sample) are provided in Figures 15 and 16. The Mann-Whitney U test was used because it provides the most adequate statistical test for two independent test groups using a small sample size (N = 20). The results of the Mann-Whitney procedure are provided in Figure 17.

In the Strauss study (1964), he was able to show that his attitude scales could separate those professionals who strongly subscribed to a particular set of psychiatric views from those who tended to reject them. The major methodological difficulty encountered by Strauss was also carried over to the present study, namely, in attempting to isolate particular ideological dimensions, attention had to be paid to the danger of missing the fading-out, breaking-away, or coalescence of beliefs which signal the emergence of "new" ideologies. By extending the scope of Strauss' study to include seven new ideological dimensions, the author attempted to ameliorate some of the methodological difficulty encountered in that study.

The use of ten ideological scales assisted the researcher to isolate groups which represented diverging ideological positions. If the scale was an accurate measure along a postulated ideological dimension, then a response along that dimension should be higher than among groups which did not subscribe to that orientation. Further, clusters

Figure 15

PSYCHIATRY SCALES

Group Psychiat	SOM	BEHAV	PSYCHIAT HEG	COMM	PSY-DYN	HUM	CUST	RAD	SOC	PSYCHOL HEG
RESPONDENT 1	2	-2	-10	20	4	10	-24	-22	16	2
2	14	-16	-10	10	-16	20	-22	-20	12	-12
3	20	-24	-10	16	8	6	-16	-30	10	-4
4	8	-14	-16	34	-6	-4	-32	-16	20	-6
5	26	-10	-18	12	-4	-2	-24	-16	0	-8
6	-4	-24	-12	14	-2	14	-18	-20	-4	-6
7	24	-2	-16	34	-8	26	-12	-4	20	-12
8	14	-14	-16	6	-28	16	-28	-26	6	-2
9	20	-18	-16	24	-22	18	-36	-4	18	-12
10	4	-24	-22	12	-8	18	-34	-22	16	-12
$\bar{x}$	12.8	-14.8	-14.6	18.2	-8.2	12.2	-24.6	-18.0	11.4	-7.2
$\bar{x}$	3.7	-4.8	-13.1	17.3	-12.2	11.6	-24.4	-11.0	11.9	-4.8

Figure 16

PSYCHOLOGY SCALES

Group Psycholo RESPONDENT	SOM	BEHAV	PSYCHIAT HEG	COMM	PSY-DYN	HUM	CUST	RAD	SOC	PSYCHOL HEG
1	-12	4	-18	28	-10	26	-24	24	22	-12
2	4	-8	-2	18	-4	18	-18	6	8	12
3	-4	32	-16	20	-32	-4	-34	6	30	6
4	0	30	-16	24	-18	12	-20	-26	10	-4
5	-2	-16	-6	10	-16	8	-22	-20	0	-10
6	-20	4	-12	10	-14	2	-20	-12	0	-6
7	-2	12	-12	24	-14	4	-30	-6	12	0
8	-18	-18	-18	14	-22	30	-30	26	22	-10
9	4	8	-10	6	-16	4	-22	-30	4	0
10	-4	4	-6	10	-16	10	-22	-8	16	0
$\bar{x}$	-5.4	5.2	-11.6	16.4	-16.2	11.0	-24.2	-4.0	12.4	-2.4
$\bar{x}$	3.7	-4.8	-13.1	17.3	-12.2	11.6	-24.4	-11.0	11.9	-4.8

Figure 17

Mann-Whitney U
Group Comparison

Scale	Sum of Ranks Psychologists	Psychiatrists	U	Significance (2-tailed)
SOM	147	63	8	P < .001
BEHAV	141	69	14	P < .001
PSYCHIAT-HEG	117.5	92.5	37.5	N.S.
COMM	100	110	45	N.S.
PSY-DYN	89.5	120.5	34.5	N.S.
HUM	111.5	98.5	43.5	N.S.
CUST	120	90	35.0	N.S.
RAD	134	76	21	P < .05
SOC	107	103	48	N.S.
PSYCHOL-HEG	128.5	81.5	26.5	P < .05

of "ideological compatibility" should be consistent along more than one ideological dimension, e.g. a high score on Psychiatric Hegemony should "attract" a high score on at least one other psychiatric dimension and a low score on the psychology hegemony scale. The figures presented in this section provide information about response styles for each individual respondent, his occupational group, and for the whole range of "mental health professionals" as a separate entity in this study.

RESULTS:

As a professional group, the psychiatric sample responded in a positive direction on the Somatotherapy, Community, Humanism and Sociotherapeutism Scales. The psychology sample responded positively to the Behavioral, Community, Humanism and Sociotherapeutism Scales. Responses on the Somatotherapeutism-Behaviorism Scales were the most clearly defined area of professional dissimilarity. The psychiatrists scored a high 12.8 mean response on the somatotherapy domain, and a low -14.8 on the behavioral domain, psychologists scored a high 5.2 on the behavioral domain, and a low -5.4 on somatotherapeutism. There was a uniform negative response set for all psychologists to the psychodynamic position, which suggested that as an ideological or professional view that orientation was untenable in the psychological sample. Coupled with their rejection of the somatotherapy position, the psychologists may be seen as having rejected the ideology of the psychiatric "medical model."

This finding reinforces the proposition that the major ideological

difference between the professions is still related to the content areas of their educational backgrounds. Psychiatry, as part of the medical profession, is (in the Province of Manitoba) significantly more concerned with the "medical" component of psychopathology than the psychologists. Conversely, the psychologists orientation toward "behavioral analysis" as opposed to "medical diagnosis" was shown to clearly separate their view from the psychiatric view. ($P < .001$ on both sub-scales)

Ideological dimensions which showed a high level of compatibility between the professions were Community, Humanism, and the Sociotherapeutic orientations. The custodial dimension was almost equally rejected by both professions. The radicalism dimension was rejected by both groups, but was more strongly rejected by the psychiatric sample than the psychology sample. A significant level of difference in the degree to which each profession rejected this position was found ($p < .05$). This finding is consistent with the research hypothesis which predicted a higher level of "conservatism" among psychiatric respondents, and greater ideological "activism" in the psychology group as indicated by their stronger endorsement of the radical view.

Unlike the Strauss study, a strong "psychodynamic center" of the psychiatric profession was not present in this study. The psychodynamic view was rejected by both professional groups, though, consistent with the research hypothesis, this position was more strongly held by the psychiatric sample and more strongly rejected by the

psychologists. The most strongly endorsed position by both professional groups was the "Community" position. This response was constant for each profession and across professions. Equally, the Custodial view was the most rejected position by each group individually and for the whole test sample.

No significant difference between the professions was found on the psychiatric hegemony scale. On the psychology hegemony dimension a difference which was significant at the .05 level was present.

The responses to the Hegemony scales gave some information about respondents' perceptions of their various professions vis-a-vis the other group under study. There was an overall negative response-set to this group of items (rejection of Hegemony) by the whole test sample in both groups. However, the psychiatry group was more rejecting of the notion of "hegemony" in the mental health sector whether such hegemony was presented as emanating from the psychiatric or psychological profession. The psychiatric sample did not support a position of psychiatric Hegemony ($\bar{x}$ = -13.6) but they also rejected the psychology hegemony dimension more strongly than the psychologists did. ($\bar{x}$ psychiatry -7.2, $\bar{x}$ psychology -2.4).

The response of the psychology group to the psychiatry hegemony domain ($\bar{x}$ = -11.6) constituted a strong rejection to perceived hegemony of the psychiatric profession in the mental health sector. This view was further reinforced from their responses to the interview material. The psychology sample was also more willing to endorse a position in the direction of greater hegemony by their profession than

the psychiatry sample had been willing to make about their profession. The author suggests that some of this effect may be attributable to psychologists perceptions of themselves as enjoying a lesser rather than a greater degree of hegemony over the mental health sector.

This assumption is in accord with the earlier research (Brody 1974) which identified the psychology profession as both dissatisfied with the hierarchical features of the mental health professions, and their relative inability to displace the hegemony of the more established psychiatric profession.

