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ASPECTS OF THE SOCIOLOGY OF PSYCHIATRY

by

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Tell me, said Socrates to the psychiatrist, about your problems. What are you psychiatrists attempting to do, and how well are you doing it?

This is the kind of question, unceremonious philosopher, that I prefer to ask others. But I too, recognize the authority of logic, when I cannot escape it, and I admit that I cannot in all decency evade a question I continually pose to others. I am already afraid, as you must perceive, that the inquiry will prove no easier for me than for my patients, especially since we psychiatrists form a diversified fellowship, and I can hardly claim to represent the entire guild.

Your tact would appear becoming a politician, Socrates remarked in an amiable tone, but your teachings have already shown me how to spot a rationalization when I see it. Say what you can; your errors will implicate no one but yourself.

A comforting thought, rejoined the psychiatrist. How skillfully you allay my anxiety.

No compliments are necessary. Just answer the question.

(Kovitz, 1969)

There can be little doubt that for the social scientist interested in the case of psychiatry there is much to learn. Not only is psychiatry a specialty in medicine, with a variety of subspecialties, is also enjoys links to other professions such as clinical psychology, psychiatric nursing and psychiatric social work. While in some sense this provides psychiatry the opportunity to be the renaissance man in medicine -- a situation which might elicit envy from others less universal and catholic -- it also causes it great difficulties and troubles. Noone seems to know where psychiatry begins and ends; it suffers sizable difficulties in setting its own boundaries, delineate areas of knowledge and skill where it and it alone reigns supreme, and because its boundaries appear vague, at least to outsiders, it is vulnerable to attack and to raids by not always benign neighbors.

Thus we come upon a professional group subject to heaping criticism. Its detractors within medicine accuse much of it as wedded to "soft" science which to some is tantamount to magic, while others, in particular mental health law

people accuse it of cruelty, of depriving patients of their human and constitutional rights. Judges accuse it of opportunism when opposing sides in criminal proceedings present their expert who supposedly speaks in the name of objective science, and lawyers write articles and studies, one of the best known seeming like an attack on the face of it. It is entitled "Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom." (Ennis and Litwack, 1974).

But psychiatry also has its heroes. Despite the fact that Sigmund Freud has been derided from the day he published his first work to the present day when medical students "hiss" at the mention of his name (or at least some of them) a world without his language and his often uncredited influence on the thought processes of all of us is beyond imagination. Karl Menninger's books have sold millions of copies and so have those of Erich Fromm and Rollo May. Their names and those of others have indeed become household words in the lives of educated people everywhere. Beyond that, hundreds of thousands of patients regularly fill the clinics and private offices of psychiatrists. It would appear that the more the attacks on the specialty the more patients visit psychiatrists to get well, or just better, or to have someone to talk to whom they can trust. Psychiatry is like America in general: whatever one might say about it is true; and that because just like our country it is peopled by persons answering to all the varieties of descriptions, praises, honors and condemnations leveled for and against it by both friends and detractors. The United States, too, is a confused and confusing country and yet it has cohesion, identity, character and central attributes. So it would appear in the case of psychiatry.

Psychiatry is a specialty in medicine; it is not a profession itself. It thus receives from as well as contributes to medicine (Menninger, 1936). In this simple observation are buried many problems. If it is true that psychiatry is in fact medicine, it would then have to show its medical characteristics convincingly, for not just any group can make the claim of belonging. The standard way of presenting a professional claim is, of course, education and practice. Since psychiatrists are graduates of medical schools that part would seem beyond challenge. However, there are medical doctors who doubt that at least in part psychiatric practice can be said to be medical. As one might expect such charges cause both consternation and the wish to correct such misunderstanding, at least as some practitioners would perceive it.

I hasten to point out that it is not for the sociologist of medicine to say who is right and wrong in that debate; for him/her it is to present the evidence and the various aspects of the issues and problems in psychiatry in the hope that as issues become clarified, others might do whatever they wish to do with them. The aim is to shed light, rather than to praise or condemn.

