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Chapter 2

A Scientific, Scholarly, Nonresearch Doctorate for Clinical Practitioners
Arguments Pro and Con

PAUL E. MEEHL

A vigorous alternative to Kubie's [*1971*] *proposal has appeared on the scene during the past decade: a new kind of graduate training in clinical psychology, frankly professional in emphasis and leading to a new degree, probably Doctor of Psychology. As we shall see in Chapter 16* [*Holt, 1971*]*, several such programs are actively under way and an organized group of psychologists is clamoring for more professional schools of psychology. The paper that follows is a revision of the initial presentation at a convocation*[1] *of the Department of Psychology of the University of Minnesota and other interested clinicians who were involved in training students in the Minnesota clinical psychology program, which was called to discuss the idea of inaugurating a professional degree program. After considerable discussion, the department voted against the proposal, though it is not entirely dead at Minnesota.*

In his presentation, Meehl gives a clear picture of what this new kind of mental health professional would learn and be capable of doing. In the course of arguing his case, he touches on many of the problems that a school of psychotherapy must also face, and decisively routs many familiar but fallacious arguments against either new undertaking.

Paul E. Meehl, Ph.D., spent his professional life at the University of Minnesota, where he got his undergraduate and graduate degrees. The diversity of his interests and competences is suggested by the fact that he had some formal training in biometrics, neuropsychiatry, law, mathematics, logic, projective techniques, psychotherapy, and psychoanalysis; he engaged in the part-time practice of psychotherapy from 1951. He [*was*] *Regents' Professor of Psychology at Minnesota's College of Liberal Arts, and also* [*held*] *professorial appointments in its schools of medicine and law and in the Minnesota Center for Philosophy of Science. A past president of the American Psychological Association, he published widely and extensively but is best known to many as the author of* Clinical versus Statistical Prediction (*1954*)*. He received the Distinguished Scientific Contributor Award of the American Psychological Association* (*1958*) *and the Distinguished Contributor Award of its Division of Clinical Psychology* (*1967*)*.*

Everything I have to say presupposes that the present training of clinical psychologists for professional practice is unsatisfactory. I do not mean merely that the training is imperfect and could be improved in certain respects. I mean that there are deficiencies sufficiently serious and longstanding to raise the question whether radical changes in the academic and practical training of clinicians should be seriously considered at this time. Anyone with eyes and ears knows that

[1] [The conference took place at Stillwater, Minnesota, on October 15-16, 1964. Copies of the complete report may or may not still be available from the Department of Psychology, University of Minnesota, Minneapolis, 55455.]

considerable dissatisfaction exists among those involved in providing such training, whether employed mainly as academic personnel or as clinical teachers and supervisors in practicum facilities; not to mention the frequent expression of critical attitudes and frustrated feelings by students currently in training. In case there are a few who feel that things are pretty good as they are, I can only say that I believe them to be badly mistaken, and that my remarks are not addressed to them. For my part, I need no more evidence than my experience as an examiner for the American Board of Examiners in Professional Psychology to be firmly persuaded that most clinical training is in a pretty sorry state.

It is admitted by all who are acquainted with the statistical facts that current doctoral programs in clinical psychology must inevitably fail to meet society's mental health needs because they are not turning out an adequate supply of professional personnel. The Ph.D. in clinical psychology takes too long (Minnesota figures average 5.1 years) and the number of trainees that a department can admit is too small. By traditional standards of graduate training we at Minnesota have an overloaded faculty (I myself currently supervise 12 Ph.D. candidates!), and the steady expansion of numbers recently forced our faculty to impose an arbitrary limit of 15 new trainees in clinical psychology (adult plus child) to be admitted yearly.

Less clearly demonstrable but strongly urged by many are the qualitative weaknesses of selection and training. Some feel that the screening procedure for the admission of applicants, as well as the self-selection of potential applicants on the basis of their knowledge of what is required in the course of training, lead to a biased selection of doctoral students. Hence many potentially able clinical practitioners are not being trained, and there are data showing that many who receive training subsequently experience considerable vocational dissatisfaction in their role as practicing clinical psychologists. The other qualitative aspect is the question whether the character of most training programs provides anything like an adequate preparation for the realities of clinical practice.

If additional reasons were needed for this thesis that all is far from well, I would add the chronic conflict and disaffection within the American Psychological Association and the very grave problems concerning legislation, which in 1962 became so acute in New York as to lead to the appointment by Charles Osgood of the special *ad hoc* committee which I had the honor and misfortune to chair. It was replaced by the so-called Clark Committee, which is currently exploring in depth this whole problem between professional and scientific aims of psychology.

Because of space limitations, and a feeling that I could best contribute by discussing the aspect of this whole problem that most interests me personally, I shall confine the rest of my remarks to one major aspect of the larger problem of professional training, to wit, the proposal that we create an alternative doctorate, let's say a "Ps.D." degree, in professional clinical psychology. I do not wish to maintain here that this is the most important problem, although that is my belief; but clearly it is one of the important problems, and the stance one adopts toward the Ps.D proposal will affect the consistency with which one can defend certain solutions to some of the associated problems.

Over the years I have found myself moving steadily away from the position I took as a fresh Ph.D. in clinical psychology, when I was strongly opposed to the creation of an alternative doctorate for clinicians. Four years ago I had moved along this continuum to the opposite end, and was a pretty strong advocate of the Ps.D. As a result of committee discussion and a good deal of other informal conversation and correspondence, my enthusiasm has been somewhat dampened, I hope on rational and realistic grounds. I count myself at present, therefore, as a

moderate but not zealous advocate of the alternative doctorate.

FALLACIOUS ARGUMENTS AGAINST A NEW DOCTORATE

I want to make it clear that I recognize the merits of some strong arguments against the alternative doctorate. Later in my remarks I shall develop these objections briefly and with whatever intellectual honesty I can command. Before doing that, however, I shall clear out of the way some objections which, with the best will in the world, I cannot characterize as other than silly. In case you are yourself opposed to the alternative doctorate, do not think that I am attempting to liquidate the opposition by lumping all their counterarguments together as fallacious; I am reserving consideration of the good arguments against the alternative doctorate for later in my discussion. I cannot avoid, as a sometime amateur logician, the conclusion that many of the standard objections made by members of the profession are just plain foolish, and in order to prevent the discussion from being cluttered with this tiresome garbage I shall take the liberty of christening the commoner fallacious objections by pejorative labels which have the propaganda aim of eliminating these silly arguments so that we can get on with the serious business at hand.

We must abandon the use of denial, repression, and "muddling through" in preference to a critical examination of the root problem. American psychology has attempted, by patchwork methods and gaseous conferences invoking pious platitudes and trite generalities, to sweep this problem under the rug and to pretend that if we all agree that psychology is a science and that we want to help people and that research is a fine thing, etc., etc., somehow the problem will solve itself or go away. This hysteroid type of maneuver has now been employed for over 20 years and the problems have not only failed to go away or to resolve themselves but have, on the contrary, become increasingly acute. Anyone familiar with American Psychological Association affairs, and particularly anyone who has had the opportunity to read the kind of correspondence that the executive officer gets almost daily from clinical practitioners on the one hand and hard-boiled Division 3—Psychonomic Society types on the other, knows that the denial-and-repression procedure has simply not worked. It is high time to quit employing it. The Ps.D. is one concrete, nongaseous effort at realistic problem solution.

The first fallacy to be avoided is what I call the "panacea fallacy." It consists in judging a concrete proposal by the preposterous criterion that it does not solve all problems. Example: At a meeting of "Big Ten" department chairmen under Lloyd Humphreys of Illinois a couple of years ago, when Humphreys and I suggested the idea of an alternative doctorate, a distinguished clinical psychologist objected to the proposal on the ground that there was also a shortage of college teachers and that if we were going to move in this direction, why did we insist upon requiring the Ph.D. degree with research thesis for everybody who was going to be a college teacher of general psychology? I admitted to him that the Ps.D. for clinical practitioners would not alleviate the shortage of college teachers; nor, I added, would it solve the class struggle or provide a sure-fire cure for Hodgkin's disease. Need I say more?

Then there is the "perfectionism fallacy," which rejects the alternative doctorate on the grounds that it will not *completely* solve even the specific problems to which it is directed. Of course it won't. It is valid to point out that in partially solving the present problem by means of an alternative doctorate there is good likelihood that certain other problems, which we do not have at present, will be generated thereby and will have to be dealt with in their turn. What makes the perfectionism fallacy a fallacy is not the principle involved, namely, that most

solutions to difficult social problems carry as a consequence the generation of further problems. The fallacy consists in failing to recognize that problem solving in any pragmatic context will always involve a kind of bookkeeping, in which one compares the positive and negative utilities and chooses the solution for which the net utility will be at least positive, and, hopefully, somewhere near as high as it can practically be made.

Example: A common objection to the alternative doctorate relies upon the admitted fact that vocational choice is a fallible activity, even when made in the context of skilled educational and vocational counseling, and that therefore there will always be a certain proportion of persons who enter a training program on the basis of inadequate vocational diagnosis or inadequate knowledge of the world of work, and who subsequently come to the realization that they have made a mistake. We do not need a research study to say with confidence that some of those who take Ps.D. training will decide after getting the degree that they want to be college professors engaged mainly in teaching and research. (I shall try to show later that this need not constitute such a major personal or social tragedy as it sometimes does for persons who mistakenly take medical training with a C score on the physician key of the Strong Vocational Interest Blank and after a good dose of medical practice conclude that it is not their dish of tea and therefore take a job as a salesman for a medical supply house.) We can predict in advance that some people will take Ps.D. training who should not do so and will realize that after it is "too late." Such a class of vocational outcomes must of course be recorded among the negative utilities associated with an alternative doctorate. The question is whether this negative utility is so great in magnitude, and applies to so many people, as to make it a heavy countervailing argument. It is valid when employed as one among a set of countervailing arguments; what I am calling the perfectionism fallacy is the all-too-frequent tendency to advance it triumphantly as if it were a fatal objection, whereas a similar situation exists in many fields and will presumably always exist so long as vocational guidance remains a probabilistic enterprise and some people are stubborn and lack insight. All over the United States at present there are hundreds of students studying hard in law schools and engineering schools and medical schools who are ultimately going to end up doing something else, with resultant personal distress and a sizable amount of social and economic waste. I do not understand why, in discussing the training of clinical psychologists, we should impose a requirement of infallible vocational choice when we would not think of requiring it in any other professional field.