THE INTERVIEW PHASE:

While a high proportion of respondents defined themselves as having an "eclectic" orientation to their work, some significant ideological dimensions operating in their professional milieu emerged from both the questionnaire and the interview material. Stock questions were addressed to each respondent followed by more specific and focused items when the initial response was deemed to be evasive, ambiguous or worthy of further investigation via the "probe" methodology. (see Appendix IV) The interviews provided the following information.

a) The Psychology Sample

The respondents in this group did not view clinical psychology as dealing in quite the same area as psychiatry. Differences were expressed with regard to psychiatry's focus on "the medical model" and heavy reliance on chemotherapy as a therapy form. Psychologists viewed their orientation as being "more broadly based," dealing in "all things psychological" rather than a focus on the psychopathological aspects

of behavior only. One respondent reported a view that psychiatrists were "more concenred with maintaining their professional prerogative that psychology was "more open to other systems," and that more research findings were "borrowed" from psychology by psychiatry than a reciprocity model might suggest.

In regard to their "professional" role as clinical psychologists, the largest group (50 per cent) considered therapy and research as being of equal importance and being equally central to their role. One respondent indicated that therapy was research if outcome data were recorded. Two respondents indicated that research was the prime role of the clinical psychologist, in that therapeutic intervention offered only "stop-gap" value for a few individuals, while clinical research addressed itself to infinite populations for changing behavior, by providing "preventive measures for whole groups." This group perceived the role of clinicians as "educators in the best research methods." Those respondents who viewed therapeutic intervention as the prime role stressed the "healing" role as the more appropriate "professional" aspect of clinical psychology. This group viewed evaluation, diagnostic understanding and treatment as the prime role of clinical psychologists.

The whole sample of psychology respondents (with no exceptions) expressed a concern about the need for greater autonomy and professional input into the mental health system for their profession. A question which probed for receptivity to the idea of a "private practice" model for the services of clinical psychologists (such as

inclusion under Medicare) was endorsed with a few reservations, by the whole sample.

One respondent opposed the medicare model but strongly favored a "fee for service" payment scheme for psychologists. Three respondents were strongly in favor of an increase in socialized medicine, to include the services of clinical psychologists and a concomitant reduction in the fees for services of the psychiatric profession. One respondent opposed the role of primary therapist by psychiatrists as being untenable, in that in many therapy forms (management of neurosis, interpersonal relationships) the "medical" component of input was not central to therapeutic gains. Reservations about an expanded professional role for psychologists were expressed by the psychology sample in regard to the following:

a) One respondent expressed concern about the ability of both the professions under study to provide adequate services at all.

b) One respondent found no qualitative differences in the type of services provided by the two professions, but expressed support for a "medicare" model which would provide a referral system to psychiatrists for medication and an upgrading in the training of clinical psychologists in the areas of psychopharmacology and psychotropic medication.

c) One respondent expressed approval for a "medicare" type program which would decrease the cross-professional areas

> of conflict, but which stressed greater accountability by each practitioner with regard to "quality of care." Such a model might be affected by more extensive certification examinations for clinical psychologists to increase the level of competence demanded for attainment of the professional title of "clinical psychologist."

On the issues of territoriality and professional rivalry, the psychology sample demonstrated a high level of involvement and consistency with regard to their perceptions about the structural and status features of the mental health establishment. One respondent's reply was indicative of the thinking of the whole sample:

"The shrinks have it sown up. The distribution of hierarchical functions was an issue, is one, and will continue to be one in the foreseeable future."

In attempting to gain some level of validation between the questionnaire responses and the self-perceptions of each respondent about his professional orientation, each respondent was asked to define his "professional ideological orientation." The self-definitions of each respondent are reproduced here in their entirety:

1) An analytically oriented eclectic.
2) A Research person, a holist, drawing on theory from all disciplines. I am not concerned with the individual that much at this time.
3) A humanist, psycho-dynamically oriented and relationship therapy. I'm traditionalist in therapy and hold some

radical theories about questions of mental illness and its treatment.

4) An empirically oriented social learning theorist. I include such factors as genetic loading. I accept others' views as equally legitimate.
5) Ego-psychoanlytic.
6) Behavioral, client-centered, cognitive.
7) A Behaviorist.
8) A Gestalt-humanist. I have an appreciation for the analysis of behavior.
9) Eclectic, with a slight favoring of Behaviorism.
10) I try to think like a learning theorist, live like a humanist.

In response to probing about the direction in which practitioners considered the best "quality of professional service" might lie, the following views were presented. One respondent felt that development of better mental health services lay in a more "preventive" direction. Additional training in other basic services not traditionally regarded as the preserve of "mental health" was deemed to be valuable in the training of mental health professionals because of the increased overlap of economic, political and social factors in the complexity of mental health services.

A second respondent favored the "medicare" model, which would include a government-sponsored and partially controlled provision of individual and group psychotherapies. The thrust of this

group of respondents was in the direction of advocating a "fuller" training perspective, with more emphasis on the "problems in living" approach to mental illness, preventive and holistic orientations to treatment and a greater awareness of the "real life experiences" contributing to psychological dysfunction.

A second view of how the most adequate services might be achieved was linked to a direction away from the medical model orientation to diagnosis and treatment. This view suggested that the "psychologist in training" was not sufficiently client-oriented in the experimental phases of graduate training, while the psychiatric trainee "suffered from too much responsibility with too limited knowledge of behavior disorders--a sink or swim model." It was posited that an integration of both approaches would result in a stronger theoretical and practical model for practitioners from both disciplines.

The directions for future development of the professions, which were presented in this position, were that psychologists might benefit from more client-involvement in their orientation, by approaching their work with more humility and tentativeness with regard to their theoretical conclusions. This position also maintained that the outcomes research available at this time did not provide "the answer" to definitive intervention techniques.

It was suggested within this framework that less secrecy and hoarding of professional knowledge (psychotropic medications in the psychiatric profession and "behavioral tricks" by psychologists) did not serve the professional goals of either discipline, and that the subtlety and/or complexity of each discipline's tools were not so great

that they could not be shared with other mental health professionals. The focus of this view was that interdisciplinary forums should be attempted in more tangible ways, and that "what little we do know should be pooled." It was also suggested that more emphasis on "human potential" rather than "psychopathology" was appropriate.

In line with this view a model which supported greater liaison and alignment with general-health-care systems was suggested. Rather than isolation as a sub-sector of the delivery of health services, mental health facilities might be more effectively involved in the general net-work of health-services. Some suggestions were offered about how the whole mental health sector might enhance its visibility and credibility. A weakness in professional links with other social groups was presented as detracting from the effectiveness of both professions. A point made earlier in this research was that such an effect would occur, where ecumenic and parochial goals were at variance or not being met.

More publicity about specific problem areas in which help was available was suggested, as well as more consultation between professionals and the schools, private organizations and government agencies. This view stressed the development of a greater "scientist-practitioner" model among mental health professionals, with greater emphasis on a systems-analysis approach to research, less "seat-of-the-pants" approaches to treatment, greater attention to the collection of data, and a movement away from a reliance on "medical do-alls."

One respondent expressed a view that less "political

interference" from social scientists researching the ideologies of mental health professionals would be of benefit to the development of the mental health professions. A single respondent indicated that greater attention be paid to models of therapy which were geared specifically to the treatment of "family" concerns. The same respondent also pointed to the increased need for treatment facilities specifically geared to the special problem areas of children and the aged.

In the psychology sample there was a wide range of views with regard to the effects of social issues on the nature of professional work. The whole sample expressed the view that "social" issues played some part in shaping their professional styles and attitudes, but there was considerable spread with regard to how they perceived themselves as being affected by these issues.

One respondent suggested that social values define what is socially and behaviorally aberrant. This respondent stated that professionally he viewed ideology and attitudes toward behavior as being almost synonymous. Social values were seen as the process by which the relationships between people in the social system were defined. Hence social issues and questions of social change were viewed as determining his clinical interventions to a significant degree.