One might nevertheless ask why the outsider sociologist should be concerned at all with psychiatry? The answer is quite simple: psychiatry just as all other professions, and especially those dealing directly with the lives of people, is a social force of great consequence. It is far more than a collection of disconnected people, each practicing by himself/herself without much consequence for the public good. Quite the contrary: it is an organized way of social control, of taking a hand in society, of explanations about crucial aspects of the human condition. Psychiatry, after all deals with learning, with thinking, with feelings, with important aspects of brain functions,

in sum with behavior and with motivation, with conflict in human affairs and increasingly with human development in the service or prevention of mental illness. That makes it a powerful social force, a force of great relevance to the social body. It is for that reason that sociologists and other social scientist observe it, try to understand more about it, and are ever fascinated by it. Perhaps I may be permitted a personal observation in this connection. It would be that while one may understand the defensiveness of people under observation or even under attack, one can easily document from the literature, that much of the attack against psychiatry stems less from what individual psychiatrists do or do not do, but rather that compared to the amount of human suffering existing in this world all of us know so little. The knowledge we possess, in comparison to what is asked of us, stemming in turn from people's demands for even a better and more satisfying life, is so small. Medical doctors and social scientists know so much more than they did only fifty years ago, yet the demand by far outruns the supply.

I shall in this paper examine three aspects of psychiatry. To elaborate on some of the recent historical developments in American psychiatry, I shall do a limited review of the literature of psychiatry in relation to the boundary and substance problems I have already touched upon. Much of this will show how gradually the preponderance of the psychoanalytically oriented writers has shifted to a more even balance with those who call for a "return" of psychiatry to the model of physical medicine.

Next I shall speak of psychiatry from the standpoint of "What is a Profession?" This will enable me to consider some of the newer and more recent approaches to the sociology of the professions with special emphasis on psychiatry.

Finally, I will highlight some of the major "schools" of psychiatry. Rather than offer detailed explanation of each such school I shall approach the problem from an epistemological, i.e. philosophy of science point of view. What shall concern us here is how various schools of psychiatry think and what kinds of logic informs their theories and their practice.

1. Review of Literature

A complete literature review on the state of contemporary psychiatry is impractical because of the voluminous writing on the subject, as well as unnecessary in light of the repetitiveness of much of what has been written. Besides a certain amount is purely partisan and does not qualify for inclusion in scientific discourse.

Quite helpful for the sociologist of medicine is the way in which psychiatrists have looked at their own profession -- and in print. We are thereby helped to obtain a rather graphic picture of how the specialty's members do what psychiatry indeed helps patients do, i.e. look at themselves. Thus, on page one of volume one of the Bulletin of the Menninger Clinic (1936) Karl Menninger, its founder, offers an article entitled "Psychiatry and Medicine," a simple enough statement of his position at the time. Whatever is wrong with the patient that he brings to his psychiatrist, says Menninger, is to be considered illness; therefore, a physician is needed to treat it; and the physi-

cian who treats it is a psychiatrist, just as much physician as all other medical doctors (Menninger, 1936). Less than a year later in a Freud birthday number of the same journal one reads that:

Psychoanalysis in the United States has always identified itself with medicine and the medical profession and, having been itself strengthened by medical tolerance and recognition, is now in a sufficiently well entrenched position to contribute new concepts and techniques to medical science at large.

(Bulletin of the Menninger Clinic, 1936-37)

By 1940 we find that Karl Menninger seeks a link between psychiatry to psychology. He makes the point that in its academics psychoanalysis is a part of psychology whereas in its application it is part of medicine (Menninger 1940). But two years later, in 1942, the reader could be entertained to a definition of psychiatry prophetic in its suggestiveness for both its joys and its troubles of the future. Writes Alan Gregg:

I could not be satisfied with the definition of psychiatry as that specialty of medicine which deals with mental disorders. Like a bad newspaper headline, such a definition confines while condensing and misrepresents by oversimplifying. Psychiatry deals also with the disturbed emotional and social life of man, not merely his reasoning and mental operations. Insofar as experience has shown you that emotional thinking is different from logical reasoning, you see why mental is an inadequate word. Indeed, the province of psychiatry is the disturbances in the conduct of man, his experiences and his way of experiencing, his reactions, his behavior as an indivisible sentient being with other such beings. Until recently medical attention has been given only to grossly disordered conduct -- to persons locked in asylums -- but now the field is far more inclusive because it spreads into the anxieties, the fatigues, the instabilities, the maladjustments, the disturbances of normal everyday living, and also because it includes the effects of mental and emotional functions upon the component organs of the body as well as the effects of disordered organs upon the function of the human being as a whole. The psychiatrist, then, studies emotions as well as mental processes, and over the whole vast range from optimum health to incurable disease.

