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MEDICAL MODEL INFLUENCE IN COUNSELING AND
PSYCHOTHERAPY: COUNSELING PSYCHOLOGY
TRAINING DIRECTORS' VIEWS

by

Dallas R. Jensen

A dissertation submitted to the faculty of

Brigham Young University

in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

Department of Counseling Psychology and Special Education

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BRIGHAM YOUNG UNIVERSITY

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As chair of the candidate's graduate committee, I have read the dissertation of Dallas R. Jensen in its final form and have found that (1) its format, citations, and bibliographical style are consistent and acceptable and fulfill university and department style requirements; (2) its illustrative materials including figures, tables, and charts are in place; and (3) the final manuscript is satisfactory to the graduate committee and is ready for submission to the university library.

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ABSTRACT

MEDICAL MODEL INFLUENCE IN COUNSELING AND PSYCHOTHERAPY: COUNSELING PSYCHOLOGY TRAINING DIRECTORS' VIEWS

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Doctor of Philosophy

The practice of counseling and psychotherapy is influenced by a number of ideologies, models, and paradigms. Among these, the medical model's influence is particularly salient. The ideology of the medical field pervades the theory, research, and practice of psychology and its influence deserves close examination. The few studies in this area that have been conducted are descriptive and basic in nature. The present study aimed to contribute richness and depth to conversations about medical model influence. By interviewing Counseling Psychology training directors and applying a qualitative analysis, this study provided the following themes that characterize views of the medical model's influence on professional practice:

1. Psychology can't afford to be dogmatic or deny reality, yet must critically examine the influence of the medical model.
2. Counseling Psychology has a lot to offer—so get in the game.
3. The tension between medical model influence and the values of Counseling Psychology has increased.
4. The medical influence on research is a two-edged sword—we need to think complexly about our science.
5. Medical model focus on pathology is reductionistic and restrictive.
6. Preparing students for the “real world” medical influence on practice while trying to teach values of Counseling Psychology is at times a balancing act.
7. Cautious about Prescription Privilege: Are we trying to be physicians or psychologists?

It is hoped that finding and reporting the themes that emerged will lead to increased discussion, thinking, consideration, and examination of the model's influence among counseling psychology professionals.

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Introduction

Medical and human science paradigms have been closely related for centuries (Smith, 1997). At present the profession of psychology is powerfully affected by the medical paradigm, including the practice of counseling and psychotherapy. The application of theories, techniques, and other principles to helping people with behavioral, psychological, and emotional problems often appears very similar to the manner in which medical professionals treat organic illnesses. Current trends suggest that the practice of psychotherapy is influenced by the metaphor or ideology of medical practice, due in part to economic, philosophical, and cultural factors that will be discussed later. The influence of the medical model is a salient issue deserving of critical examination particularly within the practice of psychology (Duncan, 2002).

The purposes of this study were to identify professional leaders' views about the influence of the medical model and explore the impact of the model on the practice of counseling and psychotherapy. A particular emphasis was placed upon the implications of the medical model's influence for the practice of counseling psychology. With regards to Counseling Psychology, this study provided a richly informed starting point for some much-needed dialogue and research on the impact of the medical model. The literature is sparse at best when it comes to discussing the medical model and counseling psychology. A very few visible contributions have provided the impetus and suggestion for further consideration (e.g., Wampold, 2001), but in general it appears as though Counseling Psychology is either content with the opinions being expressed by those in other areas of practice or is under the assumption that such issues as these will not impact counseling psychologists the same way they do other practitioners of psychology. The author

believes that the unique philosophical foundations of counseling psychology have a useful contribution to make to the ongoing dialogue about the medical model.

To illustrate the lack of clarity, recent discussion of Evidence-Based Practice included one author who held out the idea that counseling psychology generally “eschew[s],” (p. 498) and feels “disdain” (p. 499) for, the medical model (Chwalisz, 2003). In the same publication, however, another author takes issue and suggests this premise to be incorrect, that instead counseling psychology is “ambivalent” (p. 542) at best or only concerned about the model’s appropriateness (Wampold, 2003). Fretz (1980) may have best summarized this apparent ambiguity about what counseling psychology believes regarding this and other significant issues: “Counseling psychology, it seems, is in the eye of the beholder” (p. 9).