Next we have the "missionary fallacy," which sets up the aim of converting all the unbelievers. In order to achieve this conversion as a precondition for having a try at the alternative doctorate, we would not only have to solve the genuine problems which that proposal engenders, we would also have to solve all the pseudo problems that the mind of man is able to concoct in the course of controversy. I don't suppose that anyone who has ever innovated anything socially significant has delayed pushing for the innovation or carrying it into practice until such time as everybody agreed in advance that it would work. This is particularly true where strong passions are involved and vested interests threatened. I therefore operate on the assumption that whether the alternative doctorate turns out in retrospect to have been a good idea or a punk one, in either case it will meet with considerable resistance in the beginning. Anyone who takes the Ps.D. suggestion seriously must do his best to be fair to the objections and criticisms, to answer the objections that can be answered on the basis of available psychological principles and research data, to evaluate in relation to reasonably anticipated gains the cumulative negative utilities attached to objections that cannot be plausibly answered, and then go

ahead in the hope that he has not miscalculated too badly. To wait until everyone is convinced would be immobilizing, and there seems to be no cogent reason for doing so, inasmuch as those who are unconvinced are not in any way coerced into participating, cooperating, or even approving of the social experiment.

Associated with this unrealistic goal to convince everyone before trying anything is its internalized form, namely, the idea that one cannot embark upon an educational procedure unless one possesses thoroughly researched scientific propositions guaranteeing its educational outcomes. I call this the "scientific-guarantee fallacy." Example: It is objected that we ought not to be training people to engage in psychotherapy because we aren't sure how to do so, and besides, the effectiveness of psychotherapy as a technique for behavior change is at best limited and, according to some critics, has not yet been scientifically established at all.

No one disputes that we would be much more comfortable training students if we had thoroughly researched the questions of diagnostic, prognostic, and therapeutic efficiency on the part of the practitioner in relation to the composition of his training. Nor do I personally have much sympathy for clinicians who put up a resistance against scientifically investigating their own effectiveness. On the other hand, it seems to me rather strange to hear college professors argue that it is illegitimate to construct a program for training people to do something in the absence of adequate research on the educational outcomes of such training when, so far as I am aware, the same criticism can be made with equal force against probably 90 percent of the educational procedures we currently employ in training people for teaching and research, including the procedures these critics are anxious to retain as against the Ps.D. elimination of them. I am not aware that anyone has empirically demonstrated, for example, that the academic hurdle of the doctoral dissertation makes a man a better teacher, a better scholar, or even a better scientific investigator. I am not aware that anyone has demonstrated any such correlation with educational outcomes for written or oral prelims, studying foreign languages, or, for that matter, taking required courses or passing examinations in the graduate school. I doubt that anyone has ever studied the effect upon a physician's clinical practice of including or excluding embryology. I would be quite nervous if I thought my physician had never studied gross anatomy as a freshman in medical school, but I will lay odds that no one has ever researched the impact of this backbreaking course upon the practice of medicine. Furthermore, is it not obvious that there is no possibility of researching the educational outcomes of a training program without creating it and putting some people through it? I find it hard to imagine a scientific empirical answer to the question "Will an alternative doctorate lead to a superior performing practitioner?" on the basis of extrapolation from experimental studies that do not include such an alternative doctorate applied to real trainees undergoing real-life professional preparation.

Then we have the "eternal-hope fallacy," which in its various forms has the common property of assuming that sometime, somehow, the present unsatisfactory state of affairs will change if we just keep plugging away doing what we are now doing and have been doing for a generation. Example: Many students aiming at full-time clinical practice dislike being put through certain educational experiences that are obviously intended to turn out academic research producers. Faculty members not in the clinical field sometimes defend these requirements on the grounds that they prepare clinicians to do research and, hopefully, interest clinicians in doing research. If one points out in reply to this laudable goal that the modal number of publications of post-World War II clinical psychology Ph.D.s is zero, and that the great majority of them never publish anything (even their own doctoral dissertations, which they

carried out under academic duress in many if not most instances), one is met with the astonishing rebuttal, "Well, maybe it hasn't worked, but we have to keep trying anyway." I am at a loss to understand this kind of argument coming from psychologists, who presumably ought to think like behavioral engineers and accept the facts of human conduct as they really are. If cumulative experience shows that you cannot stamp out delinquency or divorce by hanging up signs reading "Be a good citizen" and "God bless our happy home," after a while it becomes irrational to continue relying upon such incantations.

One bizarre argument is offered not only by opponents of the alternative doctorate but sometimes even by proponents of the idea. I must confess that I have at times caught myself making this argument, when discussing the appropriate content of the Ps.D. curriculum. I call it the "ceramics fallacy," with reference to the paradigmatic statement, "A good course in ceramics never hurt anybody." If it is pointed out that a thorough knowledge of the history of British associationism does not conduce in any obvious way to the effective practice of psychodiagnostics or psychotherapy, you would be surprised to know how many academicians will counter by saying, "Oh, it doesn't hurt a graduate student to learn that stuff, and it might even do him some good."

I dare say that it doesn't hurt a graduate student in psychology to learn anything, and I am quite prepared to admit that it might do him some good. But this is truly a remarkable criterion to employ in curriculum planning, especially when we begin with a serious logistics problem as part of the current professional difficulty. When our task is to turn out more people, and preferably in a shorter time, to meet the pressing community mental health needs, it does not seem to me very rational to defend a course or experience on the ground that it "doesn't do a person any harm." The ceramics fallacy is no doubt one of the main reasons why idealized curricula for training clinical psychologists regularly drag in every course that anybody on the committee fancies (either because he *had* to take it, or because he *wishes* he had taken it), with the result that anyone who went through this much training would be almost as old as the thoroughly processed Freudian psychoanalyst is before he is considered qualified to work with patients.

Opposite in spirit to the ceramics fallacy is the "self-made-man fallacy," which says that we ought to pick bright people, let them study what they want, if they want, and then turn them loose on the patients, figuring that something good will come of it one way or another. Addicts of this fallacy like to point out that surgeons evolved from barbers, internists from empirics who had learned about foxglove from an old wives' tale, and that Freud never had the benefit of a didactic analysis. Now I admit that Paracelsus was a clever fellow, and he no doubt helped some of the patients who came to him. But I must confess that I personally have a preference that my own physician will not be quite so self-made a man as Paracelsus was. I believe it was Mark Twain who made the point that the trouble with most self-made men is that they illustrate the horrors of unskilled labor. When we require that a law student take the class in torts (in the law school they even mark on attendance because they want to make sure the student has heard as well as read a discussion of every case), we do not presuppose that it is impossible for a person to learn about torts by hanging around a law office or by studying on his own. That is the way one used to become a lawyer in the old days, and the great John Marshall only had about six months in a law school. But how many of you, in the light of this biographical datum, and about to litigate a $10,000 civil action, would prefer to go to a lawyer who in this generation was a "self-made man," rather than seeking out a law school graduate?

I notice that if one suggests including a certain substantive course as part of the curriculum, some will object on the grounds that studying and passing a course is neither necessary nor sufficient for utilizing the information presented therein. Who ever said it was? When we send a student to read a book or to attend a lecture, or when we examine him on the results of these academic activities, do we *ever* assume that there is one and only one way in which certain information can be obtained? Of course not. What we assume is that people by and large will learn what they are set to learning. Requiring a certain formal course as part of the training for a practitioner is an educational procedure based not upon the naive notion that you can *only* learn things in courses, nor upon the notion that you will necessarily make adequate practical use of what you have learned in courses, but on the probability relationship between what a man has learned and what he is likely to use subsequently. So far as I am aware, there is absolutely no way to guarantee that anybody will put his knowledge to practical use. There is, however, a way to guarantee that he has been *exposed* to certain information—whether this information involves facts or generalizations or methods—and that his exposure has at least "taken" to a minimum degree, a fact ascertainable by examination procedures. Do the invokers of the self-made-man fallacy really suppose that a curriculum planner is so naive as to think that the relation between course work and knowledge, or between knowledge and practice, is other than a probabilistic one?

Suppose that I am a nonprofessional and that I have a 55-year-old relative who takes to not sleeping nights, wringing his hands, worrying about his health or his sinfulness, and showing a marked loss of weight. Not knowing what is the matter with him, I see to it that he gets into the hands of a clinical psychologist. Now there is no ironclad guarantee that the psychologist, just because he has taken a good course in descriptive psychiatry or abnormal psychology, will recognize these signs as indicative of an involutional melancholia and will therefore take appropriate action because of the major suicide risk involved. But I take it that one difference between a psychologist and a layman is that the psychologist knows that these are signs of an involutional melancholia and the layman does not. It is difficult to see how we can expect a person to apply knowledge that he has never acquired. It is equally difficult to see how we can have any confidence that he has acquired knowledge to which he has never been exposed, or upon which he has never been examined. Do we have to do a research study on training outcomes to say that anyone who is going to deal with mentally upset people should at least have been exposed to the major descriptive aspects of abnormal psychology? This line of thought leads me to what I myself use as a kind of touchstone when I become doubtful about whether a certain course or experience ought to be included as part of the training program for a clinical practitioner. When the abstract and philosophical considerations get a little fuzzy and the pros and cons seem to be adding up about equally, I ask myself this question: "If I were referring someone I loved—a member of my immediate family or a close personal friend—to a clinical psychologist for assessment, referral, or treatment, would it make me nervous to think that the psychologist in question had never had a class in subject X?" If I find in contemplating this very down-to-earth personal situation that it *would* make me nervous, I incline very strongly to include a course on subject X in the curriculum. In the present state of knowledge, I submit that this is a pretty good touchstone for most of us to use.