The very breadth of that definition would suggest to the reader nearly forty years later that the issues that concern the specialty currently existed when modern psychiatry was half its current age. Henri Ellenberger in 1955 brings a European and far more limited view of the same subject of which Gregg

spoke earlier. First, Ellenberger points out that in Europe the emphasis is on symptoms, in the United States on problems. In Europe the physician matches symptoms with precise diagnosis and with the logically following intervention. Secondly, Ellenberger advises his colleagues at home -- home being Switzerland -- to bring clinical psychologists and psychiatric social workers on the scene as soon as possible for what they can offer. In other words, Ellenberger who saw American psychiatry firsthand envisioned a much more restricted role for psychiatrists than Gregg.

Ilza Veith, that fine historian of medicine reminded her readers in "The Infancy of Psychiatry" that the issue of service delivery by psychiatry or as we now say, the problem of access, existed in ancient Rome. That issue was of great importance in 1964 when Veith wrote because in that year the Community Mental Health Center movement began to develop as a result of congressional legislation the year before. Says Veith:

Clearly, in ancient Rome, only those of sufficient means could afford to keep the many servants which were required in this regimen. Only the wealthy could afford the soft bedding and the choice of a sick room that was best suited for their condition, not to mention the costly diversions, extending even to ocean voyages.

(Veith, 1964)

The hints of the impending storm surrounding psychiatry were plentiful from the 1930's on. It was Lawrence Kubie a generation later who in 1966 in "A Look into the Future of Psychiatry" broke wide open the smoldering issues of overextension in psychiatry. This is the same Kubie who suggested in 1954 that the existing mental health professions should be abolished, including psychiatry, and be combined and re-formed into a single mental health profession (Kubie, 1954). But in the paper under review he condemns what he considered to be the excessive claims for psychiatry but also the excessive attacks upon it. He condemns both "organophobic" and "psychophobic" excess.

Some are so dedicated to the organic approach that they are terrified lest their fragment of truth not contain all the answers and they thereby be lost. Out of such terror come furious and poison-penned attacks on all psychologic considerations and methods. The same terror assails some of those who approach psychiatric disorders from an exclusively psychologic bias. They too live in terror lest a drug come along to destroy their life's work and hopes; and they too react with rage.

(Kubie, 1966)

Incidentally, in 1973 Abrams and Greenfield picked up Kubie's suggestion and re-introduced the idea of a new mental health profession. In that same year Lowinger reviews books and articles written by psychiatrists who speak out against psychiatry. In a somewhat exasperated tone he wonders how and why Szasz can be a psychiatrist/psychoanalyst and hold the views he held then (and holds now) about and against psychiatry. (Lowinger, 1966)

In 1967 we find a most thoughtful analysis of psychiatric models -- "medical" and "social" -- by Ralph Kaufman. (Kaufman, 1967) One may see in

that article how the issue of scope, theoretical framework, professional monopoly (a sociological term), and centrality of functions in psychiatric practice crystallize.

In the late 1960's there begins also a series of addresses by presidents of the American Psychiatric Association, the Canadian Psychiatric Association and the British Psychiatric Association on the subject of the scope, history, and future of psychiatry. Tompkins at the end of his term as APA president spoke on "The Physician in American Society" (Tompkins, 1967), Kolb on "American Psychiatry, 1944-1969 and Beyond," Garber on "The Proper Business of Psychiatry," and Busse on "There are Decisions to Be Made," in which he declared that:

... it is my opinion that a mental illness is an altered physiologic and/or anatomic state of the nervous system manifested by maladaptive signs and symptoms, including emotional and thought disturbances and/or alterations in behavior, that prevent the individual from functioning in a manner acceptable to himself and others.

(Busse, 1972)

Sir Martin Roth as president of the Royal College of Psychiatrists (London) spoke to his Canadian colleagues in 1972 also, taking on the anti-psychiatrists Szasz, Laing, Cooper and Basaglia (Roth, 1972). Talkington's APA presidential address in 1973 stressed the public image of psychiatry, the need for more legislative influence by APA than heretofore, as well as the problems surrounding access by the non-moneyed to psychiatric care (Talkington, 1973).

To provide some further indication of the breadth of concerns by key persons in psychiatry in the United States and elsewhere, I briefly mention M. N. Beck's presidential address of 1973 to the Canadian Psychiatric Association on "Christ and Psychiatry" (Beck, 1973), stressing Christian morality as the substrate of Science, F. C. R. Chalke speaking to the same group a year later, also on leaving its presidency, traces the history of science in psychiatry; but it seems a rather monolithic view of science (Chalke, 1974).