"Yes social changes affect what I do clinically. Problems-in-living must be viewed in the social arena in which they occur."

A second group of respondents viewed social issues as the contingencies by which individuals become appraised about how one

should behave in order to be reinforced or avoid punishment. The effects of therapy were viewed as shaping appropriate or "less-punishing" social roles. Prediction about behavior was thus seen as having the value of minimizing the effects of social conflict, through prevention rather than post-hoc intervention.

Specific social issues which have relevance for the provision of mental health services were presented by some respondents. Female roles and the prescribed social norms governing such social concerns as human sexuality, the family and the education process were raised as social areas which had caused changes in attitude among mental health professionals, and had affected their clinical practices.

Other social areas which were alluded to, included the question of "consumerism," ethical norms in the larger society, the pace of living in the twentieth century and its negative effects on behavior, questions of social justice in society, differences between social deviance and criminal or pathological behavior, the expert-supplicant nature of "professional" mental health services, and the rights of individuals to refuse treatment in a non prejudicial fashion.

Of the psychology sample, two respondents did not view social issues as central to the immediate locus of concern in their job situation. Questions dealing with social concerns were not viewed as paramount in the provision of mental health services by those respondents.

A final question addressed to the psychology sample solicited their attitudes toward "radicalism" in the mental health professions. The radical perspective was presented in terms of the views held by such theorists as Claude Steiner, R. D. Laing and Thomas Szasz,

regarding the mental health professions from that perspective.

Some respondents expressed satisfaction and agreement with that view, though no respondent in this sample expressed personal identification with that orientation in its entirety. Some respondents ventured that that orientation offered an enlightened perspective which was not wholly consistent with the "official" line on professional practice. Within this view, delineations were presented which distinguished between the approaches of such theorists as Laing, Thomas Szasz, and "the Berkeley Radicals." One respondent viewed the approach of Szasz as having "a kernel of truth" form of validity in his approach to radical psychiatry. Psychological orthodoxy was viewed by these respondents as being based largely on socially prescribed norms (e.g. emotional disturbance would be seen as the result of social pronouncements about behavior).

A different view of the radical movement posited that those facets of radical practice which had core validity were legitimate and of value, but that some of the radical people were just "blowing their own horn." These respondents felt that "professional ethics demanded that practitioners would be prudent to avoid placing too much stock in sensationalized new discoveries and truths." These respondents indicated that even radical theories of mental health would have to stand the test of time since their theories had not been shown to have been proven "beyond a shadow of a doubt." It was proposed that Behaviorism and Freudian theory each had represented very radical thinking in their respective eras and had gone on to become "mainstream" theory. One

practitioner responded:

"Much of behaviorism was radical in its time. It is interesting to note the social concerns of this ideology, but their time has probably not come yet. There is a need for 'magic' every ten years or so."

A single respondent from the psychology sample expressed strong dissatisfaction with the radical perspective. This respondent claimed that "the radical therapists did more harm than good." Their radical position was viewed as resulting from a "basically political out-look on life; their assigned role being to attack the status quo, without any real concern for therapy." This respondent felt that instead of honesty, the radical movement was invoking ideology under the guise of providing psychotherapy.

b) The Psychiatry Sample:

The self-definitions of "professional ideological orientations" of the psychiatric sample are also reproduced here in their entirety:

1) I'm a psycho-dynamicist.
2) An Eclectic.
3) An Eclectic.
4) A "hybrid," more along psychodynamic, environmental humanistic lines, but I can talk up drugs with the best of them."
5) Eclectic, what I like to do is psychodynamic psychotherapy.
6) An analytically oriented psychotherapist (dynamicist).

7) I subscribe to social learning theory and hereditary-biochemical theory.

8) A skeptic.

9) Eclectic, with bias toward community psychiatry.

10) No response.

The response of the psychiatric sample to the question dealing with similarity and differences in practice between the two professional groups was quite evenly divided. About one half perceived the two professions as dealing with the same subject matter. Qualifications in this position were that while subject matter remained a constant for both groups, the professions often approached it from different perspectives which led to qualitative differences in perception and understanding of the same subject matter.

The view of those respondents who did not see the professions as engaged in the same subject matter was that while large areas of over-lap could be perceived, the organic content of mental illness was solely the domain of the psychiatric profession. Real differences between the professions were perceived in terms of the specialized "medical" component which the psychiatric profession brought to their work. One respondent indicated that closer links between organic-oriented clinical psychologists and the psychiatric profession were appropriate.

The issue of "territoriality" between the professions provided a variety of responses. The vast majority of respondents (9 of the 10) perceived this as a problem area as had the psychology sample.

Possible forms of redress of this issue and reasons for its continuance varied over a wide range of responses.

One position suggested that the issue was strictly a "political" one, having no bearing on matters pertaining to quality of care. It was suggested that the psychiatric profession maintained its position "since we cannot afford to lose our identity as doctors." In line with this position but opposing it, an alternative view proposed that the problem of territoriality was one which was only resolvable between practitioners themselves at a personal rather than a professional level. This respondent indicated that perceived differences in hierarchy structure, and power-struggles for "control" over the types of therapy did have deleterious consequences for the patient population, thus affecting the quality of care.

While some respondents viewed this problem as existing across professional lines, its impact was regarded as muted or insignificant in particular work settings. One respondent felt this to be the case for the whole province of Manitoba. This view entertained a model of "co-operation" between the professions and suggested that the great need for mental health services at this time made ideological competition between the professions an ill-afforded luxury. In contrast to that position, a number of respondents expressed a need for "dialogue" between the professions, since their orientations were deemed to be essentially conflictual in the philosophies which they brought to the work situation. One respondent expressed such a core area as involving polarization between

psychiatric principles and the use by psychologists of behavior modification techniques. A similar response indicated that no effective "therapy" was possible without the medical component of diagnosis.

One group of respondents (3 of the 10) viewed the locus of conflict between the professions as existing outside of ideological concerns but as a consequence of the attitudes of clinical psychologists to their own position in the mental health network. This view proposed that part of the conflict stemmed from a basic resistance of the psychiatric profession to the surrender of any established sovereignty over the mental health domain, as well as a view held by the psychiatric profession that "psychologists were not equipped to deal with the mentally ill." It was suggested that a more comprehensive licensing procedure would allow psychologists to feel a greater "legitimacy" about their profession and reduce anxiety about the identity of the profession of clinical psychology. This view allowed that at the present time, the position of clinical psychologists was too tenuous to allow them an inordinate amount of responsibility and security, or specific delineation of their own "area" in mental health.

The psychiatric sample expressed attitudes about two major concerns regarding the future development of the mental health professions in the direction of better quality of care:

a) The relative support or non-support of the "community" mental health enterprise as an effect on the provision of services.

b) The isolation of areas of research or specialization which were identified as most related to quality of care issues.

Those respondents who favored the "community" model expressed the need for input from all mental health professionals in a "team" structure which made use of their various inputs, and tended to homogenize the level of intervention to a group rather than an individually-based approach to therapy. They suggested that such a model offered the benefit of a multi-discipline approach and the potential for use of greater social resources such as the schools, business, and local community organization. The central base of the "team" was the "community mental health centre" which could provide the centralizing and coordinating aspects of treatment. One respondent from this group expressed the need for placement of more mental health teams throughout the province of Manitoba (particularly in the non-urban areas), better liaison of social agencies and more financial allocation for training programs involving Indian and Native people as "local" mental health workers.

Resistance to implementation of "community" mental health treatment centered around a position which viewed this model as producing "a nondescript mental health worker who would not have the professional skills of any of the specialized fields in mental health." This group supported a model which retained "what is unique in each profession" and made shared input into treatment a function of professional accommodation rather than a matter of policy.