Next I come to the "poor-persecuted-student fallacy," which seems to be predicated on the assumption that obtaining a Ph.D. or Ps.D. degree and engaging in the practice of clinical psychology is one of the natural rights of man. I take it as axiomatic that when we are discussing

a training program that aims to produce professionals who will take genuine responsibility for sick, unhappy, or ineffective people, and who will earn a comfortable living and receive high prestige and personal gratification in the occupation, our policy about the training requirements and the selection criteria should be what Lee J. Cronbach calls "institutionally oriented" rather than "individually oriented." The primary function of training programs, like the primary function of certification and other forms of social control over professional activity, is to protect the interests of society and of the help-seeking person; it is not primarily to protect the interests of the practitioner or the candidate for such professional training. Since around 1950 the clinical psychology faculty at Minnesota, in evaluating applicants, has operated on an explicit policy of "When in doubt, reject." We don't make any secret of this policy, and we are prepared to defend it on ethical, economic, and social grounds. No one has a "right" to become a psychologist, any more than he has a "right" to become a physician, an engineer, or a lawyer; and the burden of proof is upon him to show that he should be admitted to candidacy.

By the same token, once a student is admitted to candidacy, the training institution is clearly entitled to rule that when it is doubtful whether a certain course or practical experience is highly relevant to the aims of professional training, he may be subjected to it whether it pleases him or not or strikes him as relevant at the time. (Incidentally, in the early fifties the Minnesota department did some statistical research on the question, and we were interested to discover that a sizable number of our Ph.D. products, in replying to our questionnaire, mentioned requirements that struck them as unreasonable and pure "make-work" at the time they were in training, but which in retrospect they were glad to have been exposed to.) I am myself willing to be quite high-handed about this part of the question, since I categorically reject the notion that the average graduate student has sufficient knowledge, perspective, wisdom, or practical experience to make valid judgments about what he should be learning, not to mention the usual motivations to distort, which are present owing to the chronic pressure of the graduate student's role and environment.

A fusion of the perfectionism fallacy with the poor-persecuted-student fallacy is what I call the "rare-pearl fallacy." In this one we fix all of our horrified attention upon the hypothetical student who, had he gone into research, *would* have been a genius but who, because of the availability of a practical professional degree, was somehow seduced into that curriculum and consequently became a full-time practitioner, living happily ever afterward hewing wood and drawing water. The idea is that if this Ps.D. avenue had not been open to him, he would have been forced to get the traditional Ph.D. degree and would probably have solved some of the great problems of our science.

I point out first of all that no professional training program for any practical discipline can afford to define its aims and curricula in terms of the rare event of a research genius. It is simply not practical for human institutional arrangements to be predicated upon the idea that in training for the ordinary, normal, run-of-mine operations of practical life, the rules of the educational game must somehow preclude the possibility of failing to discover a hidden genius. The possibility of derailing or even of squelching a genius is a necessary consequence of any form of educational control. Personally I am convinced, although I admit I can't prove it statistically (any more than this objection can be proved statistically on present evidence), that if you are really talking about this kind of research genius, you are talking about the sort of person whose intellect and creative drives will almost force him to get the right training, either before or after his union card, in the same way that great composers are inspirationally seized or forced to write music

and chess geniuses are driven to organize their lives around the game of chess. As I shall attempt to show in discussing the curriculum, it is a mistake to assume that Ps.D. training will fail to provide the kind of intellectual stimulation necessary for such a latent research genius to have something to chew on. He will be taking the same basic science courses in psychology, and in that process will be exposed to the same books and journals, listening to the same professors, hearing about the same unsolved research problems, as will the Ph.D. candidates. The person with this much brains and research drive will quite probably decide fairly early in the game to become a qualified clinical practitioner first and then go on acquiring the necessary research skills (with or without picking up a Ph.D. degree). I remind you that medical school faculties in the clinical fields, and even in the preclinical fields, consist largely of persons who are first of all qualified to practice medicine, and who continue to engage in clinical practice and clinical teaching even when they have defined their long-term career as being that of a medical investigator.

Of course I am thinking in terms of a very rare bird when I talk of a research genius or near genius. By contrast to my conception, I have the impression that some of my colleagues see a tragedy in the possibility that a sizable fraction of current Ph.D. candidates might enter a professional program and as a result not be research-productive. How much of a tragedy this amounts to will of course depend upon one's views about the net worth of current research in clinical psychology. I can't expect to convince you in a few moments of my own philosophy on this question, so I shall content myself with remarking that, in my view, 90 percent of the research published in the journals at the present time could just as well have been left undone, does not actually contribute anything that will be built into the permanent edifice of psychological knowledge, and serves very little function except to reduce the guilt feelings of psychologists who have been indoctrinated in graduate school with the irrational notion that if you don't publish research articles you are some kind of an inferior being.

A final comment on the rare-pearl fallacy is to question its strange assumption that faculty members who have contact with this kind of student will be so uniformly blind to his hidden potential that no one will ever raise with him the issue of making a career of scientific investigation rather than a career of clinical practice. I am not suggesting that no rare pearls will ever be missed. To insist that an educational proposal provide some kind of built-in guarantee that no such events will ever take place is, of course, a form of the perfectionism fallacy.

Opposite to the "eternal-hope fallacy," in which irrational optimism is maintained regarding the spontaneous improvement of the present system, we encounter—often in the same people—an irrational pessimism, which I shall label the "fatalism-and-impotence fallacy." This one consists of bringing up certain possible or even probable undesired outcomes of the alternative doctorate and then stating with dogmatic certainty that these outcomes will necessarily occur.

Now I have no objection to somebody's refusing to lay bets on a particular horse, but I find it strange that psychologists will include, as *inevitable* outcomes of a proposed social action or institutional development, consequences that are at least theoretically subject to administrative control. It is one thing to say, "Such-and-such might happen, and I predict it will; therefore the idea has to be judged keeping in mind that this undesired consequence may, in probability, accrue." It is quite another thing to say, "If you do so-and-so, then a certain consequence is absolutely inevitable." This kind of fatalism or impotence seems especially inappropriate when the content of the adverse prediction involves behavior or properties of persons that are subject to unilateral decision policy. Example: It is repeatedly stated with great assurance that the

students who embark upon Ps.D. training will be those of inferior intellectual caliber and that they will take it because it is the easy way. Aside from the unproved supposition that clinical majors are less able intellectually than nonclinical majors (which is not true at Minnesota in terms of Miller Analogies Test scores, course grades received in graduate school, or prelim performance),[2] and the unproved assumption that the chief objection to the current doctoral program on the part of trainees aiming at full-time professional practice is its conceptual difficulty, it seems unduly fatalistic to assume that the intellectual caliber of degree candidates is something that lies outside the training institution's control.

One of the few things that we clinical psychologists can be unqualifiedly proud of in our technology is our ability to assess intelligence. It is obvious that the intellectual caliber of candidates for any degree can be made as high as the training institution sees fit to make it by a sufficiently determined combination of rigorous selection procedures (utilizing both psychometric data and previous academic performance), and the establishment of an educational curriculum sufficiently "tough" in both quantity and quality so that nobody would be likely to enter it on the grounds of laziness or inferior academic ability. I remind you that while a person who enters medical school is likely to differ in interests and ultimate vocational goal from one who enters graduate work in biochemistry or physiology, that difference is not mainly a matter of lack of brains or aversion to hard work! The same can be said of the difference between someone who enters law school in contrast to one who undertakes graduate work in political science; or one who enters the school of engineering in contrast to one who enters graduate work toward a Ph.D. in physics.

Of course it can be plausibly argued that if the standards are set sufficiently high and the curriculum made sufficiently solid, the number of people interested in such training and who meet these standards will be so small as not to justify the creation of such a program in terms of ultimate personnel output. We should honestly recognize that there is no way to predict this in advance. I can only say that when the possibility of such an alternative doctoral program was presented to a roomful of current clinical psychology trainees, the social fact is that over half of them expressed great enthusiasm for the idea and stated that they would prefer such a program, even after I warned them that they would be taking a certain economic and professional risk by so doing.[3] To ignore this kind of anecdotal evidence because we can't be sure that they would *really* do it if presented with the opportunity seems to me a variant of the perfectionism fallacy and the scientific-guarantee fallacy.

Lastly I would mention the "guilt-by-association fallacy," which has in it such a sizable component of validity that I am not sure that I should include it in the list of fallacies, and will say something about its valid and important component later on in my remarks. It is quite apparent from published and semipublished (professionally circulated) statements, and even more apparent on the basis of correspondence and conversation in American Psychological Association committees and at other special meetings, that support for the idea of an alternative doctorate is rapidly growing among a segment of psychologists who might at first be thought very unlikely to favor such an idea. I refer to the academic psychologists in the so-called "hard science" areas such as physiological, experimental, mathematical psychology and the like, who are dominant in

[2] [At New York University, too, these same criteria have repeatedly shown that clinical students are at least the intellectual equals of nonclinical graduate students.—Ed.]

[3] [I have had the same experience, with about the same proportion of positive response, in talking to groups of graduate students at half a dozen universities.—Ed.]