John H. Spiegel's 1975 APA address is -- significantly enough -- entitled "Psychiatry -- A High Risk Profession." Spiegel rests psychiatry's claims on the perception that "psychiatrists provide a wider range of information during a discussion than is possible for other professionals". Yet, Spiegel adds, "this does not mean that we will have mandated control over the other professionals." (Spiegel, 1975) Spiegel's successor, Judd Marmor, sharply and with gentlemanly consideration nevertheless disagrees with Spiegel as follows:

As the only profession in our field whose training background encompasses not only the psychodynamic and sociopathologic roots of behavior but also its biophysiologic determinants, we are capable of bringing a unique mix of knowledge to bear on the vicissitudes of human experience. (Marmor, 1975)

He adds that other mental health professionals operate "on a narrower base of scientific knowledge." Unfortunately for the ongoing debate, Marmor cited no evidence to document this case.

Occasionally one obtains other examples of confrontation among psychiatrists. Thus, for example, Doi who is a Japanese analyst (although trained in the United States) argues with Haven (Haven, 1968; Doi, 1968) to the effect the Doi views the psychiatric specialty as neither art nor as objective science. He, Doi, prefers a Polanyian view of science. As is well known, Polanyi attempts a reconciliation between positivism and personalism in science.

I shall stop my review of a bit of the literature at this point; but even this very partial citation of sources suggests to me several themes that have concerned psychiatrists for at least forty years if not more. These themes may be stated as the following:

First, the medical status of psychiatry.

Second, the theoretical models needed to bring psychiatry into consonance with medical tradition in the twentieth century.

Third, the scientific status of psychiatry.

Fourth, the reconciliation of the traditional split between body and mind.

Fifth, the uniqueness, if any, of psychiatry; the centrality and therefore unifying aspects of all psychiatry.

Sixth, optimum relationships between psychiatry and the non-medical mental health professions.

Seventh, the nature of mind: is there mind? And how, especially if one thinks it does not exist, can one best influence a sick mind?

I submit that what unifies all the cited literature -- and much that I have not cited -- is the concern with the establishment and later the survival of psychiatry. From Halleck's somewhat political approach (Halleck, 1976) to Smith's discussion of psychiatry's three challenges" (resource allocation, the poor and psychiatric standards) (Smith, 1975) to Kendall's concerns with disease in psychiatric logic (Kendall, 1975) and Miller who defines psychiatry as "neurology without physical signs" (Miller, 1975), Ludwig who takes the same stance (Ludwig, 1975), and the brilliant and prolific Fabrega ("The Position of Psychiatry in The Understanding of Human Disease") all speak to basics. And that is what still characterizes much of what is written in psychiatry and by its leading figures at that. Unless the rest of medicine, psychiatry tries to face its reasons for its very existence.

Having identified some of the major themes that have engaged psychiatrists for at least four decades (in some cases longer), we are ready to consider what professionalism means in American occupational sociology and particularly so in psychiatry. Sociology as well as other disciplines is subject to changing conceptions of itself, especially through its theoretical approaches. I shall introduce two of these into the discussion, mostly in order to show how relatively static and relatively fluid conceptions of psychiatry may shed light upon the specialty and its relations to other professional groups. First a few words about the sociology of professions.

Yet -- just a minute. I nearly forgot that in 1969 the residents of the Department of Psychiatry of McGill University in Montreal conducted a trial of psychiatry to which they invited Thomas Szasz as prosecuting attorney and Dr. Vivian Rakoff as defending attorney. After giving their opening statements they called witnesses for each side. At the end of the trial the jury consisting of seven hundred voted two to one against the initial charge that "by replacing religious rethoric with medical, theological sanctions ... institutional psychiatry has continued the practice of the Inquisition." (Applied Therapeutics, 1969)

Now we may continue with our consideration of the study of professions.

2. Approaches to the Study of Professions

The literature on the sociology of professions is referred to by Bucher and Strauss as representing either a functionalist or a process point of view. "Functionalism sees a profession largely as a relatively homogenous community whose members share identity, values, definitions of role, and interests ... by and large, there is a steadfast core which defines the profession, deviations from which are but temporary dislocations" (Bucher and Strauss, 1961; Goode, 1957).