Although admittedly not without bias in some areas, it was not the author’s intent to cast a wholly negative light on any overlap of medical and psychological practice ideologies, nor to conversely suggest that the medical model be adopted wherever possible and without reservation. Rather, the principal aim of the study was to conduct a qualitative inquiry that will add depth, richness, and understanding to discussion of the medical model as it is viewed and used in the practice of counseling psychology.

Definitions

As a construct central to this study, defining “medical model” warrants some specific attention. In reference to the term “model,” Ogles, Anderson, and Lunnen (2001) present a definition that seems to fit this study: “...A *model* is defined as a collection of beliefs or unifying theory about what is needed to bring about change with a particular client in a particular treatment context” (p. 202). However, finding a universal definition

of “medical model” in the academic literature proves impossible. Differing conceptualizations exist that focus on various aspects of medicine’s influence on psychology. These include, among others, the following definitions of the medical model in psychology as:

- The belief that mental illnesses are like any other illnesses
- The treatment of specific mental illnesses by specific therapeutic ingredients
- Biological, materialistic, and causal-deterministic explanations of psychological problems
- Practices borrowed from medicine that are superimposed on psychological treatment (Simon, 1994; Wampold, 2001a).

In these and other attempts to define the medical model, it seems appropriate to consider two related themes, namely an ‘etiology’ (causal-descriptive) medical model, and a ‘practice’ (help or treatment) medical model. Such a division, while clearly not without limitation, has served a pragmatic purpose for several authors in discussing the many conceptual variants and applications of the medical model (Kihlstrom, 2002). For example, Svensson (1995) proposed that a distinction can be made between “explanatory” and “conceptual” aspects of the medical model. The explanatory model and practice model are not mutually exclusive, as both share common philosophical underpinnings; but the etiology-based medical model has ebbed and flowed in psychology while the practice model appears to maintain a strong influence. Accordingly, the focus of this study was specifically on the influence of the medical model on practice, rather than on conceptualizations of and theories about causes of psychological problems. Interviews were conducted with training directors of counseling psychology programs

due in large part to their experience in both academic and practice spheres. Therefore the purpose of this qualitative study was to explore counseling psychology training directors' attitudes about the medical model's influence on the practice of counseling and psychotherapy.

Brief History

A chronological examination of the relationship between medicine and the human science precursors of what we now call psychology shows the difficulty in clearly separating the latter from the former. The presence of medicine and its influence not only on psychology but also on culture in general is clear (e.g., Hergenhahn, 2001; Koenig, McCullough, & Larson, 2001).

Throughout the late 1800s and into the next century psychology emerged as a scientific discipline. From Wundt and Titchener to Watson and Skinner, experimentation, empirical observation, and scientific data gathering became the foundation. Out of this also grew a desire to functionally apply learned concepts for the benefit of society, leading to the practice of psychotherapy. Psychologists adopted many of the existing scientific and philosophical foundations of the time into practice, as mental illnesses were treated by a variety of treatment approaches believed to have specific efficacious effects, not unlike the administration of a medicine. In this way some believe that psychology's very origins are immersed in the medical model (Wampold, 2001b).

Freud advocated a new talk therapy, yet at the same time his theory of treatment retained the reductionistic, mechanistic perspective he learned from the medical and physiological fields (Perlman, 1982). The health care industry was simultaneously undergoing a transformation from home-based treatment to professional care

administered in hospitals and other institutions by highly trained professionals (Cohen, 1993). Decades later behaviorism would follow psychoanalysis as the next treatment for psychological disorders, based primarily on the reductionistic, deterministic theories of Pavlov, Watson, Skinner, and their contemporaries (Wampold, 2001a).

By the 1950s the influence of dynamic, humanistic, and other theories led many psychotherapists to abandon the medical model ideology and seek new, psychosocial understandings of mental problems (Leifer, 1990). Along with this came an increase in psychotherapists entering the private sector, as well as the funding of community mental health centers (Barney, 1994). Lasting just up until the 1970s, however, this movement away from medical influence eventually gave way to a re-medicalization of therapeutic endeavors sparked by the development of psychotropic medications, biological research of mental illness, and curiosity about brain functioning (Wyatt & Livson, 1994), trends that have continued to the present day. In particular, the methodology employed by the medical field has become a large part of psychological practice, reflected in aspects of language, theory, technique, research, and treatment. George Albee (2000), a past president of the APA, argued that a particularly influential decision was made inviting the current level of medical model influence when clinical psychology endorsed the Boulder model, thereby also accepting then prevalent organic conceptions of mental illness, medical language, classification and diagnosis, and more. Since then the medical model, especially for the practice of counseling and psychotherapy, has been highly influential in psychology.