Division 3 and who are most clearly exemplified by the founders and active members of the Psychonomic Society. (I have nothing against the Psychonomic Society, being a charter member myself.) I am revealing no great secret in stating what everybody knows, that some of this support from such an unlikely quarter reflects attitudes and motives on the part of these persons which are not wholly consonant with the intentions of those of us in the clinical field who want the alternative doctorate. Their motivations could perhaps be most charitably described as ambivalent; less charitably, as unsanitary or malicious. Not to mince words, many psychonomes both fear and despise clinical psychology as a domain, and specifically abhor the "typical" clinical practitioner.

I have not myself been able to fathom the dynamics behind these attitudes with any confidence, but you do not have to introduce concepts of depth psychology in order to state that the motivations are often hostile and aversive rather than task oriented and socially constructive. Some of these persons view the academic Ph.D. degree as some kind of a sacred thing, rather like the ecclesiastical conferring of holy orders, and they feel that conferring this scholarly priesthood upon a person who merely wants to help unhappy people with their problems amounts to an act of sacrilege. Some of them perhaps wish that no such thing as clinical psychology as an applied professional discipline existed; but since they cannot seem to make it go away or render it a negligible influence in American Psychological Association affairs, the next best thing is to denigrate it by associating it with what they themselves believe to be a second-rate, unscientific, unscholarly, low-level degree.

These attitudes exist in a sizable and rather vocal minority of the profession at the present time, and are especially strong among the power and status figures in the great universities with strong departments of psychology; therefore they represent an important social fact which must be given proper weight in evaluating the proposal for an alternative degree. But one should keep distinct the possibly adverse effect of these attitudes upon the social image of the degree, a question which must be examined on its merits, and we must not conclude that everyone who advocates an alternative degree shares these unsanitary attitudes. I particularly wish at this point to dissociate myself from this group, and to emphasize that insofar as I have any insight into my own motivations, they are of a very different kind. I think that the touchstone here, for a clinical psychologist in an academic setting, should be whether he himself would have been likely to enter such a training program had it existed when he began graduate work. Even though my vocational aim from the age of 15 was to become a college professor, I have little doubt that I would have entered such a training program, with the intention of following the professional degree with such additional graduate work as would have been necessary to get the traditional Ph.D. degree besides. This is a common pattern for men aiming to become teachers and researchers on medical school faculties.

SETTING UP A NEW TYPE OF TRAINING: GENERAL CONSIDERATIONS

With these fallacies exposed so that we may be alert to our own tendencies to fall into them when arguing the pros and cons of the Ps.D. degree, let me move now to a consideration of the alternative doctorate idea as I see it from the armchair.

We take as our primary goal the construction of a training program in which the academic courses and the practical experiences are aimed primarily at turning out competent practitioners of the science and art of clinical psychology. We recognize in advance that some of these

persons will make contributions in other ways than direct service to patients, but that these are not the outcomes at which the training program is mainly aimed. We select applicants on the basis of appropriate interests and motivations for full-time clinical work. If, as some of the evidence about professional interests seems to suggest (Campbell, 1965; Clark, 1957; Shaffer, 1953; Strong, 1943; Thorndike, 1954, 1955), the correlation between scientific interests and "helping" interests is at best negligible and may actually be negative, we set up the double requirement that a person should be at least interested enough in the basic sciences of psychology to master the subject matter, given adequate ability, and that he will have enough social service interest (Strong Group V)[4] to be happy in a helping profession that is frequently somewhat discouraging. Hence, a portion of the applicant population will have to be rejected (pending further research) on the basis that they fall below some arbitrary critical standard in one of these two broad areas of interest and motivation even though they are adequate or superior in respect to the other.

The psychometric model appropriate for selection in this case is a successive-hurdles rather than a summative (compensatory) model. A person cannot make up for his very weak social service interests by having superlatively high interests in psychological science. The idea that nobody with a high Miller Analogies Test score or a solid A interest on the psychology key of the Strong ever wants to help people or wants to spend his time in psychodiagnostics or psychotherapy is simply not true; and we can all point to examples among our students and colleagues that show that it is not true. Even if we were forced by the structure of interests to select people from the sparse quadrant of a fourfold table, it is a psychometric truism that we can always arrange to do so by adopting a small enough selection ratio.

I assume further that most of us operate on the principle that the best way to train people to do certain tasks is to have them practice what they will be doing! The choice of courses and practical experiences must therefore avoid the ceramics fallacy, and we must keep in mind that we are not trying to turn out some kind of a Renaissance universal man, or train for good citizenship or scholarly productivity, but that we are trying to train people to be psychodiagnosticians and psychotherapists. Anyone who wants to include a particular academic or practical experience in the required training program must make a reasoned case that the proposed requirement is plausibly related to the stated outcome of being a skilled clinical practitioner.

It would seem desirable that such training programs first be established at high-prestige universities with top-ranking psychology departments. This is, alas, only a necessary and not a sufficient condition for a department's being appropriate. Equally important is that the faculty (and particularly the power elite among the faculty) must be sincerely committed to training clinical practitioners, rather than being actuated mainly by the unsanitary motivations I alluded to above.

At the risk of institutional immodesty, I should say something about the kind of psychology department I was trained in and presently work in, because this social matrix helps explain my orientation to the Ps.D. degree, and the departmental image I associate with such a curriculum. The Minnesota psychology department has a long and noble tradition of emphasis on applied psychology starting with the pioneer work of the late Donald G. Paterson and extending through the contribution of my teacher and colleague, Starke R. Hathaway, in the clinical field. At the

[4] [The reference is to a group of vocational scales of the Strong Vocational Interest Blank; see Strong (1943).—Ed.]

same time, our intellectual tradition is strongly imbued with the quantitative, scientific, empirical, and critical spirit, and the commitment to the advancement of knowledge is reflected in the research productivity of the clinical faculty as well as the unusually high publication rate of our Ph.D. products in clinical psychology over the past 20 years. That we have a strong and sincere *double* commitment, which we have largely succeeded in implementing by our selection and training procedures, is shown by the fact that our Ph.D.s in clinical psychology since 1945 are now distributed about equally between those working in full-time clinical jobs and those engaged primarily in teaching and research. If it were otherwise—if the great majority of our Ph.D.s were in the VA or in private practice, or if almost all of them had become nonpracticing college professors—we would be very unhappy. In addition, this department has been almost completely free of the kind of internal conflict and jockeying for power and status, or competing for the allegiance of bright students, or maliciously flunking one another's students on written and oral prelims, and the other shenanigans that characterize some psychology departments in this country at the present time. The departmental faculty meetings and the lunch-table conversation show the differing values and, at times, competing interests of our diverse faculty, an inevitable phenomenon of academic life. But it has never been possible since I have been on this faculty to predict the opinions or the votes of faculty members by assigning them to the "clinical wing" versus the "psychonomic wing."

I believe that any psychology department undertaking to try out the Ps.D. degree would have to obtain from some source, probably the National Institute of Mental Health, a sizable subsidy to beef up the professional staff, partly by freeing some staff from major teaching and administrative commitments, but, more important, *to strengthen the faculty by the recruitment of top-flight, seasoned, clinical practitioners whose main function would be in advanced and intensive clinical supervision.* I also believe that departments of psychology should make a much greater part-time use of practitioners from the nearby community than they do now, and that the tradition that has existed in medicine of making clinical appointments to contribute to the practical teaching should be encouraged.

I find it rather tiresome to hear the objection continually advanced that we cannot construct a curriculum because not everyone will agree about what should go into it. This question is one that is rather easily researchable and I have, in fact, done a little unpublished, informal "research" on it myself in meeting with various groups. It is, of course, foolish to argue that one cannot concoct a curriculum unless there is 100 percent unanimity among all competent persons about precisely what should be in it. I do not know of any kind of training, whether for primarily academic or primarily applied work in any field, of which this can be said. Whence arises the absurd idea that social institutions are immobilized pending attainment of Quaker-meeting consensus? (I submit, brethren, that there must be psychopathology at work. How else can one explain the reiteration of such fatuous objections by men with the brains to become college professors?)

What I suggest is that we investigate whether a respectable consensus exists among seasoned practitioners, present-day teachers (whether classroom or in-service supervisors), and recent Ph.D. trainees with regard to course content and supervised experience. It would even be possible to study this by such methods as the Q technique, where we would find out the size of the Q correlation between the Q-sort placements of various courses and practicum experiences when ordered as to their importance or "core" status by members of these groups. On the basis of such data, which would represent the best available educated guesses of the most competent

people capable of making an informed judgment, it would be a simple matter to arrange proposed elements of the training program in a hierarchy as to their judged centrality. One would take into account both the average placement and the dispersion, both within and between groups, in assigning each proposed educational experience a position on a "core-versus-peripheral" continuum. For example: One of the silliest arguments I have heard in connection with this question points out that some faculty might think physiological psychology more important than social psychology, and others would disagree. So? How central or peripheral a course is deemed to be is obviously a continuous rather than a dichotomous variable, and the situation of the curriculum planner is first to order such subject matters on the basis of weighted or unweighted expert judgment, and then to move down as far into the list as the logistics of the training situation permit.

The point is that you do not have to decide "arbitrarily but for certain" between physiological and social psychology. If they are both ranked fairly high they will both go in. If they are both ranked low, they will both be left out. If they are ranked about equally, have equal dispersion, and are located in the over-all hierarchy just about at the cutting line imposed by the necessities of curriculum size, it will probably not be a major tragedy if you make what is a mistake in the eyes of Omniscient Jones. For that matter, in such instances you could decide by flipping a coin. In the most important areas there will be no problem: Courses in abnormal psychology or developmental psychology or psychodynamics or basic mental measurement are certain to appear somewhere in the upper regions of the hierarchy and therefore will automatically be included in the curriculum. It amazes me that psychologists, when they get to talking about this subject, suddenly forget everything they supposedly learned about statistics and psychometrics, or the theory of practical decision-making, and begin to think and speak as though the facts of disagreement and imperfect reliability and validity in human judgments automatically bring about a complete paralysis of practical action. One would hope that psychologists, when thinking about curricula and training programs, would be able to think somewhat better than lawyers, physicians, or engineers.