In contrast Bucher and Strauss refer to their own preferred view as a "process" view. Their basic point is that "professions consist of a loose amalgamation of segments which are in movement. Further, professions involve a number of social movements in various kinds of relationships to each other." (Bucher and Strauss, 1961). At the same time these segments can be studied fruitfully only in relation to each other. The main difference between a totalistic, holistic approach to the study of professions which is implied in the functionalist view and the process approach is that the latter takes account of the many processes within professions and which describe the many differences and conflicts among segments, vis a vis such issues as unique professional mission, work activities, methodology and techniques, clients, collegueship, interests and associations, as well as "spurious unity and public relations." (Bucher and Strauss, 1961).

My approach to the sociological study psychiatry is to view it partly from a functional point of view and in part from a process standpoint. Clearly, not all psychiatrists are the same. Even their common medical identity does not make them so; and the many differences within psychiatry needing constant monitoring serve to document the process approach. Process emphasizes the dynamic, negotiated nature of human interaction, suggesting change within and between segments of psychiatry, sub-specialties and the whole discipline. Examples of the last of these are psychiatry in relation to social work, clinical psychology and nursing. Yet, while taking account of the usefulness of process analysis, it is also true that certain themes may be identified which characterize professions as wholes.

Goode lists the characteristics of established professions as descriptive of communities as follows:

Each profession is a community without physical locus and, like other communities with heavy in-migration, one whose founding fathers are linked only rarely by blood with the present generation. It may nevertheless be called a community by virtue of these char-

acteristics: (1) Its members are bound by a sense of identity. (2) Once in it, few leave, so that it is a terminal or continuing status for the most part. (3) Its members share values in common. (4) Its role definitions vis a vis both members and non-members are agreed upon and are the same for all members. (5) Within the areas of communal action there is a common language, which is understood only partially by outsiders. (6) The community has power over its members. (7) Its limits are reasonably clear, though they are not physical or geographical, but social. (8) Though it does not produce the next generation biologically, it does so socially through its control over the selection of professional trainees, and through an adult socialization process. . . Of course, professions vary in the degree to which they are communities, and it is not novel to view them as such.

(Goode, 1957)

Talcott Parsons details attributes of professions by listing certain categorical requirements for occupational functionaries to be considered professionals. (Parsons, 1951). Wilensky and Lebeaux refer to these as constituting the "professional self" consisting of universalism, affective neutrality, functional specificity, collectivity orientation. Universalism refers to the practitioners' willingness to accept all who for his/her function on the basis of their needs in professionally relevant terms; affective neutrality refers to the control, or self-control of the professionals' feelings vis a vis the patient; functional specificity refers to rendering proper services as clearly and expertly related to the patients' condition; and collectivity-orientation speaks to service giving over personal gratification. I think that these categorical dimensions are somewhat out of date in psychiatry but I cite them because they have had a profound influence on American conceptions of professionalism, because they are functional in a prescriptive and categorical sense and lastly, because they followed as well anticipated other attempts -- starting with Flexner in 1915 (Flexner, 1915) -- to define professions and professionalism in what in this day appear to be rather static ways. It should be noted, for example, that patients are not at all mentioned. Yet, were one to leave the matter at the level of functional versus process analysis, it would be unlikely that psychiatry as part of medicine would appear as a cohesive whole. I think that psychiatry can be understood far better in process, in living, negotiative, even conflictual terms than by categorical, functional classificatory language, although it should be obvious that certain anchor points in ethically as well as functionally specific ways might be of some utility. Zinberg provides us with a sense of process in both his comments on where psychiatry fits with medicine and in his discussion of psychoanalytic psychiatry and its relation to American culture.

Zinberg says:

This separation between medicine and psychoanalytic psychiatry is partly inherent in the nature of psychoanalysis. "Psychoanalysis" is a method of treatment; a technique by which the processes of the mind are investigated; and a broad psychological theory. In the first and the second of these meanings, it is anchored in medicine, but equally and partially overlapping in the second and third it is anchored in the social sciences.

As if this were not quite enough of a complication for any professional group or discipline or specialty, Zinberg points to another issue, namely the distonicity of parts of psychiatry with American culture:

Given the multiple factors that may have played a part in the acceptance of psychoanalytic psychiatry in this country, it might be assumed that the implicit values of psychoanalysis would be consonant with some of these forces. Surprisingly, this does not seem to be the case. Any investigation of the values system of psychoanalysis -- reveals little in common with much of American culture. The entire implicit and explicit value system of psychoanalysis has never been thoroughly delineated, but we will touch on a few values that seem to conflict with the culture and especially with the general values system of the medical profession, of which, after all, psychiatry is a subdivision. These differences in values may explain something about the separation of psychiatry from medicine, and why a psychiatric referral has unpleasant moral and social connotations.