Key figures in the debate about the medical model's influence in the helping professions have largely come from the psychiatric field. George Engel (1977) asserted

that the medical model is inadequate for both the scientific and social aims of not only psychiatry, but also medicine as a whole. His biopsychosocial model proved fertile ground for exploring alternative conceptualizations. Thomas Szasz (1960) criticized the conception of mental illness as equivalent to bodily diseases, and argued strongly that the very term ‘mental illness’ is itself a myth perpetuated by culture and the medical tradition within psychiatry at the time.

Current State of the Profession

At present, the profession of psychology continues to grapple with competing ideologies. The medical model is highly influential and drives many aspects of the field. What follows is a brief discussion of some of the areas of psychological practice currently most influenced by the medical model ideology.

The medical ideology potentially begins to have impact the moment a client enters into contact with a counselor or psychotherapist. Individuals themselves are seen in a qualitatively different light; from the medical model lens, individuals are not responsible for their problems or solutions, but need only treatment (Brickman, 1982). The problems of clients are seen as diseases or illnesses just like any other. Under this model, one possible result is that clients can be defined primarily by their pathology, disorder, or mental illness—effectively making the mental disorder the person or client (White, 2002).

Further influence of the medical model is found in the diagnosis and classification of disorders. Some have suggested that diagnosis is positioned at the very heart of the medical model of psychopathology, entailing an expert assessment and decision about

what affliction a person suffers from, and from which all other decisions and processes of therapy flow (Kihlstrom, 2002).

Another significant influence of the medical model is evinced in the focus on specific therapeutic techniques as having efficacy relevant to positive outcomes. Much like the pharmaceutical model which looks for the best drug or intervention for a given disease, the specific ingredients and techniques of therapy approaches are believed by some to be responsible for change. This perspective is the foundation of the movement toward manualized treatments and empirically supported treatments (Hubble, Duncan, & Miller, 2001). However, others argue that these critical components are shown to be negligible compared to other more salient, general factors (Ahn & Wampold, 2001).

The Empirically Supported Treatment (EST) movement is related to ideas about specific ingredients in therapy responsible for change. Originally called Empirically Validated Treatments, the EST is patterned after medical programs that demonstrate specific treatments for specific disorders (Bohart, O'Hara, & Leitner, 1998), and even borrows terminology from the FDA approval process for new drug treatments (Wampold, 2001b). Some favor the EST movement and the empirical stability it brings to the profession (Elliott, 1998). Others have championed the cause of the 'best' treatments, arguing that research evidence of their effectiveness for treating certain emotional disorders signals a big forward step in establishing the validity of the psychotherapy industry (Barlow, 1996).

Researchers have suggested that technical therapeutic interventions and protocol-driven interventions, with their accompanying treatment manuals, are becoming the standard of care in the practice of psychotherapy (e.g., Ogles, et al., 2001). Questions

have been raised about their appropriateness and about the implications of following the medical metaphor to this conclusion (Addis & Waltz, 2002), one which makes the therapy the ‘medicine’ of sorts, applied in standard, careful ways so as to most effectively attack the ‘disease.’ While some have championed their use and benefit to the process of psychotherapy (Wilson, 1998), others have argued that while potentially helpful in some situations, manuals have been around in some form or another for decades and have added little of substance to the profession (Lambert, 1998).

Another current aspect of the profession receiving much attention is the debate about whether or not psychologists should enjoy the privilege of prescribing medications to their clients. This is a particularly poignant issue at present in the field. Some in psychology believe that such changes are a positive sign of psychology’s alignment with the health care paradigm and are a natural progression for the field (DeLeon & Wiggins, 1996). Others argue that securing this privilege would lead to a loss of profession-wide identity, raise questions of safety, and disrupt training (Hayes, 1996), or would be incompatible with the philosophical assumptions of a psychology that in its infancy attempted to separate itself from the existing medical practices (Sanua, 1996).