In case these fancy psychometric approaches strike you as unduly democratic, I hasten to add that I do have a considerable respect for aristocracy and for the wisdom that we hope comes with age and experience, so that if I myself were to play an important role in planning the curriculum for a particular department, I would be quite willing to throw my weight around with regard to two or three of my favorite courses, even if they did not accord with the national consensus. There is nothing inconsistent in this attitude, so long as it is kept in mind that one can do it only for a very limited number of favorite courses and that it is a basis for *inclusion* but not *exclusion.*

It is my own conviction, for instance, that one of the deficiencies in the assessment and therapeutic procedures of psychiatrists is that they have an insufficient awareness of the vast range of normal individual differences and hence tend to overpathologize. I further believe that in order to get the idea of individual differences really built into your psychological substructure so that it's in your blood and bones rather than merely an abstract statement that "people and groups differ," there is no substitute for the kind of detailed treatment of the empirical facts of differential psychology that impressed itself so deeply upon those of us who had the privilege of studying this field under the late Donald G. Paterson. Therefore, if a national sample of clinicians did not place differential psychology very high in the hierarchy, I would still go to bat for it as part of the curriculum at the University of Minnesota. But in doing this locally, I would not attempt to force it upon programs elsewhere, and I would operate on the assumption that the

faculty at other schools would be playing their own favorites, so that over the years the profession might slowly come to adjudicate the merits of such differing emphases. I would, however, consider it grossly inappropriate on my part to advocate the inclusion of individual differences if it meant leaving out a course in projective techniques when I know that projective techniques would come out almost universally high in the national consensus.

So I do not mean to automatize the curriculum planning by my psychometric suggestions concerning reconciliation of curricular disagreements. It is obvious that different schools will have different strengths in their faculties, and it is desirable at this stage of things to allow considerable variation with respect to those elements of the curriculum that are judged to lie somewhere on the borderline or intermediate range of centrality to the work of a practitioner. On the other hand, *it must be emphasized that the very idea of a professional degree involves the repudiation of the traditional freedom of the Ph.D. degree.* It is intolerable that an idiosyncratic graduate advisor or an autonomous degree candidate should unilaterally decide that the trainee will not take a course, say in abnormal psychology, because it doesn't appeal to his interests. This is intolerable for the same reason that it would be unheard of, even in the most flexible and experimental medical school, to free one who aims to become a physician from studying bacteriology, anatomy, or pathology in the course of his formal training.

With regard to the question of agreement about the centrality of certain courses, I shall be foolhardy and record here my prediction that a group of university professors who are involved in clinical training, but who also are themselves engaged in some kind of actual clinical work and who are A.B.E.P.P. diplomates by examination, if taken together with recent Ph.D. products in present training programs and with seasoned practitioners and supervisors in clinical installations, would show a gratifyingly high consensus about many, if not most, of the academic and practical experiences to be included. Given that high-consensus minimum core, we need not be disturbed by, but should rather welcome (pending long-term empirical research on training outcomes), a certain amount of diversity among schools based upon the interests and skills of their particular faculties.

I am inclined to favor the entrance requirement of a full undergraduate major in psychology, although this meets with objections by those addicted to the "poor-persecuted-student fallacy." I do not see any reason why it is more onerous to require this for a profession like ours than to require certain kinds of preprofessional academic background for students wishing to enter medical school or law school. Unless this requirement is imposed, it is not logistically feasible to do what we want to do during four graduate years. It goes without saying that some students will make their vocational choice so late in their undergraduate career that they will have to use a little extra time and money in order to prepare themselves for admission to the Ps.D. program. This is a social fact which we shall have to learn to live with, as medical schools and would-be applicants to medical schools have lived with it for many years.

In addition to the requirement of an undergraduate major, I would include a small number of specific course prerequisites. A person who had an undergraduate major in psychology lacking one of them would be in the same situation as someone who had undergraduate courses fulfilling most of the premedical requirements but had never taken a course in qualitative analysis or zoology. His situation today in attempting entrance into most medical schools is that he simply has to take those courses unless he can, in special circumstances, persuade the admissions committee to make an exception in his case. One would not have to be absolutely rigid and hard-nosed about this, but the main point is that a widespread social expectation would have to be

developed to the effect that the proper and normal basis for an application to the Ps.D. training program includes these undergraduate prerequisites. Specifically, I would think of including here a good solid senior college course in abnormal psychology, a course in statistics and mental measurement, and at least a survey course in basic biological science. (How decide if the student's learning from an abnormal psychology course was "good and solid"? I'll let you in on a trade secret: You *test* the applicant, that's how!) I do not make this specific list very long, because I sense the temptation in myself to succumb to the ceramics fallacy.

It is also worth mentioning that there are a number of subject-matter domains that students can learn enough about for the practitioner's purpose without being held to a formal course requirement in them. In making the choice between a course in statistics and a course, say, in cultural anthropology, I have been greatly impressed by the fact that one can learn the essential facts, and can acquire the important message of cultural anthropology (such as the avoidance of ethnocentrism) by doing some moderately systematic bedside reading. But we all know that bedside reading without classroom instruction and the necessity to study for examinations does *not* suffice, except for a very unusual student, to acquire an adequate mastery of such a field as statistics. One must further keep in mind the principle that we should not allow the good to drive out the better. For example, since patients often have money problems, it would be nice if all clinical psychologists had a good course in economics. I have seen "model" curricula that included economics, but it would be absurd to allow five credits of economics as a substitute for statistics or abnormal psychology.

The aim is a four-year doctorate. Some have suggested three years, which I would prefer but have reluctantly concluded is unrealistic. I assume that students will really complete it in the stated time, as is uniformly true (except for very special circumstances, such as illness) in law, medicine, and engineering. Conceivably it could be three years provided we put the mandatory internship postdoctorally; but if the language requirement, prelims, and thesis are eliminated, I don't see that it makes very much difference whether the degree is awarded after the third year or after the fourth. I should think the considerations would be chiefly those of the advantage in advanced training of being entitled to be called "Dr." by the patients, and the possible economic significance of having the degree in the late stages (it might mean a higher salary). I think on the whole that four years is to be preferred. Furthermore, a certain element of maturity is desirable in a psychotherapist, who will in any case be at this point obviously younger than most of his patients, and we are dealing here with an age region in which one or two years seem capable of making a sizable difference in degree of maturity for some people. A genuine four-year program cuts the doctoral training time by 20 percent on the average since, as I mentioned above, the average time to the Ph.D. at Minnesota for clinical psychology trainees is currently 5.1 years. We will therefore already have made a respectable dent in the manpower-shortage problem by organizing a curriculum in such a way that trainees actually do complete it in the officially stated four-year time. We achieve this partly by lock-stepping the curriculum but mainly by eliminating those traditional academic hurdles that are at present the source of almost all degree delays.

THE CURRICULUM

We should aim to put into the first year as much of the basic science and preclinical work of a lecture-attending, examination-taking nature as possible, so that only a small fraction of the student's time during the second year would involve academic course attendance, and none of his time in years three and four would do so. This means that the student would be deeply

immersed in clinical work, spending well over half (my curriculum makes it over 80 percent) of his time in this way during his second graduate year, and in years three and four close to 100 percent of his time would be spent clinically. (Exception: A continuous literature seminar, to be discussed below.) This does not mean that he would not be attending any kind of seminar, but it does mean that these seminars would all be directly related to his clinical activities, would be taught by personnel who are themselves engaged in at least part-time clinical practice, and would not involve any kind of mental set toward passing examinations, etc., that today usually impairs full clinical commitment and zeal so that very few of our students have the patient-oriented attitude that is characteristic of a medical intern.

In choosing (or creating) didactic lecture courses for the preclinical, "basic science" period of year one, we avoid any purely theoretical or academically oriented courses with the exception of those that are considered to be pretty close to rock-bottom basic sciences, without which one can hardly be considered a psychologist, professional practitioner or otherwise. (Don't say "Who's to judge?" without rereading the material several paragraphs back. Those of us who are both bona fide practicing clinicians *and* college professors are to judge, that's who.) We eliminate courses primarily aimed at preparing a person for a nonclinical teaching or research career. We eliminate all of the academic frills that are (even for the Ph.D. program) primarily unexamined cultural survivals of the medieval system of doctoral education. (I don't use "medieval" pejoratively; I mean it historically and literally, in the sense that the "thesis" in the Middle Ages, and the oral defense of it, had a meaning rather different from what it typically has today.) We would eliminate the foreign-language requirement (which is even now a fake requirement, serving nothing but a hurdle function; see Bird et al., 1947) and we would eliminate the written and oral prelims, the doctoral dissertation, and the final oral.

Eliminating these things does not mean what many take it to mean, that we have eliminated all of the "scientific training" or "basic knowledge of general psychology" or "scholarly courses." *Why do we assume that the only way to be intellectually responsible, scientifically informed, and scholarly in attitude is to be a producer of research?* The world—even the academic world—is full of people who are extremely well informed, have very able minds, and a thoroughly scholarly attitude, who are not research-productive. Typically, psychologists of this genus are to be found among the better and more dedicated teachers in the smaller, private, student-oriented liberal arts colleges.

So far as scholarship goes, and the synthesizing of various domains of knowledge, which has become so imperative in our vast and proliferating field, it is well-known (and it has recently been statistically documented) that most reasonably competent psychologists even in academic settings do not have time (or at least must not think they have time, because they don't allow themselves time) to read the periodical literature; the main reason being that everybody is too busy writing articles to bother to see what somebody else has written. The statistics indicate that this tendency is so pronounced that one can best characterize the situation as comic.