(Zinberg, 1965)

I would like to comment that Zinberg is undoubtedly right; but not right enough to make such sweeping generalization in a country in which in one way or another psychoanalytic derivatives -- if not psychoanalysis directly -- find a place from television commercials to education theory, to medicine, social work, clinical psychology and salesmanship. Yet all these considerations, Zinberg's and my own, point to the dynamic, process orientation that describes and explains professions as living, human processes. One would wish that these observations might give hope to beleaguered colleagues who are frequently pressed by insurance companies, patients and others to say categorically, definitively and with an air of finality what psychiatry in all its forms "is". Viewed from my standpoint, i.e. a process of view, what happens in psychiatry is descriptive of a dynamic flow (Fliessgleichgewicht) with changing boundaries, negotiation, compromise, conflict among its components. Surely, there are also constancies and concurrent as well as governing themes that describe the specialty as essentially a part of medicine. Furthermore, professions are voluntary arrangements subject to whatever its members wish to make of them, and thus able to stress at given junctures in their development the integrative versus the revolutionary, the experimental versus the traditional verities.

I would then move on to a discussion of the concept of professional monopoly. I do so for several reasons. The first is that it is traditional in the investigation of the professions to define their boundaries in terms of what it is that makes them unique. Secondly, one may obtain a strong sense of the process aspects of a profession by observing how it deals with problems of boundary, i.e. where a profession begins and where it ends. Thirdly, in the case of psychiatry considerations regarding its boundaries are of importance not only in terms of what takes place within the specialty but, in some ways more interesting than that in terms of its relationship to other professions.

Most specialists in medicine upon hearing the announcement that a non-medical person can perform what they would consider to be medical procedures would either consign such news to the category of the absurd or would file charges against the perceived offender for practicing medicine without a license. For psychiatry the experience occurs daily and without legal consequences. The reason is that professional monopoly -- the bulwark of professional exclusiveness -- has largely disappeared. Yet, that is not true for the prescription of medication, for electroshock therapy, neuropsychiatry and psychosurgery. It is true enough in the area of psychotherapy, social and hospital therapy, group therapy and forensic psychiatry. Competing claims in these areas arise from the activities of social workers, psychologist, nurses and others, although occasionally under other names. In fact, there are some examples of other professionals resenting the intrusions of physicians into their territories, as for example, family therapy, community work and other activities claimed by social workers and psychologists. The increasingly sophisticated training programs of schools of nursing and schools of social work (clinical psychology education has been ahead of medicine, social work, and nursing for a long time) tend to increase rather than decrease competing claims.

It is instructive to ponder how a professional specialty might deal with such competitors. The issue at hand is psychiatry versus other mental health professionals; but in reality it is an example of the options of accommodations potentially open to all professions whose exclusivism is challenged. In other words, the implications are sociological in nature and for the sociologist of professions of considerable interest as professional boundaries become weakened in many instances, not only in psychiatry. It is a good example of process approaches to the study of professions rather the more rigid functional, categorical approaches of yesterday.

I shall list some of the options psychiatry possesses in response to its perceived competitors. They may be conceptualized as follows: 1) the open invitation which holds that all comers are welcome, that the only prerequisites for full rights to practice are professional education in one of the mental health professions, plus demonstrated clinical competence. 2) the tight boundary position which holds that the only valid prerequisite for mental health practice is the degree of Doctor of Medicine plus an approved psychiatric residency. (This implies, of course, that residencies in psychiatry are standardized learning experiences which because of their largely apprentice character they are not). 3) The limited admissions position is an option to deal with psychiatry's boundary problems recognizing the validity of non-medical professionals but which at the same time insists that non-medical professionals must be subject to medical supervision and control regardless of personal competence, experience and knowledge. This is a position often supported by insurance companies and also leads to certain dysfunctional processes as, for example, when a medical resident offers to supervise the work of psychiatric nurses or psychologists with twenty years experience. 4) The exclusivist position holds that the monopoly of total medical control must be based on the fact that only physicians may prescribe medication and selected other medical procedures. I would observe in this connection that the practice of psychiatric psychopharmacology represents the strongest link to the rest of medicine, not only because the function is legally licensed, but also because it corresponds most closely and clearly to the physical model of medical practice, something

I will henceforth refer to as the man-as-a-machine model. 5) A further option still is the integrative position which grants legitimacy to non-medical practitioners but which rationalizes medical control on the claimed grounds that only physicians know how to integrate biological, psychological, as well as social aspects of practice. One must point out in this connection that thorough grounding in social sciences and often in psychological sciences is most notable for its absence in medical school and in residency training; and furthermore that 'integration' is a highly advanced and difficult process. Perhaps all that is really meant in the rhetoric on integration is 'coordination of functions' which is an administrative process. Finally, there is as far as I know no scientific evidence permitting the reasonable inference and conclusion that any currently known mental health profession or specialty trains its practitioners to accomplish that task. My own view is that the integrative position is a defensive maneuver, more rooted in conflict management than in science.

