I. INTRODUCTION

In accordance with the purpose of The Group for the Advancement of Psychiatry, "of surveying and studying various fields of knowledge and interest within and related to psychiatry, with the intention of stimulating progressive action, research or further study in those spheres where such may be needed," this Committee has attempted to examine the relationship of clinical psychology to psychiatry. While recognizing that clinical psychology is concerned with such fields as counseling, vocational guidance, retraining, remedial reading, personnel selection, etc., this report is limited to clinical psychology in its relationship to psychiatry.

II. THE NATURE OF CLINICAL PSYCHOLOGY

Dr. Alan Gregg and his associates defined psychology as "the systematic study, by any and all applicable and fruitful methods, of organisms in relation to their behavior, environmental relations, and experience. Its purpose is to discover facts, principles, and generalizations which shall increase man's knowledge, understanding, predictive insight, directive wisdom and control of the natural phenomena of behavior and experience, and of himself and the social groups in which, and through which, he functions. Psychologists seek to provide a basic science of human thinking, character, skill, learning, conduct, etc., which will serve all the sciences of man (e.g., anthropology, sociology, economics, government, education, medicine, etc.) in much the same way and to the same extent that biology now serves the agricultural and medical sciences."

One of the specialists in this science is the clinical psychologist. Of the 6,000 members of the American Psychological Association, about twenty percent so designate themselves by this title. At present it is difficult to define the word "clinical" as related to psychology. To a physician "clinical" pertains "to the sick bed of a hospital patient as used in connection with medical instruction." It also means bringing together all the facts necessary in order to describe the natural history, diagnose, and treat a disease. Psychologists have attached various meanings to the word "clinical." It has referred to work with retarded and superior children, speech and reading difficulties, vocational guidance, experimental and diagnostic work in mental hospitals, work in child and adult psychiatric clinics, personnel and counseling activities, or work with normal persons from the standpoint of the personality as a whole. Some of these psychologists have had no clinical experience, in the medical sense, at all. Others have had a considerable amount. The difficulty here is that psychology like psychiatry has been undergoing such a rapid expansion in recent years that there is uncertainty as to its internal subdivisions and the limits to which it can extend itself on a sound scientific basis. Specific studies are in progress to formulate a more precise definition of clinical psychology, by the Committee on the Relation of Psychology with Psychiatry of the American Psychological Association and the Committee on the Relation of Psychiatry with Clinical Psychology of the American Psychiatric Association.

This report is concerned with clinical psychologists who work with those patients whose functioning or behavior is disturbed, temporarily or chronically, and where mental, emotional, and physical factors are of importance in the disturbance. These are ordinarily regarded as psychiatric patients. It is difficult, if not impossible, to be precise in defining who is a psychiatric patient. The well-integrated, harmoniously functioning person is a theoretical abstraction. In general, however, whenever a person is suffering from a psychosis, a neurosis (in all its various ramifications), a severe character disturbance, or a marked behavior problem of childhood, then such a person is regarded as suffering from a psychiatric disorder.

Defining the psychiatric area in this traditional way leaves out a vast range of various types of maladjustment with which a host of people are concerned, professionally or otherwise: teachers, parents, social workers, ministers, lawyers, judges, as well as psychiatrists and clinical psychologists. The increasing insights into human nature, deriving particularly from the dynamic points of view, have led to more general implications for education, for the prevention of maladjustment of all kinds, for industry, for religion, and for social problems. It is increasingly clear that early environmental influences, particularly the attitudes and behavior of parents toward each other and their children, are important in the formation of personality traits which may lead to intra- or inter-individual tensions and neurotic symptoms. Wherever there are people, there are problems to the solution of which both psychiatry and psychology can contribute. Many of these are legitimate areas for pioneering by both professions.
III. AREAS OF ACTIVITY OF THE CLINICAL PSYCHOLOGIST

1. Research

Representatives of clinical psychology have stated that a primary interest of their profession is research. The research function can be a major contribution of the psychologist to the whole field of mental disorders and emotional maladjustment. As a general rule, a research approach to problems has been the tradition of psychology, and psychologists continue to emphasize this aspect of their work in their training.

A brief survey reveals that the research activities of the psychologist in the psychiatric field are really a reflection of phases of historical development. When experimental psychology was beginning in the latter part of the nineteenth century, Kraepelin, the founder of part of our present diagnostic nomenclature of the psychoses, carried some of the research techniques of the psychologist into psychiatry. The interest in description and classification which dominated psychiatry in the latter part of the nineteenth century and in the early part of the twentieth century is reflected in the research that psychology contributed to psychiatry of that period. Psychology was concerned with the structure of the normal human mind. For psychiatry there was a general structural psychopathology and there were specific psychopathologies as applied to the various psychiatric disorders. Thus, there was an emphasis upon the measurement and differentiation of intellectual processes, of sensations, of perception, and some interest in memory and learning in the psychoses, though there were only preliminary attempts to investigate affective processes.