It is simply not true that, because a person is not a productive research investigator, either by talent or by inclination, he is necessarily unscientific, unscholarly, intellectually dead, or just dumb. When I think about the clinical practitioner as an ideal type, my thoughts go first of all to my own personal physician. This man, with whom I have been well acquainted for a quarter of a century, has one of the ablest intellects—and by "intellect" I mean sheer, abstract conceptual intelligence—that I have ever had the privilege of knowing. He took an undergraduate major in psychology, and was in great conflict when within a week's time he received notice of his

admission to a medical school and the offer of a teaching assistantship in the psychology department to work for a Ph.D. degree. His decision, for which I am grateful, was to become a physician. He is a man of wide interests, varied reading, and high intellectual passion. He is a brilliant diagnostician and has a solid reputation as one of the ablest internists in Minnesota. He is deeply dedicated to his work as a physician and as a teacher of young physicians. So far as I am aware, he has published very little since he went into medical practice, and the few articles that he has written are of an essentially "clinical" nature. I have never been able to detect in this man, whom I know socially as well as in his capacity as my physician, the slightest sign of guilt about the notion that he ought to be turning out research papers and that since he isn't there must be something the matter with him.

I consider that it would be hygienic for the majority of present-day practitioners in clinical psychology, not to mention some of the able clinical teachers and supervisors connected with universities, to adopt this rational attitude and to recognize that yardage is not a criterion of much of anything. My point is that this physician is extremely bright, unusually scholarly, and keeps up on the best current literature in medicine. You can be confident when you put yourself in his hands that he will be thinking about you with all of the brain power and passion that Sherlock Holmes used on a murder case, or Justice Frankfurter used on an antitrust case, *or that an experimental psychologist uses to think about an exciting study which he has just conceived of doing.* The order of conceptual intelligence, intellectual integrity, and scholarly knowledge that goes into thinking about a patient, whether in internal medicine or in clinical psychology, can be as great or as small as the abilities and attitudes of the practitioner make it.

I think that almost nothing exerts such a malignant influence upon the current state of the discussion about professional training in clinical psychology as the polarization of the words "scientific" or "scholarly" as against "clinical" or "practitioner." That is just not the right way to slice the pie, and it is an invidious use of language to talk that way. The distinction is between *clinical practitioner* and *research investigator* or *nonclinical teacher.* The defining property is how you spend most of your time, in what context, with what social aims; i.e., whether primarily to advance general knowledge by publication and by classroom instruction or primarily to provide service to the client or patient and clinical supervision in the field setting. There is no justification for linking these differences in aim, context, and daily activity with the honorific dimension of "scholarliness" or any of its correlates (e.g., brains). Every psychologist can think of several people of his personal acquaintance who for one or another reason have elected to spend the larger part of their time in service to patients but unquestionably possess those qualities of mind that would enable them, if so motivated, to perform very adequately as college teachers or investigators.

It is important to make a distinction, in talking about scholarship, between two relationships that one may have toward the research function. The phrase "research oriented" is commonly used, and is misleading because to be oriented toward research, in the sense of genuinely believing in it and favoring it and being receptive to its results and keeping up on the research literature, is different from being motivated or skilled in producing it. Thinking again of my own physician, what is it that I want of him when I go to him as a patient and put myself in his hands? I want him to be interested in what is going on in medical research, and to be bright and critical so that he will not be taken in by the claims of a bad research paper, so that he will provide me as his patient with the best available treatment according to the most recent developments in medical knowledge. If he never read anything but the drug ads in the journals of the American

Medical Association, I would be nervous about trusting myself and my loved ones to his ministrations. In other words, I want my physician to be competent and motivated as a *research consumer.*

Why do we talk generically about "research orientation" as if there were no difference between being a research consumer and a research producer? We should think instead in terms of job analysis, and recognize that the concrete activities of research production and of research consumption are quite different in many ways, although admittedly they do overlap in that they both require some elementary knowledge of experimental design. Isn't it strange to assume, without even discussing the issue, that the best way to train a person to be a good research consumer is to put him through the paces of being a research producer? What evidence is there that this is true? Or, lacking such research, what reasons can be given from theoretical considerations, especially in the light of the vast body of data we have accumulated over the past 50 years concerning transfer of training, that it is probably true? Learning theory does not even make it plausible. Anecdotally, I suspect most of us who do some private practice in academic settings would ruefully admit that our patients are sometimes unknowingly disadvantaged on days when we are momentarily "revved up" about some research and would really prefer to have canceled all our appointments for a week or two! When I visit my physician, I want him to be interested idiographically in *me* and not preoccupied with a research project on some disease from which I don't happen to be suffering.

Here's another place where the ceramics fallacy interferes with clear thinking. Professors say, "Well, it doesn't hurt a fellow any to do a Ph.D. thesis, and he might learn a little bit about research in the process, ha-ha." I daresay it doesn't hurt him much. Although I might point out that for some students, hell-bent for clinical activity, the burden of the usual doctoral dissertation (especially at the time when they are really getting deeply immersed in working with patients and find the thesis an unpleasant distraction) seems to make them so irritated that they react with the attitude: "Once I get this damn union card out of the way, I'll never do a piece of research again as long as I live." And I remind you that the statistics on research productivity are very consistent with this interpretation.

We know that, in general, it is inefficient to rely primarily upon remote transfer effects in teaching an organism to do a certain kind of task, and that instead one should train the organism in the activity that it is subsequently to perform. Therefore, if my aim is to teach clinical practitioners to read the test manuals, books, and clinical research articles with a critical eye for what they really show in relation to clinical practice, the obvious way to train for these research-consuming behaviors is to have a *research-consuming course,* followed by a continuous literature seminar (taught by clinicians) in which precisely that research-consuming activity is engaged in. The notion that requiring a student to spend hundreds of hours on a research dissertation that selects one aspect of behavior, necessarily employs only one kind of statistical design, and addresses itself to only one restricted set of statistical and experimental problems will have, through generalization, a marked influence upon his subsequent research-consuming ability over the diverse domains that are relevant to clinical practice is pretty absurd in the light of our knowledge of the learning process. I am confident that a bright student who sat through the six credits of differential psychology in which Donald G. Paterson spent 80 percent of his lecture time critically examining studies that allegedly proved something that they didn't actually prove, taking each study apart bit by bit and bone by bone and reiterating—until it became almost boring at times—the same old methodological errors such as criterion contamination,

correlated errors, selective migration, failure to control certain demographic variables, confusion between statistical significance and practical importance, partialing out too much, failure to cross-validate, etc., was put through a regimen that he will never forget. This course was far more effective in leading me to be a critical, perceptive research consumer than going through the medieval ritual of writing a Ph.D. thesis on some narrow topic. I find it hard to imagine that any informed psychologist should disagree with me on this.

My suggestion is that a special course be created, perhaps even entitled "research evaluation," which would combine a presentation of the major problems in clinical research with primary emphasis on how to spot defective designs and fallacious inferences, and in which the general principles, labeled with value-loaded names for easy recall, would be illustrated by a variety of concrete examples from the research literature. I would confidently bet a thousand dollars of my own hard-earned money that if I were put in charge of such a course, I could turn out research consumers who would be significantly superior *in this function* to those who are turned out by the usual method of the Ph.D. dissertation.

Turning to the specifics of the curriculum, what I have to say expresses my own predilections, but I have found that the course content I am about to list meets with a remarkably good consensus when presented to such heterogeneous psychologists as are members of the American Psychological Association's Committee on Professional and Scientific Aims.

The basic sciences in the major field would include courses in learning theory, developmental psychology, social psychology, differential psychology, statistics, psychometric theory, personality, motivation, psychoanalytic theory, perception, and physiological psychology. I want to emphasize that *the Ps.D. trainees would be competing right along with the usual Ph.D. students in the same classes as taught by the same lecturers.* Didactic, preclinical courses in the major field would include a year-one course in assessment, a year-two course in therapeutic intervention (to be continued in year three), courses in structured tests and in projective methods, a course in marriage counseling, one in group psychotherapy, and a preclinical practicum.

Outside of the major I would want to see constructed a new course in survey of medicine (including some elementary physiology). Among courses at present available, I would specify clinical neurology, clinical psychiatry, psychosomatics, medical genetics, criminology, family sociology, and a readings course in psychiatry (including some "classics" for historical perspective).

In-service clinical courses would then include the usual case conference, a literature conference emphasizing the research-consumption function (years three to four), individual diagnostic supervision, individual psychotherapy supervision, a continuous case seminar such as is conducted in psychoanalytic institutes, and regular attendance at medical, neurological, and psychiatric rounds. To provide a model for thinking about the "good criterion," I would include some attendance at the clinicopathological conference in internal medicine, which forces clinicians to match wits against a virtually infallible criterion, the pathologist's report.

Even though I have striven manfully to avoid commission of the tempting ceramics fallacy (and there are perhaps a few instances in which I have been seduced by it), I recognize that this list represents a sizable mass of academic requirements, both preclinical and basic science. How does this bear upon the critical time factor? The first thing to get through one's head and to accept without any shilly-shallying or reservations is the idea that *this is a professional training curriculum, which means that it is a tough grind.* Faculty, students, parents, and the university administrators must be brought to recognize that getting trained to be a practitioner of clinical

psychology requires brains and guts and discipline and time and money, as is currently taken for granted in medicine, law, or engineering; that this is not a tea party or a psychotherapeutic regime; that students will feel anxious and under stress and overburdened, which is the normal state of mind for somebody seriously training for a profession; and that the dilettantes and incompetents will fall by the wayside. (As my colleague Kenneth MacCorquodale says, "We are not running a spa, we are running a graduate school.") It is amazing to find that sometimes the very same psychologists who object to a Ps.D. on the grounds that it will become a second-rate degree, taken only by beatniks or dumb bunnies, later on in the same discussion, when I begin to spin out my fantasied curriculum, object to it on the grounds that it is too hard! I am willing to answer either of these arguments on its merits, but I won't allow the critic to have it both ways.