Contextual and Cultural Factors

Aside from the current areas of the profession within which the medical model influence is apparent, other factors become highly relevant when considering the question of why the model has the influence it does. These contextual factors are briefly highlighted here. It may be that utilization of a medical model in professional psychology reflects cultural ideals and beliefs, and what the society desires. Pressures to be seen as a science and those that come with the desire for economic security are also major players

One relevant contextual factor is psychology's desire to be a science, and thereby enjoy the same position and public regard as do other fields. For many, it seems that adoption of a medical model aids psychology in its efforts to be included with "hard" sciences such as biology or physics. (Bailey, 2002). This factor is addressed by Leifer (1990), who posits, "The medical model is well suited as ideology because it *appears* to represent the most authoritative and reliable source of knowledge, namely, science, as well as the most benevolent and compassionate branch of science, namely, medicine" (p. 250).

In a conversation with Mullan (1995), Laing suggested, "We use a medical model because that's the tactic that is currently most acceptable to...our society" (p. 259). Cultural factors play a significant role. Wampold (2001b) suggested that "Indeed, it is impossible to identify historically a civilization in which medicines, rituals, and healers were (are) not central features of the culture" (p. 69). As has been convincingly argued by Cushman (1995) and others, psychotherapy is culturally-bound and contextually situated, and such factors cannot be ignored in an ahistorical, acontextual way without impairing understanding of the profession. The medical model's influence is thus located within a larger culture. Supporting this idea, one study showed that the general public accepted the medical model of mental illness nearly 90% of the time, much more than either allied health professionals or clinical psychologists (Burke, 1993).

The language used in counseling and therapy, and to a greater extent within the psychological profession, also reflects the influence of the medical model. Kihlstrom (2002) suggested that whether one likes it or not, the language and lexicon of the medical model is pervasive in discussions of mental illness. This language adopted by the

profession in conjunction with the people and problems that are encountered arguably reveals foundational beliefs and underlying assumptions (Mahrer, 2000; Slife & Williams, 1995). Much of the language of the medical model is used casually with little to no thought given to the way it shapes conceptualizations. Mahrer (2000) cautioned that the foundational beliefs of our language, if kept hidden and unexamined, can be made to be immune from change and can be implicitly powerful, effectively denying the chance for the creation of alternative models with accompanying alternative language.

A strong contextual force influencing psychology's use of the medical model is the influence exerted by economic forces. For example, Bailey (2002) suggested the "chemical imbalance paradigm" (p. 45), is motivated considerably by the economic influence of insurance companies, pharmaceutical corporations, and the desire for quicker, cheaper, and less frequent treatment than would occur in psychotherapy. Problem-specific interventions have had much success in the field of medicine; their application to counseling and psychotherapy seems to some a logical extension. Particularly interested are the public and government policy makers, who see in specific ingredients models the equivalent of a "pill" to eliminate psychological distress (Hubble, Duncan, & Miller, 2001). The monetary benefits of such a "pill" are seen as potentially significant relief from constant economic pressures and trying to fit into the overall health care system.

Rationale and Purpose of Study

It was not the intent of this study to attack the medical model; rather the purpose was to examine views about the impact that adoption of this ideology has had on the practice of psychology, particularly the practice of counseling psychology. Counseling

psychology was founded on values that differentiated it from other existing models of practice (Gelso & Fretz, 1992; Howard, 1992). It is hoped that becoming keenly aware of the implications of the medical model in practice will, when needed, lead to examination of more appropriate alternatives where the current ideology falls short of the mark. The investigator's bias was that the medical model, particularly as a metaphor for practice, can be confining and inappropriate when applied to some psychological problems, and yet is a recognized reality that for a multiplicity of reasons continues to gain in strength in the field.