Viewed from the standpoint of conflict management, it is indeed possible to understand that since physicians have generally high social prestige, one would in turn put the most prestigious professional in control positions; that in so doing the expectations of patients -- the rational and the non-rational ones they have of physicians in general -- would thus be met; and finally third-party payors, esp. the insurance companies could treat psychiatry in the same way they relate to other medical specialities.

We shall at this point leave our consideration of psychiatry as a professional specialty among other non-medical mental health specialities, despite the fact that a great deal more could be said about it. But our purpose here is to understand selected aspects of psychiatry and at the same time observe how a social scientist might approach them.

3. The Logical Structure of Psychiatric Thought

The sociologist of the professions is among other things interested in the logic or rationales that underline every aspect of professional practice. Thus, he/she begins to understand not only what professionals do but also how they think about it, i.e. the nature and the structure of their espoused theories. To assist that effort I decided to divide psychiatric practice theories into classes. The first of the ones I shall consider here I call the man-as-a-machine approach.

The notion of man-as-a-machine is used to point up the emphasis on the organic nature of man. It is not used to render moral judgements upon practitioners, or to suggest that they are unfeeling and ungenerous or uncaring human beings. One can, after all, even be good to one's car. My purpose is to call attention to the fact that 1) it is the model Freud employed in the first major phrase of his professional life, including his work with Charcot in Paris; 2) that it conceptualizes mental disturbance as susceptible to physical intervention (pharmaceuticals, electroshock therapy); 3) that the pathways to behavioral change is neurological, biochemical, or both; 4) that while therapist-patient interactions are, of course, engaged in for instruction, discussion and advice they are not in themselves subject to detailed understanding and conscious processing as in interpersonal and psychodynamically based treatments.

Secondly, a variation of the man-as-a-machine concept in psychiatric prac-

tice is diagnosis and treatment based on operant conditioning, social learning theory and behavioristic models. One must hasten, however, to point out that behaviorism in post-Skinnerian days is not nearly as irreconcilable with psychoanalytic and interactionally based theories (one thinks here particularly of Harry Stack Sullivan's theory of interpersonal relations) as once thought to be the case. Behaviorism rests, after all, on the active participation of patients together with their therapists. While in behavioristic treatments the therapeutic relationship as such is not subjected to dynamic interpretation, behaviorism enlists actively the motivation of patients in their own learning, re-learning and unlearning.

A third class of psychiatric practice rests on relational models where human interaction, the interpretation of unconscious conflict, problem solving in human relations and so on form the central preoccupation; and where therapist-patient interaction is subject to considerable attention. Where the biological model tends to stress man-as-a-machine, behaviorism emphasizes both man-as-a-machine and active learner. Relational psychiatry addresses man, the interactor, capable of understanding and of insight into his/her own condition, discoverer of heretofore unconscious behavioral and motivational processes. But in addition, just as is true in behavioristic methods, the relational, often psychoanalytically based therapies deal with behavior, with learning and to some extent with behavioral learning in the here-and-now. In other words, even a brief glance would reveal that logically and scientifically speaking, man-as-machine models, behavioristic models and relational, i.e. basically psychoanalytical models are capable of considerable synthesis and integration. All must be respected for what they can offer and all should be studied in considerable detail.

The term psychoanalysis is often used quite loosely. In a more stringent sense it refers to Freud's theory of human development, and to therapy based upon the management and understanding of unconscious conflict. In the loosest sense it is used to refer to psychiatric practice dealing in any way at all with the understanding of interpersonal processes between patient and therapist as well as in human affairs generally. Therefore, most modern day references to psychoanalysis suggest (rightly or not) that treatment rests on: a) relationship; b) relationship between patient and therapist; c) interpersonal relationship affecting both patient and therapist. In other words, latter day psychoanalysis rests heavily on Harry Stack Sullivan's work even though the fundamentalists among analysts would probably deny that this is so. I think that Sullivan's theory of interpersonal relations is in turn both Freudian as well as heavily influenced by American social psychology, especially that of George Herbert Mead. In fact, Sullivan says so.