Most people who have taken courses in such subjects as medicine, zoology, physics, chemistry, mathematics, or statistics have found them to be more taxing than most courses in the social sciences. I do not feel that I have a special intellectual deficit for studying the hard sciences. Nevertheless, I was always sure as a student that those academic quarters in which all of my classes were in the psychology or sociology departments were the ones in which I could get As and still spend a good deal of time drinking beer in the Bridge Cafe. I remind you that a medical student is required to take 18 to 20 credits per quarter of difficult courses in his freshman year in medical school. I have verified with the assistant dean of the law school at Minnesota that a freshman law student who is content to squeak by with the minimum passing grades will have to read at least 5,000 pages in his freshman year; and I can tell you, since I have been attending law school classes of late, that this material is extremely taxing, both to the abstract intelligence and to the memory. It distresses me when some of our clinical psychology students come in and complain that the curriculum is "too hard," their evidence being that it makes them feel anxious and work-burdened. Whoever said that a student in a professional curriculum is supposed to be relaxed? For law students, medical students, or engineering students, a good deal of realistic anxiety is par for the course.

Since I believe that our subject matter is conceptually easier than that of law or medicine, and since the published distributions of Miller Analogies Test scores show that Ph.D. candidates in psychology are considerably above law students or medical students in intelligence, I argue that we should operate on the assumption that *we can put up to 20 credits per quarter into the preclinical year.* This means that by the start of the second year, the trainee would be taking very few didactic credits per quarter (all distinctly clinical in content) and would be finished with *all* didactic courses by the start of the third year. Actually, there is no compelling reason to push it quite this hard, since a few of the didactic courses I have included are really quite "clinical" in nature, such as the second- and third-year lecture courses in psychotherapy. Years three and four are then totally free of any formal, didactic, "academic" requirements involving lecture attendance, assigned reading, and studying for examinations. All "classes" in years three and four are seminar-style courses of a kind directly related to the student's current clinical work, such as continuous-case seminar, current clinical literature seminar, case conference, and the like.

Such a situation would greatly simplify the logistics of externship and internship, and would permit the kind of practicum experience we want and need. There simply is no way to provide a clinical psychology trainee in four years (or, as it stands now, even five years) with a combination of adequately diversified clinical experience—i.e., diversified in clientele, institutional setting, and range of orientation of the supervisors-while maintaining adequate experience in depth, particularly with regard to the practice of intensive psychotherapy. There will always be

some logistic problems here, of course, but one of the worst sources of sabotage with which we have to contend at present is the way our candidates disappear periodically into the woodwork because they have to study for their prelims, or because they want to spend all of their time doing their doctoral dissertation instead of working with the patients. It is an open secret that one of the major complaints of psychiatrists against clinical psychologists is their relatively lower degree of feeling of professional responsibility, and this unprofessional attitude is certainly fostered by the primacy given to academic and research activities during the formative period of the professional training process.

I shall not raise here, partly because of space limitations and partly because I have no strong view on the matter myself, some of the generally agitated questions concerning the practicum and internship experience, such as: What proportion should be on an inpatient or outpatient basis? How much of it should be in a psychiatric setting? Is it desirable for at least part of the experience to be secured in a clinic where the "psychologist is king"? These are very interesting and important questions in their own right, but it does not appear to me that they are critical for evaluating the pros and cons of an alternative doctorate.

It must be obvious to you from what I have said that I am operating throughout on the simple, straightforward pedagogical principle that if you want a training program for turning out professionals who will do a certain sort of useful work, you pick the courses and the practicum experiences in the light of the learning-theory rule that the way an organism learns to do things is by doing those things and getting reinforced therefor.

SOME SUBSTANTIAL DIFFICULTIES

I come now to the objections that seem to be most serious, and that inhibit me from advocating the Ps.D. degree with unqualified enthusiasm. The most weighty objection, in my opinion, is that it seems unwise to institute such major social change as this involves to create a professional the precise character of whose daily clinical activities is not foreseeable. This is the "training-for-obsolescence" argument, and we should frankly admit that there is something to it. While a good deal of uninspired and third-rate clinical practice going on today is in the doldrums, and some practitioners seem impossible to shake out of their dogmatic slumbers, the more enlightened elements—both in the field and in the academic teaching of clinical subjects—are conscious that ideology and practice are in a state of flux. We are training people to do something that is at least reasonably similar to what most clinical psychologists spend their time doing today, although we know that there is a probability, by no means negligible, that persons so trained will not be mainly required to perform these same functions in the prime of their professional lives.

At times this objection seems to me so strong as to countervail my desire to do something about the current program, with which I am only moderately dissatisfied. Since I look upon it as a good argument I am not going to try to rebut it. I might, however, try to soften the blow a little by re-emphasizing that these Ps.D. psychologists will have studied more undergraduate psychology on the average (since they will all have had psychology majors) and as much graduate psychology of the basic science type on the average as will current Ph.D. candidates. They will therefore qualify as "general psychologists" in terms of their mental furniture, and in terms of their ability to absorb or evaluate new ideas and techniques.

Here, again, the analogy can be to medicine. When we train a physician we take it for granted that, when he reaches the prime of his professional life 20 to 30 years after graduating from

medical school, many notions and techniques he studied in school will have become outmoded, and that some completely novel theories and healing procedures will have replaced them. The situation in psychology is not qualitatively different from what it is in the other applied disciplines, but I must admit in all honesty that from the quantitative point of view it seems to me at present that the amount of change in clinical psychology is likely to be greater than that in other areas; therefore, I record this argument as one that must be given considerable weight in opposition to the proposal for an alternative doctorate. Example: How much emphasis should be placed upon the new developments in behavior modification, at the expense of deepening the exposure to more traditional interpretive psychotherapy? I don't know, and neither does anybody else. But I would argue that it is unwise for us to turn out clinical psychologists who are so ignorant of Skinner that they will be unable to think about the clinical merits of therapeutic intervention based on operant conditioning principles.

The next major objection is not a substantive one but deals rather with social perceptions of the degree. The existence of academic psychologists who advocate this degree for what I have called unsanitary reasons, and their numerical preponderance in power positions all over the country, makes it unfortunately rather probable, if not certain, that some graduate departments of psychology would (if the American Psychological Association gave the green light) institute such a training program with the covert intention of using it as a kind of booby prize or consolation prize, regardless of their commitment to high standards on paper. No amount of official resolutions or pious hopes can counteract the subtle eroding effect upon student morale, not to say clinical faculty morale, which occurs in a department dominated by a group of academikers who basically distrust and despise applied psychology generically and the clinical tradition in particular. If clinical faculty members and clinical students get the feeling that everybody wants to spit on them when they pass in the hall, nobody would want to enter such a program.

If you ask me how I propose to prevent this from happening, I must tell you that I do not have an answer. I know that it would not happen at Minnesota because it has not happened here with the traditional Ph.D. degree, and the same reasons would continue to be operative. I do have a list of self-diagnostic questions that I myself would put to a department chairman before I would approve him or his department to give this professional degree. Among these are the following: Will I feel the program is a success even if none of the Ps.D. products ever does any publishable research? Would I hire a seasoned practitioner with a reputation as a brilliant psychotherapist who had never published any articles? Am I eager to obtain the services as lecturers, supervisors, case-seminar leaders, etc., of local practitioners by giving them academic rank in my department? Am I free of a tendency to deflect bright students away from the Ps.D. program, because of a feeling that brains are largely "wasted" in a clinical practitioner? Am I willing to adopt a policy of hiring and promoting faculty who teach "clinical" courses that will give heavy weight to such factors as A.B.E.P.P. status, personal experience of therapy, amount of clinical experience, quality and amount of supervision, and the like? Am I prepared to insist that faculty who teach clinical courses must maintain some contact with clinical material other than via research, i.e., must continue to see patients in a professional capacity? Do I accept the fact, long recognized by medical schools, that to attract and hold really topflight clinicians in an academic post, I must either pay very high salaries or permit them to engage in a moderate amount of private practice? Am I free of a tendency to deride or denigrate service-orientation, clinical skills, or the "clinical attitude" in my lectures, seminars, or casual conversation? Am I willing to see clinical faculty members among the power elite in my department? Do I earnestly

desire to establish the relationships with departments of psychiatry, social work, education, child development, etc., that may be necessary in my particular institution to provide proper breadth in the Ps.D.'s perspective and professional skills? Am I willing to make some perhaps inconvenient arrangements in the curriculum or in the class schedule or in teaching assignments because of the special logistic needs as regards time and the sequential arrangement of the large mass of densely packed preclinical credits in such a program?

I could extend this list, but I trust you get the general idea. Any department chairman, or group constituting the power elite of a given department, who could not wholeheartedly answer most of these questions in what I score as the "right way," I would say is unsuited to undertake such an alternative degree. This is the way I would arrange things if I were dictator of the universe. I am not dictator of the universe, however; and I do not have any adequate system of social controls to propose for screening departments as we screen candidates. It is, I fear, doubtful whether as many as half a dozen department chairmen in the U.S. could pass these tests. It is even more doubtful that the American Psychological Association is prepared to impose any such criteria.