With the growth of dynamic psychiatry, a shift of emphasis in psychology occurred and studies appeared involving personality tests. At first personality tests used a structural framework of personality traits, such as introversion and extraversion. Later they came to employ concepts based on needs and drives. There also developed an interest in studying dynamic mechanisms in the experimental laboratory. Needs, drives, defenses against anxiety, mechanisms of adjustment—such concepts occupy a considerable place in present-day clinical psychology. This is an area where psychological research, of a basic character, needs to be done. The structure of psychiatry (its facts, its theories, its hypotheses) has come largely from the psychiatric clinic, hospital, or the psychotherapeutic setting. The whole structure of psychodynamics has developed from clinical observation. Research in the psychodynamics found in the clinical setting should be both challenging and fruitful. In general the problems should originate in the clinical situation and should be checked by clinical facts. The clinical psychologist should also retain an interest in the broader problems of psychodynamics as well as those phenomena found only in mental illness or seriously maladjusted individuals.

Possible fruitful areas for both collaborative and independent research which seem to us to be of considerable significance at the present time are:

a) The development and refinement of diagnostic devices for the detection of various types of maladjustment and abnormality;

b) The nature of personality structure and psychodynamics;

c) The classification, clarification, and delineation of syndromes of maladjustment;

d) The relationship of attitudes, feelings, conflicts, emotions, etc., to physiological malfunctioning such as found in psychosomatic illnesses;

e) Experimental psychodynamics—the reproduction of psychopathology in controlled settings;

f) The nature of the psychotherapeutic process;

g) The development of new therapeutic techniques.

In connection with these points, it is important that psychologists who wish to do research in these areas should have fundamental training in the psychodynamics of diagnosis and therapy. Such training is invaluable from the standpoint of research, since it is especially in the interpersonal relationship of the psychotherapeutic process that the deeper dynamics of personality structure are most clearly revealed. No psychological microscope has yet been devised which can compare with the high-powered lens of this relationship. In this setting, the "subject" is moved by suffering to reveal dynamic forces in his personality which ordinarily are hidden. Probably one of the most useful approaches to the nature of the therapeutic process is by means of observational and recording techniques. We regard training in the psychodynamics of therapy as essential to the clinical psychologist who is going to do research in this area. Such training should be given in a psychiatric clinic or mental hospital.

2. Diagnosis

Traditionally the contributions of the psychologist have been mainly in the important area of psychodiagnostics. The procedures employed have included, among others, verbal and nonverbal intelligence tests, tests of sensory, perceptual and motor functions, tests of memory, reasoning and learning, tests of special disabilities such as reading, aphasia, speech, and educational achievement, vocational aptitude tests, personality tests, situational tests, and diagnostic psychodrama. More recently, diagnostic testing has proceeded in the direction of the analysis of clusters of signs and symptoms that form syndromes, of the development of standards and norms for various age ranges, and of the relationship between diagnostic tests and racial and cultural backgrounds. Some work is being done with diagnostic techniques as indicators of prognosis. Diagnostic tests gain in value as they become oriented more toward an analysis of the dynamic and motivational forces that are involved not only in the testing and interviewing situations, but also in the more fundamental psychopathology or psychodynamics in a given patient.
In psychiatry, as elsewhere in medicine, there is often a tendency to put too great an emphasis upon some laboratory or diagnostic procedure. Psychiatric diagnosis is difficult because it must take into consideration a multiplicity of factors: for example, genetic, cultural, individual psychological, physiological, physical disease, and psychiatric disorders. It is frequently hard to evaluate which factors are most important and which should be treated in a given case. No test or laboratory procedure can replace clinical evaluation or experience. For example, a test may report that the patient shows evidence of deterioration. However, this must be checked by corroborative findings. Similarly, in connection with projective techniques, there is a tendency to assume that dynamic factors uncovered by the technique must have a significant relationship to the patient's problem. Practical experience indicates that sometimes the reverse may be true. Projective techniques are only one method of attempting to uncover psychodynamics. They may give a one-sided emphasis to the total dynamic picture. Again, sometimes the untimely administration or unwise choice of a diagnostic test may aggravate or precipitate an emotional disturbance in a patient. Uncritical use of psychological tests reflects, on the one hand, a lack of psychiatric sophistication or therapeutic experience on the part of the clinical psychologist and, on the other hand, on the part of the psychiatrist, an unfamiliarity with the nature and purpose of the various tests. Like other laboratory procedures, a psychological test does not make a psychiatric diagnosis, but only contributes to it.