Specific areas of development for the mental health

professions were isolated with regard to the up-grading of services available at the present time. One respondent expressed the need for greater exploration of the behavioral therapy treatment modality, as well as greater emphasis on "the family" as the unit of treatment. The cultural determinants of behavior was an area which demanded further research. More efforts on research into biochemical and pharmacological aspects of treatment, and the use of persons trained in these specialties in thehospitals in day-to-day clinical work with patients was suggested. Further specialization in "the use of somatotherapy" and better follow-up procedures, sexual counseling, and psychotherapy with children and the aged were viewed as areas which merited further development.

One respondent focused on the relative neglect of "chronics" in the treatment network as an area in which quality of care was an issue. This respondent viewed the hospital as the place where therapeutic needs should be met. The respondent indicated that the relative avoidance of these populations by professionals from both disciplines detracted from the provision of services to a sector where professional skills were most needed.

Like the psychology sample, the psychiatric respondents viewed social issues as having some effect on their work. Two respondents indicated that while social events had a bearing on the values that they brought to their clinical practice, the impact of these forces on their work was minimal in that they did nothing to "change" the basically medical criteria by which psychiatric practice was

conducted.

Responses which acknowledged the presence of social forces as shaping psychiatric practice included the following:

1) Even a purely psychodynamic orientation required certain adaptation in a changing society.
2) The mental health professional constitutes part of the "social matrix" hence changes in society have a rapid and significant effect on the nature of psychotherapy. The change in meaning of terms such as "the family" and "marriage," as well as the more vocal demands of the disadvantaged members of society were perceived as necessitating a shift in the attitudes of those parts of the social matrix which make contact with those new social conditions.
3) Social events with specific bearing on mental health reported by these respondents dealt with questions of economics, the "feminist" movement, homosexuality, questions of "identity," the quality of life, and racial and ethnic differences as social forces which have traditionally come under the aegis of "mental health."
4) One respondent indicated that behavior that had been previously regarded as grossly abnormal was much more easily tolerated in the modern social milieu--"even regarded as normal."
5) One respondent commented on societal responses to mental

illness and the issue of mental illness as a concern of the larger society. He perceived a lessening of stigma as resulting in more people seeking treatment, particularly for the psychoneuroses, depressions and conversion reactions (hysteria).

Responses by the psychiatric sample to the "radical movement" in mental health were generally in terms of disagreement. Some respondents ventured a position that "radicalism" in any form was wrong by definition, others, that the adherents of the radical position were "crazy" and had nothing new to offer the mental health professions. One respondent felt that the radical movement's position was motivated by humanitarian concerns, but that its direction was amiss. Concern was expressed about the implementation of radical theories and clinical practice in mental health since this involved "tampering with human lives."

Tentative support for some of the radical views was offered by three members of the psychiatric sample. One respondent perceived the radical position as serving a "watch-dog" function to prevent the profession from growing overly-complacent, but stressed the danger of overreaction by "throwing out the baby with the bath-water." A second respondent found some substantive value in the radical view but perceived it as essentially "faddish" in nature and the source of future mainstream-thinking within the profession.

This section of the research provided some in-depth support for the propositions which were suggested by the literature, and for

the findings of the test instrument. The interview material tended to reveal an ideological constancy and structure among the respondents which reinforced the positions identified in the test instrument. The use of an empirical source of measurement alongside idiographic material (practitioner interviews) provided the researcher with two methodological systems which showed a high level of consistency despite the variation in data gathering procedure.

SUMMARY AND CONCLUSION

a) The Empirical Test

This research set out to identify and explore the ideological working of two groups of mental health professionals. An attempt was made to extend the work of Strauss et al (1964) in order to delineate further the ideological orientations of these professionals beyond the three psychiatric groups which Strauss presented. An attempt was also made to present a comparative distribution of the orientations within the two professions, and to provide an account of the degree to which each profession believed itself and the other profession to be qualified to perform psychotherapeutic functions.

The research demonstrated varying degrees of ideological support along the 10 dimensions used in the test instrument. It also showed the relatively "high" level of ideological input into the shaping of their professional styles.

The psychology sample broke down along the major ideological positions identified in this research. The psychiatric sample endorsed two of the three ideological positions which were isolated by Strauss

(not "psychodynamism") as well as some positions which were not included in that study. Some ideological overlap between the groups was demonstrated in the test instrument and from the interview data. The degree to which ideological data has had input into professional practice was most clearly demonstrated by the correlation between attitudinal responses and the responses to the interview questions.

On the question of "professional hegemony," the data tended to show a high level of group cohesion within each profession. Consensual validation of the "declared stance of each profession" through its professional association and the job demands of the work situation tended to coalesce around occupational parochial norms.

Some level of professional "deviance" was present in those areas where respondents' views were not in line with mainstream occupational policy. The "radical" view which was endorsed on some items by practitioners from both groups was an example of non-orthodoxy of views among some respondents.

The question of professional hegemony was most clearly demonstrated in the area of rivalry for territoriality. The psychology sample posed questions about ideological hegemony related to their strivings for a stronger position in the mental health super-structure, and for part of the sample, in relation to their ideological views about social control.

Methodological difficulties which were encountered in this research were basically of the following type:

1) The relatively small sample used in the study placed limitations on the generalizability of the findings to

other mental health groups.

2) The test-instrument was developed specifically for the purpose of conducting this study and hence established norms from other professional groups were not available for comparative analysis.

3) In attempting to extend the number of ideological dimensions from the three which were used in Strauss's study of psychiatrists, to ten dimensions which reflected the ideologies of both groups, some specificity was lost. In the Strauss study, each ideological domain had more items than the ten provided for each domain in the present study. A possible extension of the number of items on each dimension in future research should alleviate some of the "overlap" between items and ideological domains. A more extensive grouping of every ideological domain however, brings with it the problem of creating an unduly "bulky" test instrument which would be more expensive and time-consuming to administer.

b) General Conclusions

"Ideology" among mental health professionals was shown to exist at three different levels. It was present as a trait or characteristic of individual practitioners, and between members of an occupational and larger professional group. In simple terms, the ideological content in these professional groups defined "who believed which ideological dimensions, for which reasons, and with what effects."

Constancy of their ideological premises was shown to be linked to the social (as opposed to specifically functional) aspects of professional practice. Conflict between the groups for the attainment of hegemony over the mental health sector was shown to be a major concern. The extensive history of ideological rivalry in this sector was shown to be located in the formulative or training phase associated with each group and not to be an explicit recognition of newly discovered professional differences.

Ideological content was shown to operate in the abstractions, conceptualizations and evaluations which each group made about the other test-group. One can only speculate about what the unconscious motives which underlie these ideological tenets might have been. Any effort to "interpret" the reasons for these ideological differences was complicated by the reflected ideology which the researcher brought to this task.

The most adequate solution to this type of problem involved attempting to find reliable evidence to support the validity of the research hypotheses. The first step in this direction lay in the identification of the content areas of the ideology from their explicit formulation, or from an analysis of the belief systems of the ideologies' adherents. An attempt was subsequently made to "measure" the ideological content.

When Mannheim (1936) made his distinction between ideology and Utopia, he differentiated between that which cannot be implemented and that which can. His distinctions between thought and action underlined

the premise that belief-systems did not have to have clear effects on human behavior. Manneheim suggested that because of the wide support, complexity and conviction that both ideology and action entailed, that changes in belief systems would occur slowly, if at all. This research represents an attempt to investigate Mannheim's hypothesis, particularly with regard to the nature of current mental-health ideologies and changing social conditions. Are the ideological premises of the mental health professionals in Manitoba at this time at a stage of "shift" in perspectives (action), or do those premises retain a content (ideology) which promotes professional hegemony?

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APPENDICES

APPENDIX 1

APPENDIX 1

AN APPROACH TO PUBLIC AFFAIRS:

REPORT OF THE AD HOC COMMITTEE ON PUBLIC AFFAIRS[1]

LEONA TYLER

University of Oregon

TAKING appropriate action on public policy issues is a task that APA cannot delegate to any one board or committee. If APA is to act effectively it will require: (*a*) a strong Board of Directors, (*b*) a strong Central Office staff, and (*c*) an informed constituency.