Some might argue that the medical model debate is history, already attended to and handled fully in decades past. Others may question the very relevance of discussing the medical model. Duncan (2002) speaks to the pervasiveness and influence of the medical model, and thereby the importance of considering its implications for our professional endeavors:

The end result of our Faustian deal with the medical model: Psychotherapy is now almost exclusively described, researched, taught, and practiced in terms of pathology and prescriptive treatments... firmly entrenched in our professional associations, licensing boards, and academic institutions. It is so taken for granted that it is like the old story about a fish in water. You ask a fish, "How's the water?" and the fish replies, "What water?" (p. 45)

The aim of this study was to make the "water," explicit, and to examine the in-depth attitudes of those who swim in it, with the hopes of clarifying, enriching, and organizing future discussion of the medical model's influence in counseling and psychotherapy, and the specialty of counseling psychology. The problem, as is presented in the literature

review, is one of a dearth of organization—opinion pieces that are highly varied, and a few attempts at empirical examination that lack sound foundational themes and depth. This study examined and arranged those themes and provided some organization around a topic that includes a wide variety of discordant perspectives. Due to the often controversial nature of the present research topic, a method that has as its strength the ability to capture a multiplicity of views from a complex and often contradictory world was appropriate (Kvale, 1996).

In summary, the purpose of this study was to use a qualitative methodology to take a critical look at the influence of the medical model on the practice of counseling and psychotherapy in general, and specifically as pertaining to counseling psychology. This was accomplished by interviewing training directors of counseling psychology graduate programs in order to understand their views and attitudes. It was hoped that finding and reporting the themes that emerged will lead to increased discussion, thinking, consideration, and examination of the model's influence among psychology professionals.

Literature Review

The influence of the medical model on the practice of counseling and psychotherapy has received much attention in the literature. Understandably, the vast majority of what one finds is constituted by opinion pieces, theoretical papers, and philosophical discussions. Additionally, a few descriptive studies have quantified opinion through surveys about the medical model's influence in certain areas of psychological practice. This literature will be reviewed and summarized here, with attention paid to existing themes as well as past and present thought on the matter. Due to the inherent difficulty in providing a comprehensive review on so broad a subject, this review attempts to capture a wide range of literature and opinion on salient issues, while at the same time providing a concise, integrated review. Further, although overlap is apparent in some areas, generally the review focuses on the question of interest, which specifically examines the medical ideology's influence on practice. As such, the review presents a brief historical context within which to situate current views, and a wide range of opinions about the model in general. Following this, the review focuses on a few currently discussed areas of the model's influence on psychotherapy and counseling, including the following: illness model conceptualizations; diagnosis; specific ingredients of therapy; empirically supported treatments; manualized treatment approaches; and prescription privileges. Next, the review summarizes contextual factors believed to contribute to use of the medical metaphor in psychological practice: these include systemic, scientific, epistemological, cultural, linguistic, and economic factors. Lastly, the review discusses the values of counseling psychology and shows that organization of existing opinion, as well as more in-depth discussion about the medical model is needed.

Brief History

Perhaps some of the first medical treatments of mental disease appeared in the Stone Age, when skulls were believed to be trephined to treat severe distress. Artifacts recovered from this period suggest that mental and physical illness were not distinguished one from another, and that both were understood in religious terms (Koenig, McCullough, & Larson, 2001). Pharmacological treatment also may have its roots in these early times. As early as 1700 B.C., chemicals were used to treat perceived imbalances in the body's system. Centuries later (300 B.C.), Hippocrates and others wrote of using hellebore, an herb, for treatment of mental diseases such as melancholia. Hippocrates further postulated that illness is understood in terms of four bodily fluids, and that mental disease is a disorder of the brain. Around this same period, Plato taught in Greece that healing needed to include the 'soul' as well as the physical body (Hergenhahn, 2001; Koenig, McCullough, & Larson, 2001).

The second century A.D. saw in Galen perhaps the most significant influence on the European medical field for centuries to come. His writings on medicine included ideas about the localization of psychological processes, and even the soul itself, in the brain (Hergenhahn, 2001). The Renaissance in Europe sparked a renewed interest in the humanistic, paralleled by renewed reliance on naturalistic explanations of mental illness. During the 1700s scholars such as De la Mettrie, de Condillac, Cabanis, and others commonly regarded the soul as nothing more than a manifestation of cerebral activity. Although not without criticism, theories of this nature moved explanation of behavior firmly into the realm of the organic and material. The science of the Enlightenment continued even further down naturalistic paths, reaching a position from which it was

believed everything in the universe could be explained in naturalistic terms (Smith, 1997). Humans were seen as machines and consciousness was organic in origin. In the 18th century, particular attention was paid to hypochondriac and hysteric mental disorders. The belief at the time, among clinicians, was that the spleen in men and the uterus in women were the organs responsible for producing such distress (Perlman, 1982). However, other scholars from this period also looked to psychological factors to explain anxiety and favored a more sociobiological perspective. Although opinions like these appeared to be the minority, they set the stage for later reconceptualizations of the etiology of mental disorders (Smith, 1997).