A tentative step toward social control, and one that fortunately can be applied early in the game in connection with the accreditation of a particular department (rather than having to wait for malignant attitudes to show up after the program has already got rolling and students are engaged in it), is the matter of *curriculum control by an outside accrediting agency.* One of the essential differences between training aimed at the production of professional practitioners and the traditional Ph.D. teaching and research program is that, when we begin discussing training for professional practice, the usual arguments of departmental autonomy and the sacred status of the individual graduate advisor, and part of the cluster of ideas connected with academic freedom, do not apply. I view this as the first clear occasion when a department has the opportunity to show whether it sincerely means what it says and is prepared to deliver the goods on professional training or not. And I want to emphasize that I apply this to the Minnesota department and to myself as an individual with the same stringency with which I would apply it to any other department. If somebody wanted to say that a six-credit course in sociodrama was part of the absolutely necessary core of any adequate training program in clinical psychology, I would fight them by every legitimate means at my disposal because I think such a notion is crazy. But if I lost the fight—meaning that if the national committee, or board, or whatever, that had been set up to specify the curricular requirements for the Ps.D. degree saw fit to include a six-credit course in sociodrama as part of the core requirements—I would accept that decision until such time as I might again attempt to persuade them of their mistake; and if I were a department chairman I would feel obliged to go all out to get a topflight sociodrama expert on my faculty to teach the course. *If you don't think that way as an administrator, then you do not believe in genuine professional training.* I rather suspect, in fact I think I would be willing to lay money on it, that this kind of test would separate the men from the boys in a hurry.

Suppose that a department chairman advances the argument, which I frequently come across these days, that preclinical courses such as abnormal psychology or psychodynamics are not really analogous to allegedly comparable preclinical courses in law or medicine. That may be. But the basis on which he argues is usually that *he does not believe that there is any valid knowledge in these areas.* Now I am not interested (in the present context) in debating with a psychonome the question whether this is the case or not. What I am prepared to say is that *if* a department chairman and the power elite of a department are convinced that there is no

appreciable amount of valid knowledge in such courses as abnormal psychology, then it is likely that their department is inappropriate in its atmosphere for offering the alternative degree. It seems to me that that should settle the question on grounds of social dynamics alone.

A third objection concerns the job-getting powers of the products of such a training program, particularly in the first few years after its inception. At times this seems to me a very serious problem; at other times it doesn't bother me at all. I suspect that a bright, well-motivated, personable Ps.D. in clinical psychology from the University of Minnesota would not have to worry about having to sell shoes for a living, but I can't prove it. It would certainly be imperative to explain to students contemplating the program that we have no accurate means of forecasting whether they will be welcomed with open arms and that they are therefore taking a personal economic chance. I presuppose, of course, that no such program would be started by a school unless it had at least a minimum permissive blessing from the American Psychological Association, but, unless I am mistaken, the Board of Directors can be persuaded to give such a blessing, however grudgingly.

A particular aspect of the employment problem which distresses me is that I would hope that in the long run some of these Ps.D.s would become university teachers. Some of you may think I am contradicting myself, but that is not so in the least. The men who teach in the clinical departments of schools of medicine are qualified physicians, and most of them continue to engage in both public and private practice. My suspicion is that community agencies and the general public would accept the Ps.D. practitioner much more readily than would the institutions of higher learning. This leads me to add to my list of criteria for a properly oriented department chairman, "In addition to training these Ps.D.s, would you be eager to hire a couple of them for your own training program and to give them a major amount of power and status on your clinical teaching faculty?" Anyone who answers "No" to this question I would cross off my list as a potential administrator of such a program. If a Ps.D.-trained person is not good enough to be on one's faculty and to teach others to do clinical work, then the degree must not be very good in such an administrator's eyes.

Perhaps I have some blind spots, but I am not aware of many really serious difficulties that arise in connection with formal course curriculum. There is one problem here to which my attention has been called by my colleague Wallace Russell, who does not favor the Ps.D. proposal, and to which I must confess I have no satisfying answer. Russell points out that while the idea of research consumption, as distinguished from research production, is a useful *concept*, when you get to thinking about it in detail, it becomes a bit sticky. The nature of current research methods is such that it is becoming increasingly difficult to read the published literature even in the "applied" fields of psychology on the basis of rudimentary or half-baked knowledge of modern statistical techniques and experimental design. If we could trust all of the journal editors this would not present a problem, but, as everyone knows, we cannot quite do so. Russell argues that in order to train a clinical practitioner to the level of statistical sophistication that would permit him to be a really skillful research consumer, one who would not be sold a bill of goods about a new test or a new therapeutic technique because of the presence of a subtle defect in design or interpretation in an article, we would have to give him a good deal more training in statistical techniques and in the mathematical underpinning and design of experiments than is contemplated in my kind of curriculum.

I am afraid there is more truth to this argument than I like to admit, and again, I do not have an answer. It might mean that so far as research goes, even on the purely consuming side, we

would have to extend and deepen the training and continue it further along into the clinical years, a notion that is already partly included in my proposal to have a critical literature seminar which would run alongside such courses as the continuous-case seminar through the third and fourth years. One might approach this problem, as installations of the Veterans Administration currently approach it, by making use of many consultants who belong to the mixed breed of clinical practitioners and research producers as participants in the continuous literature seminar. If this does not suffice, I cannot suggest anything except to put in more statistics and design of experiments, which will unavoidably mean that a somewhat larger amount of the student's time in, say, the second year of his graduate work will have to be devoted to this subject matter. I don't like this much, but it would still be a great advance upon the present situation.

A final objection—not substantive, but very important in terms of social process—is that the creation of such a degree might mobilize a good deal of anxiety and hostility from psychiatrists. Many psychiatrists can remain at least moderately comfortable with clinical psychologists who are doing a very great deal of psychotherapy, and making many essentially psychiatric judgments diagnostically, because the psychiatrist keeps reminding himself (and the clinical psychologist keeps telling him) that the *main* function of the clinical psychologist is to contribute a scientific, quantitative, experimental orientation, and to be a research producer. The Ps.D. psychologist will be able to contribute to team function along scientific lines, but he will not (typically) be adequately trained as a research investigator. This means that his professional role is more clearly defined as that of a practitioner, as a "working doctor," and therefore he might constitute a greater professional threat to the psychiatrist. After all, if a psychiatrist asks us why he should hire one of these people rather than the traditional Ph.D. product, if we give him an honest answer we will say, in effect, that he should hire the person partly because he has been more specifically trained to make like the psychiatrist! This interprofessional aspect is critical, because the role of the psychiatric department in such a training program is more important than in the case of a Ph.D. I might say that for any psychology department to be acceptable for this training function I personally would require it to demonstrate that it really has, again not merely on paper, a good working relationship with its medical school, and that the members of the psychiatry staff are genuinely committed to the training of clinical psychologists as psychodiagnosticians and psychotherapists.

Another valid objection is that second-rate departments of psychology may latch onto this new degree as a gimmick to attract students, if first-rate departments refuse to go along with it in sufficient numbers to meet the application rates. This would result in the Ps.D.'s acquiring a reputation for mediocrity, in this case by being from a low-status school rather than being low-status *within* a school, as is more likely in first-rate (but psychonomically oriented) departments. Here again the solution, if there is one, lies in adequate social control by the American Psychological Association (and, indirectly, by the American Board of Examiners in Professional Psychology).

Whatever the objective situation, there remains the danger that the Ps.D. trainee will *feel* that he is in a second-rate program. I make no secret of the fact that one reason (not, of course, the main reason) for a backbreaking, brain-busting, 20-credit-per-quarter basic science curriculum in year one is to minimize any such tendency. But there are additional features I would include in the training to enhance the prestige of Ps.D. students. Given the dominant value orientation of those who select themselves for such training, everything possible should be done to define the program as unique and special, as the "truly *clinical* program," the only path to fully professional

responsibility for work with real-life, flesh-and-blood patients and their problems.

I would employ all honest devices and symbolic trappings that might contribute to developing the kind of mystique concerning special opportunities and experiences generating practical know-how rarely found among traditional academic students. I have in mind the *esprit de corps* found among such otherwise different groups as engineers and psychoanalysts, who share the self-image of "We are the only ones who really know what it's all about." Provision of special courses and case seminars rigidly closed to other students and taught by topflight practitioners is the sort of thing I mean. Personally, I favor including a mandatory experience of fairly intensive personal psychotherapy, but if that is too controversial, I would minimally insist upon the training grant's making such experience easily available at reduced rates but with high-prestige local therapists.

You may think it is going too far, but I would even favor introducing some simple physical symbols of the Ps.D. trainee status, such as a characteristically colored jacket which changes color or gets a letter "Psi" embroidered on it after the degree is granted. As psychologists, we should not laugh off such symbols; they are very important aspects of social reality, like the engineer's slide rule, and the medical clerk's white jacket which is replaced by a long staff coat later in his career. I would encourage extracurricular group-definers, such as a professional fraternity, preferably owning a house, with membership restricted to Ps.D. trainees. The clinical faculty would, hopefully, show a special eagerness to meet informally with such groups to discuss professional problems.

I simply do not accept the idea that nothing but research and theorizing is valued by our clinical students, and I maintain that this is clearly not true even within our present Ph.D. program, even though the curriculum is so academic and the faculty prestige-figures largely of this type. I submit that genuine clinical values and experience hungers are already much in evidence among our clinical trainees. Every year, lecturing in the beginning clinical psychology class, I have noted that when we reach the first lecture on a practical clinical topic, where I introduce some diagnostic signs from my experience which the students have not come across in textbooks or abnormal psychology lectures, there occurs a striking mobilization of interest that keeps me after class answering eager questions. And they aren't asking about the analysis of covariance—they want to hear more of this fascinating stuff about how patients look and act and talk. The phenomenon is quite unmistakable, and sometimes a student will even verbalize it, saying "*This* is what I've been waiting to learn about." Why don't we college professors trust these motivations? I say that we are not adequately using, let alone meeting, these clinical needs at present; and I am confident that morale and group cohesiveness would receive a tremendous boost under a regime that seriously undertook to meet them. If faculty attitudes are appropriate and the program is handled properly, I predict that the Ps.D. candidates will not feel like second-class citizens, but—given *their* dominant values—will feel like an elite corps.

These are the main objections that I conceive to have appreciable validity. Lacking satisfactory answers to them, I must assess their aggregate negative force as pretty sizable. But I also view the present situation as barely tolerable. On balance, I am inclined to favor trying the alternative doctorate.

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