What the Ad Hoc Committee attempted to do was to construct a *system* for dealing with public affairs. This system has three major components: (1) a set of receptor mechanisms to detect signals of emerging issues as early as possible; (2) a decision-making mechanism for processing relevant information and choosing the action to be taken; and (3) a set of effector mechanisms to carry out the decisions. In addition to clarifying the nature of the processes occurring in each component part of the system, the Committee attempted to specify the persons or groups of persons responsible for carrying out these processes.

The Committee recognized that the system could never be a simple mechanical process for grinding out optimal decisions. Tentative decisions to be modified at later stages by feedback resulting from the first actions taken will usually be required.

Both Component 1, the signal detection process, and Component 3, the effector processes, involve the participation of a considerable number of persons and groups, differing for different issues. Most frequently, signals are picked up by Central Office staff members, who have been assigned liaison duties with various government departments and agencies, or by APA boards and standing committees. However, any APA member may become aware of an issue and initiate correspondence with officers or Central Office staff with regard to it. For best results, the sensitivity of all of these signal detectors should be maximized. Generally speaking, the earlier an issue is recognized the better. Most frequently, the final actions taken, such as, for example, testifying before a legislative committee or writing a statement for a government agency, will be the responsibility of a Central Office staff member or an officer of the association, but the task may be assigned to a committee chairman or an APA member who is especially knowledgeable about the matter under consideration.

Government policy is made at many levels, and APA may need to become involved at any of them, as shown in Figure 1. The decision about where to bring influence to bear on policy is one of the most important decisions to be made in connection with each specific issue.

The middle component of the system, the process of considering relevant information and arriving at a decision, is the most complex, and the Committee devoted the major share of its time to it. It was decided first that the responsibility for carrying out this decision-making function should be assigned to the Board of Directors or the Executive Committee acting for the Board. Two considerations led to this conclusion: (*a*) the Board is the group elected by the members or their representatives and authorized to make policy decisions, and (*b*) the Board and its Executive Committee are the only APA bodies that meet frequently enough to make well-timed decisions. With this basic assumption about *who* the decision makers are to be, the Committee formulated a set of guidelines about *how* such decisions should be made.

Structure of the Decision Process

The basic structure of the plan is roughly sketched in Figure 2. It involves two major elements, represented there as dimensions:

1. A graded series of actions that might be taken ranging from a high level of political involvement to no action at all.

2. A graded series of types of issues ranging from those on which action by APA is most relevant or most urgent to those involving little or no relevance or urgency for APA as a national association.

[1] Members of the committee: F. K. Berrien, Kenneth E. Clark, William A. McClelland, Henry Riecken, Donald W. Taylor, Leona Tyler (Chairman), and C. Leland Winder.

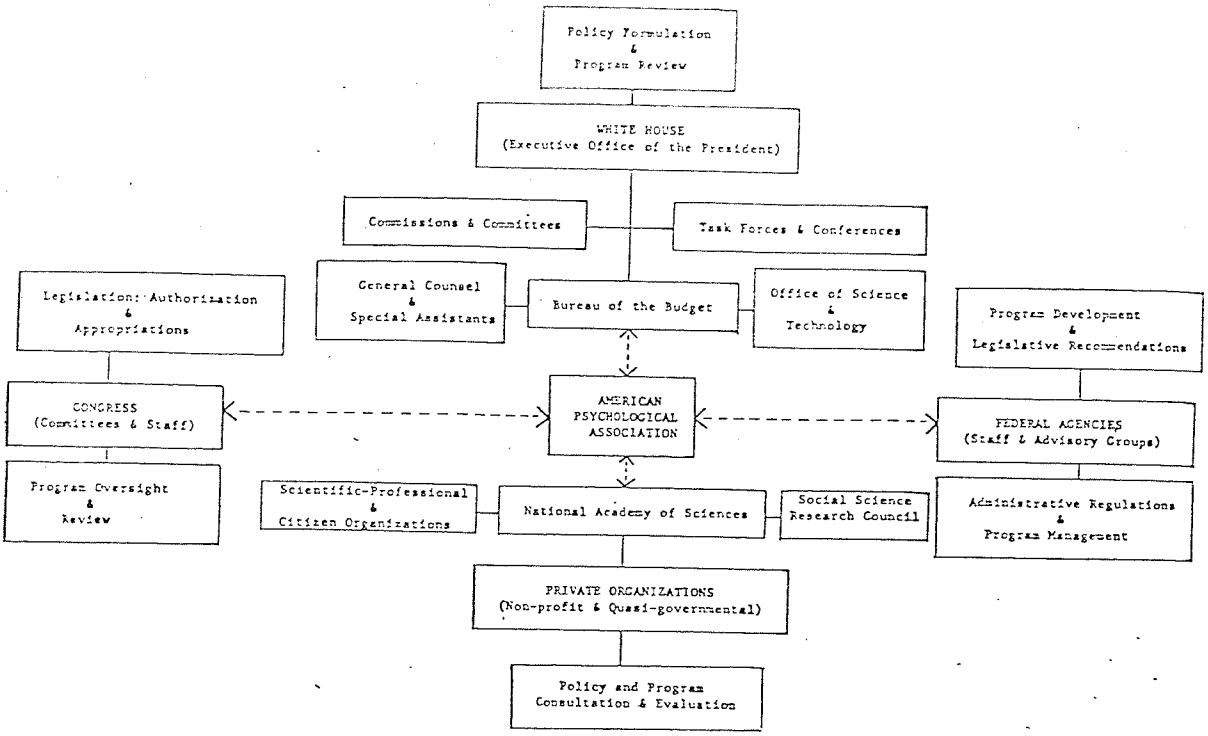


FIG. 1. A simplified schematic representation of the network of relationships maintained by APA in the complex process of government policy formulation, decision making, and program management.

The curved line in Figure 2 represents in a rough way the limit beyond which the decision makers would *not* go in selecting an appropriate action to take in any given instance. The closer to the beginning of the x-axis any issue that presents itself falls, the greater the *range* of permissible actions. In considering which *particular* action to take among those within the permissible range, the decision makers would use criteria which constitute additional constraints:

1. The importance of the problem area (primarily to psychologists, but also to society as a whole).
2. The amount of research-based information available.
3. The extent of value agreement on the issue among APA members.
4. The probability that the action will be effective.

It was recognized by the Committee that the decision-making process is not and cannot be a mechanical selection of an alternative on the basis of criteria. The graded series of actions probably cannot be scaled in any exact way; the weight to be given any criterion in a combination cannot be expressed in quantitative terms. The schema is designed to facilitate decisions, not to make them.

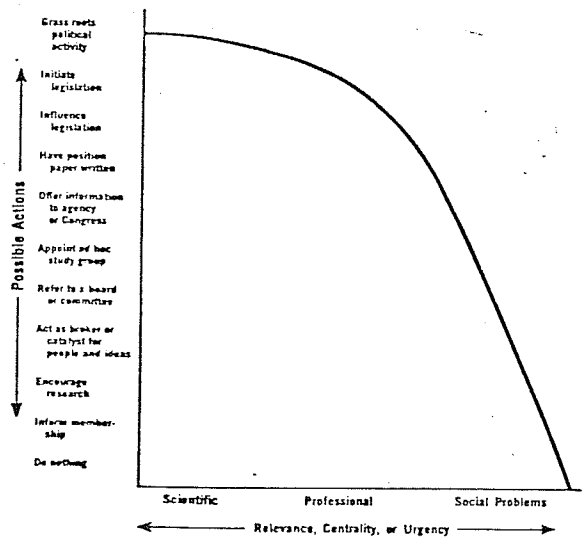


FIG. 2. Guidelines for decisions. (This diagram is intended to represent a concept rather than to show precise quantitative relationships. The Committee had no basis for deciding just where the curve should be drawn or what its exact shape should be.)