During the Renaissance, mental illness was recast in a different light, setting the stage for the medical model and the foundations of psychiatry. In the late 1700s Pinel strongly affirmed that mental illness was a disease in every way comparable to any other organic disorder (Smith, 1997). Benjamin Rush, the father of American psychiatry, called for a removal of anything that appeared mysterious or unexplainable in natural terms from the study of mental illness, and believed madness to be caused by blood circulation problems (Perlman, 1982). Samuel Woodward founded the American Psychiatric Association in 1844, and shortly thereafter Emil Kraepelin organized mental illnesses by their symptom patterns into classifications, similar to internal medicine at the time. Bleuler took *dementia praecox* and renamed it *schizophrenia*, insisting biological causation for this mystery disease. These and other figures key to the medical influence in psychology made it their quest to remove their study from the realms of physiology, demonology, and philosophy, drawing heavily instead upon the medical field.

Another oft-overlooked occurrence of the early 20th century was crucial to the inclusion of a medical model in psychiatry and further influenced later psychology research and psychotherapy practice. Torrey (1974) wrote that at the time when Freud's analysis was becoming a popular treatment, Abraham Flexner exposed quackery and poor training in a highly influential report on medical education in the U.S. Psychiatry was forced to position itself firmly within the bounds of a medical model, and laws against lay analysts were passed. He further stated, "It had taken medicine over 3,000 years to seize the province of irrational behavior from the fiefdoms of law, religion, and philosophy; once seized there was an obligation to protect it against nonmedical usurpers" (p. 21).

Current State

As for the current state of the field, only a few studies have explored the medical model's influence on practice using quantitative methods. Reasons for this are multiple: the medical model is a construct, an ideology; it is loosely defined and broadly conceptualized; and it is difficult to establish relationships using the medical model as an independent or explanatory variable. What one finds in a rigorous search of the literature, then, are those types of articles that correspond to, and make attempts to rectify, the limitations presented above. These primarily include opinion pieces, theoretical writings, philosophical critiques and defenses, and other non-empirical scholarly writings. The few quantitative studies either focus on a specific aspect of the medical model, or they opt for a descriptive approach, using surveys, and summarizing views of groups on selected variables.

Acceptance of Model

Burke (1993) examined attitudes toward mental illness among clinical psychologists, allied health professionals, and the general public. Some differences in acceptance of the medical model were found between psychologists and the other groups. Of particular interest was the finding that most psychologists accepted the medical model of mental illness (62%) in spite of rejecting the idea that mental illness is like any other illness. Results also showed that the general public endorsed the medical model of mental illness far more than did psychologists. Polonsky (1970) assessed attitudes of mental health students and professionals to investigate whether differences existed between those of differing professional affiliations. Findings suggested that differences in medical model orientation were less related to professional affiliation (psychiatrist, clinical psychologist, social worker) than to the training institution that students and professionals attended. Additionally, results did not support the hypothesis that psychiatrists would endorse the medical model viewpoint more than psychologists.

Research examining the different ideological positions of psychologists and psychiatrists was conducted by Wyatt and Livson (1994) using the 63-item Mental Health Questionnaire. Results showed that more experienced psychologists and psychiatrists tended toward more psychosocially oriented models, while less experienced professionals from the same fields were more oriented to a medical model. This supported the observation that the professions have experienced a recent remedicalization, or perhaps showed that professionals become less medical as they get older. On the other hand, results also showed that psychologists tended to endorse the medical model less than psychiatrists, whereas in other areas they were much less distinguishable. The authors

concluded that empirical studies of the models of mental illness can be achieved, although it appears that for some reason the field has not yet taken up such an endeavor.