3. Psychotherapy

Many types of activity are referred to as psychotherapeutic. In the present context, psychotherapy includes any procedure for the management and care of a patient, or the combating of his disorder, by psychological means. Psychotherapy is manifold in type, each with its own theory and technique. To mention only a few, the following have been used: reassurance, relaxation, hypnosis, play, environmental manipulation, psychoanalysis, etc. Such a broad range of therapeutic activities calls for a broad range of abilities. Because of training and experience, most psychiatrists usually find themselves using only a few of the available number of possible therapies. Whenever psychiatrists in their practice meet with cases they are not equipped to handle by training or experience, they refer the patient to some other psychiatrist who possesses special competence of the kind required, or they call upon a nonmedical person who may have this competence. Since the war especially, the practice has been growing of encouraging individual psychotherapy by clinical psychologists. This is consistent with accepted medical and psychiatric practice. The Committee believes that we should continue to follow the recent trend to refer some patients to clinical psychologists for special treatments, such as vocational guidance, remedial reading, retraining procedures, speech training, and psychotherapy. Naturally the type of psychotherapy done by the clinical psychologist will depend upon his training and competence, the type of patient being treated, and the conditions under which the treatment is conducted.

This Committee is strongly opposed to the independent private practice of psychotherapy by clinical psychologists. The Committee also feels that psychotherapy done by clinical psychologists should be carried out in a setting where adequate psychiatric safeguards are provided. This is not only the opinion of the committee, but it also reflects the opinion of the members of the Group for the Advancement of Psychiatry as a whole, as seen in the results of a recent survey made of the Group on these two points, in which 93 out of 108 replies voiced the complete approval of these two principles. (What constitutes 'adequate psychiatric safeguards' is being considered by:

1) This Committee of the Group for the Advancement of Psychiatry;
2) The Committee on the Relation of Psychiatry with Psychology of the American Psychiatric Association, and

Opinions and recommendations along these lines will be the topic for a subsequent report.)

The independent operation of clinical psychologists may lead to diagnostic error, the failure to detect serious psychiatric conditions in their early stages, or failure to recognize physical disorders which may be the basis of the maladjustment. It is worth recalling that psychiatric disorders arise from a multiplicity of causes, that any psychiatric disorder may appear in its early stages as an apparently irrelevant physical symptom or sign, or as a minor maladjustment problem. During the course of psychotherapy it may be difficult to judge whether a certain aspect of maladjustment or physical sign or symptom should be treated at once or temporarily ignored. If the clinical psychologist works in close, continuous association with the psychiatrist, he will have someone who can assume professional and legal responsibility. Anyone who intends to deal with maladjustment as an independent professional person must

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1 In commenting on this report, a small number of members of GAP presented opinions objecting to various aspects of the report. A composite minority view would be: "Clinical" refers to the bedside and the association of the doctor with the individual patient for therapeutic purposes. The relationship of the doctor and the patient has the tradition of the healing art behind it and forms one of the deepest motives for the choice of medicine as a career. This relationship has profound psychological effects in the approach to the patient's problem both diagnostically and therapeutically. Psychologists with their non-medical background cannot be clinicians in this sense. The proposals for safeguarding the patient's welfare by insisting that psychologists associate themselves professionally with psychiatrists need more precise definition, and GAP should not approve the training of psychologists as psychotherapists until these safeguards are established. The answer to the problem of the need for more psychiatric services lies in the better training of more psychiatrists.
be able to diagnose it and to cope with emergency situations. If he cannot do this alone, he should be associated professionally with someone who can. In this way, the welfare of the patient is protected.

This committee does not feel that the association of clinical psychologists as psychotherapists with general practitioners or medical specialists other than psychiatrists is ordinarily a wise arrangement. This separates the clinical psychologist from his logical professional associate, the psychiatrist. It provides medical but not psychiatric safeguards. Many medical specialists and general practitioners have not had sufficient training in psychiatry to make an accurate psychiatric diagnosis, nor do they understand the management and treatment of psychiatric conditions.