Basic Variables

Each of the three divisions indicated along the abscissa of Figure 2 represents a range of public policy issues of one general class. One thing that distinguishes the set labeled "Scientific" is that they are important to all psychologists who make use of the body of knowledge our discipline includes, and thus have relevance for researchers, teachers, and practitioners. Another distinguishing feature of such issues is that there is no other organization clearly responsible for them. If action is to be taken, APA must take it. Examples of issues falling in this class might be a drastic cutback in training and fellowship funds or the imposition of crippling restrictions on psychological research.

The set of issues labeled "Professional" has to do with matters affecting the practice of psychology in schools, in clinics, in industry, and elsewhere. Because they do not affect all psychologists in the direct way that the first set do and because there may be other organizations besides APA prepared to take action on them, they are placed a little lower on the scale and are linked to a somewhat smaller range of actions. Within this group of professional issues, some would clearly rank higher than others in urgency.

The consideration that places "Social Problems" at the lower end of the Relevance, Centrality, or Urgency scale is mainly one of appropriateness for action by APA. In each case the question to be asked concerns the extent to which an organization of *psychologists* should channel its energies and resources into this area, and the answer will clearly depend on the extent to which the specified criteria are met. Only if there is a considerable quantity of research-based information and value consensus is high, for example, would an attempt be made to influence legislation.

The actions listed along the y-axis require only brief explanation. "Grass roots political activity" means "calling out the troops," as it were—mobilizing the entire membership of APA to effect the passage of a bill or obtain a policy change. Such a decision would be made only rarely, in cases where the legislation or policy threatened the continued existence or progress of psychology as a field of knowledge and where all of the additional criteria were met at a high level.

"Initiate legislation" means to work with Congressmen or Senators to get a bill introduced into Congress.

"Influence legislation" means to testify before a congressional committee or to assist the staff of a government agency in drafting a bill they intend to introduce.

The decision to take any one of the three actions at the top of the list would never be made except on issues where APA policy has already been made clear in one or more documents. On issues where this clarification has not yet occurred, the appropriate action will often be to appoint a person or a group of persons to write a "position paper." After review by the appropriate boards and committees and acceptance by the Board of Directors, this paper can then serve as a basic document for actions at a higher scale level.

In preparing a position paper on an issue, Central Office personnel are responsible for the staff work. The person or small group of persons designated by the Board of Directors is responsible for writing the paper. The appropriate boards and committees are responsible for reviewing it and making recommendations to the Board of Directors.

Position papers may be of several kinds:

(*a*) A definitive statement of policy with supporting evidence.

(*b*) A clear formulation of conflicting positions taken by psychologists on the issue, with supporting evidence.

(*c*) A temporary statement of tentative policy with supporting evidence and indications of where gaps in it are apparent, one of a sequence of such papers, each superseding the previous ones.

"Offer information" means to send the agency or congressional committee involved in an issue a position paper or a summary of research findings on the question at hand. It may mean arranging for someone to testify before a committee or interview an agency chief. It is distinguished from actions higher in the scale by the neutrality of the information offered. In taking this action APA does not attempt to exert influence in one particular direction.

"Appoint an ad hoc study group" is an appropriate action in instances where issues are not clearly delineated and it is desirable for persons with some special competence in an area to impose some structure on it to enable decision makers to deal with it more adequately. It would often be

a first step leading eventually to some other action. Ad hoc committees are appointed by the Board of Directors, often with the advice of other APA boards or committees in whose area of concern the particular issues fall.

"Refer to a board or committee" is a self-evident action. The Committee would recommend, however, that a time limit always be incorporated in the terms of referral. This is an interim action often appropriate in situations where considerable confusion exists. If the Board of Directors makes such a referral, asking for an opinion by a certain date, and does not receive a report at the designated time, it is assumed that the Board will then take the issue up again and decide on another action possibility.

"Act as broker or catalyst" covers such things as putting an agency in touch with a person who can help or writing to an APA member to ascertain whether he has any interest in becoming involved in a movement. No APA commitment is made in such cases.

"Encourage research" is an even more noncommittal action. It might cover such specific things as announcing in the *American Psychologist* that research on some social problem is needed and that funds may be available from a particular source. It might mean referring the issue to an appropriate APA board or committee for discussion and recommendations as to how research on it might be stimulated or facilitated.

"Inform membership" simply means to let the members know through the *American Psychologist* or the *Washington Report* that an issue has arisen, on the assumption that any individual psychologist who has an interest in it can then take action accordingly.

The reason for including "Do nothing" at the bottom of the scale is that a clear-cut decision not to take action is clearly a legitimate way of disposing of some issues that arise. It is not the same as inaction arising from drift or uncertainty.

Some Related Questions

The Ad Hoc Committee considered some specific questions that will arise if this plan is put into operation.

1. Can the Board of Directors and Executive Committee take on this decision-making task in addition to the other duties their position entails? The Committee's answer is that we should like to have them try. If, even with the streamlined procedure we have described and with increased staff assistance from the Central Office, they find they cannot keep up with the demands in the public affairs area, it will be necessary for them to delegate some of the responsibility to a specially constituted committee. But because the Board of Directors occupies the highest position of responsibility in the Association, where the responsibility for APA's role in public affairs should if possible be kept, it is recommended that the Board itself make the final decision as to which of the possible actions should be taken in each case.

2. What would this recommended system cost? To provide the Central Office staff and support services for such a program would require an estimated expenditure of $50,000 a year. It is believed that by redeploying some of our resources we can carry out the program within the present APA financial structure without a dues increase. The Ad Hoc Committee supports the proposal of the Policy and Planning Board that a study of APA structure be made by an outside research agency, in order that redeployment of resources may be intelligently planned.

APPENDIX 11

1. PLEASE INDICATE WHETHER YOU BELONG TO THE PROFESSION OF PSYCHIATRY OR PSYCHOLOGY BY PLACING AN X IN THE APPROPRIATE BOX.

PSYCHIATRY ☐ PSYCHOLOGY ☐

2. THIS QUESTIONNAIRE CONTAINS STATEMENTS ABOUT MENTAL ILLNESS AND THERAPEUTIC PRACTICES. SOME OF THE STATEMENTS SUGGEST EXTREME POSITIONS WHICH WERE INCLUDED IN ORDER TO GAUGE MORE ADEQUATELY INTERPROFESSIONAL DIFFERENCES. WE WOULD LIKE TO HAVE YOUR CONSIDERED JUDGMENTS ABOUT EACH ITEM.

3. Please read each of the statements carefully in the order in which they appear and for each one indicate frankly to what extent you personally agree or disagree. You should do this by placing an X in the column which is most in accord with your view on every item.

4. Example:

	Strongly Agree	Agree	Disagree	Strongly Disagree
1) All psychiatrists should have beards.....		X		

Strongly Agree | Agree | Disagree | Strongly Disagree

...one day physical or chemical causes will be discovered which will explain mental illness.....

...ll men control and are controlled.....

...henever ward personnel's judgments about a mental ...atient's behavior seriously conflict with the ...sychiatrists' view, the psychiatrist should spend ... considerable amount of time in discussing the ...atient with them.....

... mental health specialist should be responsible not ...nly for individual patients with whom he has contracted ...or treatment, but for the entire population of both ...dentified and unidentified potentially sick members ...n his community.....

... mental health professional needs to have had personal ...nalysis in order to treat his hospitalized patients ...uccessfully.....

... is important to study human behavior from an under-...tanding of the human being "as a whole."....

...st mental patients need flight handling by the hospital ...rsonnel.....

...e "medical establishment" is not only not fully serving ...manity but holding back potential help from it.....

...re psychotherapists should have a good acquaintance ...th the theory and findings of social psychology.....

...child psychologist is usually more qualified to prac-...ce psychotherapy with children than is a generally ...ained psychiatrist.....

...ere are many hospitalized psychiatric patients who ...n benefit greatly from the new tranquilizer and ...arastic drugs, like Tofranil.....

...derstanding the control aspects of human behavior ...ll promote a better society.....

...generally trained psychiatrist is usually more ...alified to practice psychotherapy with children ...an is a child psychologist. .....