Interpersonal relations among all who are committed to it as essential to psychiatric treatment rest on the following elements: one, reciprocity, i.e. both patient and clinician influence each other; two, the relationship must be accounted for in constant detail, a notion already quite clear in Freud. From the side of the patient this is dealt with by attempting to understand transference phenomena to the therapist; and from the therapist it rests on counter-transference management. Sullivan added the interpersonal, i.e. the social dimension that is conscious as well as visible and audible. It is behavioral without being behavioristic.

I shall bring the discussion to a close by stating my own views beyond

what I have suggested here regarding the need to understand more than we do, rather than to take rigidly, doctrinaire positions based on single-theory approaches to the practice of mental health intervention whether medical or not. I think that rigorous standards regarding the evaluation of evidence are as necessary as ever; but I also think that neither man-as-a-machine models nor learning models nor relational models are in themselves quite sufficient. My central conviction has to do with the perception of what science is all about; and that leads me to Professor Polanyi, the famous and I think rightly honored organic chemist who in late life turned to philosophy of science. Before he died he produced his magnum opus Personal Knowledge (Polanyi, 1964). In it he tried to synthesize the objectivity of rigorous science with the phenomenology of personal, subjective experience. This is what he said:

...as human beings, we must inevitably see the universe from a centre lying within ourselves and speak about it in terms of human language shaped by the exigencies of human intercourse. Any attempt rigorously to eliminate our human perspective from our picture of the world must lead to absurdity.

And so, it seems to me, the issue confronting modern psychiatry as well as the exhilarating opportunity facing the specialty is the repair of the split between man-as-a-machine and man-as-mind and relationship, that is to day the split between body and mind. Taking advantage of that opportunity rests, in turn, on several preconditions:

- 1) a scientific, i.e. investigative attitude toward all human behavior, however conceptualized;
- 2) valuing science and scientific investigation ahead of fitting oneself snugly into existing conceptions of professional loyalties;
- 3) a willingness to support through research grants and other financial and administrative resource allocation every serious effort to learn more than we presently know, no matter what the specialty;
- 4) a moratorium on sloganeering about supposedly inherent superiorities of some specialties or even some professions over others;
- 5) willingness to consider seriously again and again theories we do not ourselves favor, and data not to our liking, esp. those tending to disprove our own hypothesis.

At its very core lies the fact that science is self-correcting, and it is this that has been celebrated, rightly so I believe, as making science both our opportunity and our hope.

In the year 1965 Professor Nigel Calder published his two-volume The World

in 1984; and he asked Professor Sir Aubrey Lewis of the University of London to write on "Changes in Psychiatry Methods and Attitudes." Here is what, in part, Professor Lewis predicted:

"... by 1984 medical students will be getting a much better grounding in the social sciences and in the clinical principles and methods of investigation appropriate to psychologic medicine; and much of the work now falling to the lot of the psychiatric specialist will be competently dealt with by the general practitioner, in whose post-graduate training psychiatry will play a large part, commensurate with the frequency of psychological problems.

(Lewis, 1965)

You have only five years to go.

4. Postscript

When one claims to write on "aspects" of the sociology of psychiatry as I have done in this paper, one commits oneself to leaving out of explicit consideration much more than one has included. Thus, I have quite intentionally omitted any consideration -- other than implied ones -- of the ideological implications of psychiatric models. It is an interesting and in fact challenging task to spell out the value and ideological preferences which formulators and users of certain models would appear to espouse. This can be done from several points of view. One might spell out the value commitments in the language employed in some theoretical position. To some extent Rychlak did just that in his *A Philosophy of Science for Personality Theory* (Rychlack, 1968). Similarly, Polanyi provides us with rather clear ideological implications in his developmental, deterministic approach to the discovery of knowledge; and one would observe in that connection that the author's notion of "tacit knowing" has major implications for all attempts to predict and change the human condition. Lastly, man-the-machine models of which early Freud is one of the best known examples and which some otherwise highly psychological writers such as Kernberg have used in his espousal of instinct theory as the basis of psychoanalytic object-relations theory, suggest some unexplicated value positions, also.

In sum, it is necessary for the sociologist and philosopher of science to attend the ideological implications of models and theories in order to understand not only whole professions or specialties within them, but beyond that to give insight into the value basis that make science, science beyond data, empiricism and rational inference. To this problem I shall attend in a future publication as a sequel to the work before us.

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