IV. TRAINING OF THE CLINICAL PSYCHOLOGIST

A brief historical note will help to place the problem of the training of the clinical psychologist in proper perspective. The term “clinical psychology” was coined by Witmer, who in 1896 established a psychological clinic at the University of Pennsylvania. This clinic worked with retarded and superior children and concerned itself with problems involving vocational guidance and speech disability. In 1906, Goddard at Vineland established the first psychological laboratory in an institution for the feebleminded; there one of the first adaptations of the Binet-Simon Test to the American scene was made. In 1909, William Healy established the Cook County Juvenile Court Behavior Clinic in Chicago for the study of delinquency. It is from this clinic that the child guidance movement dates its origin. While Witmer’s interest was primarily with the educational aspects of personality, Healy’s chief emphasis as a psychiatrist was on the motivational aspects of personality and on social pathology. His work early attracted the attention of psychologists as well as psychiatrists. Paralleling these developments, psychological laboratories became established in hospitals for the mentally disordered, beginning as early as 1894. The outstanding centers were at McLean Hospital, St. Elizabeths Hospital, the Boston Psychopathic Hospital, and the Worcester State Hospital. Another important line of development which has influenced the field of clinical psychology has been the establishment of counseling and guidance centers.

Whether working in an institution for exceptional children, in a child guidance clinic, in a counseling center, or in a mental hospital, the psychologist soon found himself involved in emotional and motivational factors. It became necessary to control or evaluate these factors in some way, or attempt to measure them. Out of this activity developed personality tests and devices for detecting, in a practical situation, various types of maladjustment.

It is in the context of such activities that psychologists have been vitally concerned with the development of their clinical training program. As at present constituted, this is a graduate program of four years, leading to a doctoral degree. At least one of these years is spent in concentrated field training.

The program covers six major instructional areas: general psychology, dynamics of human behavior, related disciplines, diagnostic methods, guidance and therapy, and research methods. The first year is spent mainly in basic courses in systematic theoretical psychology and psychodynamics. It provides, also, opportunities for the detailed naturalistic observation of a variety of persons, normal and abnormal, in a wide range of situations. Theory and practice of simple diagnostic devices are also provided. The second year is occupied in learning the more difficult diagnostic techniques and in obtaining a first acquaintance with principles of guidance and psychotherapy. The third year is devoted to work in a field center to provide practical experience of gradually increasing complexity under supervision. The student has the opportunity here to develop close associations with other disciplines, particularly psychiatry. He is also expected to carry out the necessary research for his doctoral dissertation. The fourth year is concerned primarily with seminars on professional problems, interdisciplinary seminars which attempt to integrate clinical and theoretical material, and with the completion of the dissertation. After obtaining his degree (Ph.D.), the student is in a position to undertake clinical work in an approved psychiatric hospital, clinic or institution, where further supervision in advanced and specialized aspects of the clinical field is available. Any intensive training in psychotherapy is obtained after securing the Ph.D. degree.

After five years of experience, the candidate becomes eligible for examination by the American Board of Examiners in Professional Psychology. At least three of the five years should have been spent in centers where supervised training is provided. On the candidate’s passing the examinations, both oral and written, and meeting the requirements as to ethical standing and experience, the Board will issue to him a diploma qualifying him as a specialist in Clinical Psychology.

Four types of control can act to assure that persons who go through this course will carry out their functions competently: the training program, the personal integrity of the individual, the ethical standards deriving from identification with a respected and competent group, and the professional controls which come from the membership in the American Psychological Association and from certification by the Board of Examiners. In addition, some states have already instituted state certification.

In conclusion, then, this committee believes that the clinical psychologist will be able to make his most effective contribution to the total area dealing with mental health and emotional adjustment if he works in direct association with psychiatrists. In such a relationship his maximal effectiveness to persons in need of help will be assured.

The Committee on Clinical Psychology wishes to acknowledge with appreciation the continuing help and guidance of their regular consultants, Dr. David Shakow of the University of Illinois, Chicago, and Dr. Margaret Brenman of Austen Riggs Foundation, Stockbridge, Mass.
BIBLIOGRAPHY


Group for the Advancement of Psychiatry

The Group for the Advancement of Psychiatry has a membership of approximately 150 psychiatrists, organized in the form of a number of working committees of about 10 members each, which direct their efforts toward the study of various aspects of psychiatry and toward the application of this knowledge to the fields of mental health and human relations. GAP is an independent group and its Reports represent the composite findings and opinions of its members only, guided by its many consultants.

Collaboration with specialists in other disciplines has been and is one of GAP’s working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisions a continuing program of work according to the following aims:

1. To collect and appraise significant data in the field of psychiatry, mental health and human relations;
2. To re-evaluate old concepts and to develop and test new ones;
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations.

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