... rate of new cases of mental disorder may be re-...ced by counteracting harmful forces before they ...e a chance to produce illness.....

...ud's theories of human behavior are still more ...id than any other theoretical orientation. .....

...ther the behavioral nor the medical "models" of ...an behavior do justice to the study of "the healthy ...an being's goals of life.".....

	Strongly Agree	Agree	Disagree	Strongly Disagree
"Once a schizophrenic always a schizophrenic"....				
It is sound practice for the "Diggers" society, (a marginal social group) to "Protect" their members from falling into the hands of the psychiatric professions.....				
In the etiology of mental illness, recent events are almost always much more important than early childhood experiences.....				
Most clinical psychologists are qualified to work with patients who have adjustment or marital problems.....				
Somatic therapies such as electric shock and drug therapies have already proven extremely effective for curing certain types of mental patients.....				
Eysenk's thesis that "psychotherapy has not worked" makes behavioral therapies the most useful intervention form at this time.....				
Most psychiatrists are qualified to work with patients who have adjustment or marital problems....				
The primary goal of treatment is not to reconstruct a mental patient's personality, but to help him achieve social adjustment in an ordinary life situation as soon as possible.....				
Ordinarily psychiatric patients cannot be expected to show <u>real</u> improvement without slow and careful psychological exploration of their underlying conflicts.....				
One cannot attribute all creative accomplishments to the demands of the super-ego.....				
With few exceptions, most hospitalized mental patients haven't the ability to tell right from wrong....				
Books such as Kesey's "Cuckoo's Nest" provide an accurate account of the methods by which the mentally ill are manipulated by mental health professionals...				
A psychotherapists treatment of mental hospital patients would be greatly improved if he spent more time learning to use the hospital as a therapeutic influence and less time on individual psychotherapy...				
Whenever ward personnel's judgments about a mental patients' behavior seriously conflict with the psychologist views, the psychologist should spend a considerable amount of time in discussing the patient with them.....				

	Strongly Agree	Agree	Disagree	Strongly Disagree
omatic therapies continue to be more effective hen other forms of treatment for hospitalized ment- lly ill patients.....				
etter living through behaviorism.....				
sychiatrists should be permitted to engage in sychotherapy in private practice.....				
here should be a continuity of professional respon- ibility as any patient moves from one hospital pro- ram to another, in an integrated network of care iving services.....				
t is unfortunate that psychoanalytically oriented sychotherapy is not being used more extensively ith hospitalized mental patients.....				
t is not the attainment of "homeostasis", but an nnate drive towards "self-actualization" which uides human behavior.....				
requent outbursts of violence on wards of a mental ospital indicate that more stringent rules governing he behavior of patients should be enforced.....				
sychotherapeutic intervention is often offensive, ppressive, and punitive, demanding political action o change its direction.....				
ll psychotherapists should receive extensive training n sociology and anthropology....				
linical psychologists should be permitted to engage n psychotherapy in private practice.....				
killful use of drugs can be at least as beneficial o a mental patient as psychotherapy....				
ncreasing technological sophistication in other reas demands that research in the engineering of uman behavior be afforded a priority position....				
n a mental hospital, staff meetings devoted to linical case presentations should be open to all on-medical as well as medical personnel.....				
mental health specialist is only one member of a roup of community agents who collectively care for entally ill individuals.....				
o significant progress can be made in psychotherapy ithout understanding the patient's basic conflicts....				
omprehending the patient as a whole person, as a nique and irreducible subject is the major value of sychiatric diagnosis.....				

	Strongly Agree	Agree	Disagree	Strongly Disagree
bnormal people are ruled by their emotions; normal eople by their reason.....				
adical political values are the most effective eans of dealing with problem-solving in a socially ppressive society.....				
nderstanding a patient in terms of his group affil- ations often contributes more than anything else o the success of his treatment.....				
linical research coming out of psychology should e made available to psychiatric practitioners for se in psychotherapy.....				
t the present time the most adequate management f schizophrenia is by means of drugs.....				
umanist psychology is pure metaphysics or worse....				
sychiatric nurses should be encouraged to take a reater role in initiating psychotherapy.....				
aximum therapeutic gains accrue where the input f each member of the mental health team is maxi- ized.....				
t is unfortunate that in the treatment of adoles- ents, the psychiatrists' concern with such factors s the patient's group membership often leads to the eglect of the deeper dynamics of the patient's ental illness.....				
he basic coin in the realm of "knowing" human be- avior lies in direct, intimate experience of that ehavior.....				
mental patient is in no position to make decisions bout even everyday living problems.....				
ffective political action is a good indicator of sychotherapeutic success.....				
ll sorts of things that happen on the ward can normously affect the degree to which a hospitalized ental patient benefits from whatever treatment he s receiving.....				
sychiatric social workers should be encouraged to psychotherapy in private practice.....				
rug therapy will eventually prove to be the major rm of therapy for the psychoses.....				
oseph Wolpe's use of behavior-modification in psy- iatric practice represents the probable future rection of emphasis for all the behavioral sciences..				

	Strongly Agree	Agree	Disagree	Strongly Disagree
...ly psychiatrists should treat neurotic patients....				
...ouber role-differentiation in the therapy functions ...f mental health professionals results in better ...ervice for the patient.....				
...he major deficiency of those forms of therapy which ...hiefly depend on socio-environmental manipulations ...s that they almost never help the patient to resolve ...is basic conflicts.....				
...ntentionality represents the "experience of self" in ...ny individual. "Self" is not merely an "objective" ...elf built up in the mind of a reflecting individual...				
...s soon as a person shows signs of mental illness ...e should be hospitalized.....				
...ental health professionals act in naive collusion ...ith the powers that be to police individuals who are ...eluctant to relinquish their experience of the world ...n favour of the official version of it.....				
...hatever the contribution of biological factors to ...he development of mental illness, its' major deter- ...inants are social and environmental.....				
...ly clinical psychologists should treat autism, ...chizophrenia and criminal offenders.....				
...rug therapy can cure many psychoses.....				
...n the modification of behavior, attention need not ...e paid to "conflicts in intra-psychic process" in ...he individual.....				
... medical degree should be the major criterion for ...valuating an individual's qualifications to practice ...sychotherapy.....				
...he mental health specialist should seek to extend ...is effectiveness by working through other people....				
...ything that tends to dilute the patient's relation ...th his therapist will slow down the patient's ...provement.....				
...he living human being, represents an open system ...th certain freedoms of operation and potentials ...r change.....				
...ere is something about mentally ill people that ...kes it easy to tell them from normal people.....				
... this period in history, most people are oppressed ...ay from psychological autonomy and wholeness as ...man beings, and are mystified by their oppression....				

	Strongly Agree	Agree	Disagree	Strongly Disagree
More psychotherapists should do research on cultural determinants of mental illness.....				
A doctorate in clinical psychology should be the major criterion for evaluating an individual's qualifications to practice psychotherapy.....				
I think that the new drugs are the greatest things that ever happened in treating patients.....				
There is no neurosis underlying a "symptom", merely the symptom itself. Get rid of the symptom (skeletal or autonomic) and you have eliminated the neurosis...				
Statements about the meaning of their behavior given to mental hospital patients by non-psychiatric personnel are likely to do more harm than good.....				
The locus of mental illness must be viewed as extending beyond the individual, and into the family, the community and society.....				
Most analytically trained therapists practice better psychotherapy than somatically or sociotherapeutically trained psychiatrists.....				
Creative work and creative handling of one's human relationships are most instrumental in a person's self-realization and transcendent "growth.".....				
Few, if any patients are capable of real friendliness.....				
We are all being taught in different ways to be behaviorally incapable.....				
One of the best signs of a patient's improvement is the degree to which he participates in ward activities.....				
Fears about the "increasing controls placed on human behavior through behavioral technology" as expressed by the lay public are distortions of the true facts governing the research on human behavior...				
Nothing works as well as drugs in treating patients...				
Stimulus and response patterns are more central to understanding human behavior than reliance on hypothetical drive states such as "actualization" or "growth".....				
Fears about psychiatric abuses expressed by the lay public are largely due to ignorance of the facts, and should not be seriously considered by mental health professionals				

(cont'd.) vulnerable to upsetting pressures.....

The analytic training centres turn out the best psychotherapists.....

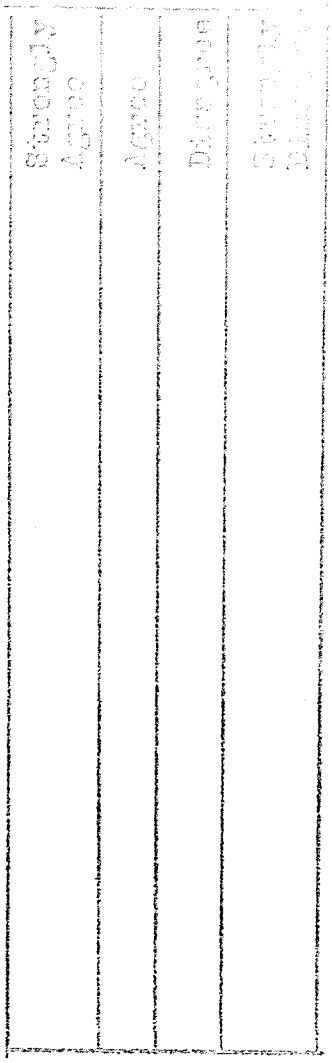
Concentration on technical proficiency in human behavior has become one of the very best ways to avoid awareness of "self".....

Mental patients need the same kind of control and discipline as an untrained child.....

Psychotherapy as it is predominantly practiced today needs to be changed radically, that is ...."at the roots".....

Sometimes informal contacts with other patients can help a patient far more than formal therapeutic sessions with his "psychotherapist".....

The lions share of "knowledge" about mental illness is presently coming from the ranks of clinical psychologists rather than psychiatrists.....



APPENDIX 111

APPENDIX 111

Manifesto

by Claude Steiner

1. The practice of psychiatry has been usurped by the medical establishment. Political control of its public aspects has been seized by medicine and the language of soul healing (ψυχη + ιατρεια) has been infiltrated with irrelevant medical concepts and terms.

Psychiatry must return to its non-medical origins since most psychiatric conditions are in no way the province of medicine. All persons competent in soul healing should be known as psychiatrists. Psychiatrists should repudiate the use of medically derived words such as "patient," "illness," "diagnosis," "treatment." Medical psychiatrists' unique contribution to psychiatry is as experts on neurology, and, with much needed additional work, on drugs.

2. Extended individual psychotherapy is an elitist, outmoded, as well as non-productive, form of psychiatric help. It concentrates the talents of a few on

a few. It silently colludes with the notion that people's difficulties have their sources within them while implying that everything is well with the world. It promotes oppression by shrouding its consequences with shame and secrecy. It further mystifies by attempting to pass as an ideal human relationship when it is, in fact, artificial in the extreme.

People's troubles have their source not within them but in their alienated relationships, in their exploitation, in polluted environments, in war, and in the profit motive. Psychiatry must be practiced in groups. One-to-one contacts, of great value in crises, should become the exception rather than the rule. The high ideal of I–Thou loving relations should be pursued in the context of groups rather than in the stilted consulting room situation. Psychiatrists not proficient in group work are deficient in their training and should upgrade it. Psychiatrists should encourage bilateral, open discussion and discourage secrecy and shame in relation to deviant behavior and thoughts.

3. By remaining "neutral" in an oppressive situation psychiatry, especially in the public sector, has become an enforcer of establishment values and laws. Adjustment to prevailing conditions is the avowed goal of most psychiatric treatment. Persons who deviate from the world's madness are given fraudulent diagnostic tests which generate diagnostic labels which lead to "treatment" which is, in fact, a series

of graded repressive procedures such as "drug management," hospitalization, shock therapy, perhaps lobotomy. All these forms of "treatment" are perversions of legitimate medical methods which have been put at the service of the establishment by the medical profession. Treatment is forced on persons who would, if let alone, not seek it.

Psychologial tests and the diagnostic labels they generate, especially schizophrenia, must be disavowed as meaningless mystifications, the real function of which is to distance psychiatrists from people and to insult people into conformity. Medicine must cease making available drugs, hospitals, and other legitimate medical procedures for the purpose of overt or subtle law enforcement and must examine how drug companies are dictating treatment procedures through their advertising. Psychiatry must cease playing a part in the oppression of women by refusing to promote adjustment to their oppression. All psychiatric help should be by contract; that is, people should choose when, what, and with whom they want to change. Psychiatrists should become advocates of the people, should refuse to participate in the pacification of the oppressed, and should encourage people's struggles for liberation.

PSYCHIATRIC DISTURBANCE IS EQUIVALENT WITH ALIENATION WHICH IS THE RESULT OF MYSTIFIED OPPRESSION.

5]]]

READINGS IN RADICAL PSYCHIATRY

PARANOIA IS A STATE OF HEIGHTENED AWARENESS. MOST PEOPLE ARE PERSECUTED BEYOND THEIR WILDEST DELUSIONS. THOSE WHO ARE AT EASE ARE INSENSITIVE.

PSYCHIATRIC MYSTIFICATION IS A POWERFUL INFLUENCE IN THE MAINTENANCE OF PEOPLE'S OPPRESSION.

PERSONAL LIBERATION IS ONLY POSSIBLE ALONG WITH RADICAL SOCIAL REFORMS.

PSYCHIATRY MUST STOP ITS MYSTIFICATION OF THE PEOPLE AND GET DOWN TO WORK!

—Claude Steiner

(*Note:* The first Radical Psychiatry Manifesto was written in the summer of 1969 on the occasion of the annual American Psychiatric Association Conference in San Francisco, which was widely disrupted by members of the Women's Liberation, Gay Liberation, and Radical Therapy movements.)

APPENDIX IV

APPENDIX IV

Interview Schedule of Questions

1) Do you view professionalized psychiatry and psychology (clinical) as being concerned with the same subject matter?
2) In the professional services provided by clinical psychologists/ psychiatrists, would you rate psychotherapeutic intervention or research on human behavior as being the most appropriate area of concern for your profession? Do you view them as the same thing?
3) Would you like to see clinical psychologists having a "fee for service" role, like that of psychiatrists? Would you support the sponsorship by government of clinical psychologists under a program of Medicare? Do you have any reservations about the ability of clinical psychologists to provide services under such a program?
4) How would you define your professional ideological orientation as a clinical psychologist/psychiatrist? (Responses to this question in earlier research have included answers such as the following: I don't have one, a humanist, a behaviorist, psycho-dynamic view, somatotherapist, purely a research person, etc.
5) Would you say that there is a problem of "professional rivalry" among the professions of psychiatry and clinical psychology at this time? Do you think that the issue of "territoriality" was never an issue, has been resolved, is an issue which merits attention by mental health professionals at this time.
6) In which directions would you like to see the mental health professions develop? How do you think the best "quality of professional

service" might be achieved?

7) Do you as a practitioner feel that "social issues" have a bearing on the nature of your work? Have changes in social values caused changes in your professional position? If so could you describe some of them?

8) Do you have any views about lay fears expressed about "professional abuses" in the mental health sector?

9) What is your position on "Radical Psychotherapeutic practise?"

10) Do you anticipate an expanded role for mental health professionals in the future? Would you care to express an opinion about the direction that you feel such a role might take?

11) Would you care to add any information about the ideological issues associated with the work of mental health professionals from the two test-groups under study?

12)* Do you think that a study of the ideological orientations of mental health professionals may;

   a) Contribute to better professional practise

   b) Be unnecessary since it is not the sort of research which should be attempted with regard to understanding the mental-health professions?

13) Do you have any questions about the research and would you like any additional information.

---

*Item 12 was not administered to all respondents, only where the researcher encountered significant resistance to the interview material.