Aspects of the Medical Model Evident in Practice

What follows are reviews of some of the key areas in which the medical model's influence is evident in the practice of psychology. A pervasive and far-reaching ideology, the metaphor can hardly be captured by covering these relatively few areas. However, a review of the extant literature shows that these areas seem to be the salient current topics of argument, discussion, and exploration.

Illness model. The influence of the medical metaphor on the practice of counseling and psychotherapy also appears in conceptualizations of presenting problems. Here again the overlap between etiology and practice conceptions of the medical model becomes evident. Conceptualization of the presenting problems of clients as *illnesses*—whether explicitly stated or implicitly assumed—gets into both theories of epidemiology and theories of treatment.

Some have argued that psychology completely abandon any search for prescriptive treatment systems that arises out of a medical model of psychopathology (e.g., Duncan, 2002). One study examined the disease view of mental disorders and the effect of such a view on stigma (Mehta & Farina, 1997). The authors found that undergraduate male psychology students actually treated more harshly those people whose problems were described in disease terms than those described in psychosocial terms. Results suggested that the disease view does little more than create some ambivalence about how a person with the problem should be treated, leading the

researchers to conclude that conceiving of those with mental/emotional problems as diseased or sick does not result in more acceptance and de-stigmatized treatment.

A similar study used a video portrayal of a young man with psychotic symptoms to measure attitudes toward mental illness (Walker & Read, 2002). Researchers followed the video vignette with either psychosocial or medical/biological explanations of his problems. Results suggested that the medical model explanations that presented problems as a disease or illness were related to perceptions of the person as dangerous or unpredictable. The authors argued against the currently accepted practice of generating efforts to convince the public that such problems are like any other medical illness. They recommended that perceptions were changed more effectively when people have contact with others suffering mental and emotional problems.

Diagnosis. The medical model has had considerable influence on practice through the use of the diagnostic labeling and classification scheme of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV TR)*. Some have suggested that diagnosis is positioned at the very heart of the medical model of psychopathology (Kihlstrom, 2002). An examination of all of the articles that appeared in the *Journal of Consulting and Clinical Psychology* during 1997 demonstrated the scope of the medical metaphor's influence. Nearly 66% centered on a psychiatric diagnosis, while more than 25% addressed specific treatments for specific DSM disorders (Hubble, Duncan, & Miller, 2001).

Although there have been a plethora of opinions expressed on the value (or lack thereof) of a diagnostic system for psychology, many seem to agree on two basic ideas. One, it is not a perfect system free from limitations. Hubble, Duncan, and Miller (2001)

argued that prescriptive matching of client problems to treatments, emphasis on technique, and identification of clients by diagnoses is based in historically-informed models, which are themselves limited in applicability. Two, diagnosis aids description, communication, and research about those problems that clients seek help for by lending organization and structure (Kihlstrom, 2002).

Specific ingredients. The medical model also brings to psychology a metaphor for how the healing (treatment) of the client (patient) takes place. In this metaphor, physical diagnosis based on symptoms is replaced by psychological diagnosis also based on symptoms of an underlying problem. The diagnosis pinpoints the problem, which is then the focus of intervention. In medicine, the physical problem is treated through specific interventions that have specific effects on symptoms. Much the same, in psychology's version of the medical model, the now-diagnosed disorder is treated through a specific form or type of therapy, with supposed specific effects on symptoms. These effects can be called specific ingredients, discussed by Wampold (2001b) as those components of psychotherapeutic treatment believed by some to be most responsible for outcomes. As in the medical sphere, these specific effects of treatment are assumed to be responsible for change—in this case, for healthy remediation of psychological problems. Further, the underlying assumption of specific effects suggests that regardless of problem, context, client and therapist factors, and other aspects, the specific treatment for the specific problem brings the desired outcomes. In this way, for example, the specific ingredients of cognitive-behavioral therapy bring about desired outcomes when treating anxiety, or the forward lean and empathic rephrasing of person-centered therapy effect change in treating depression. Following the metaphor, the therapeutic ingredients become the

medical treatment, the ‘drug’ administered to fight an infection, the treatment prescribed specifically for the presenting medical problem. This is not to say that all decisions made in either medical or psychological practice are based on strict adherence to or belief in specific ingredients of best treatments, nor that they ignore key contextual factors, as this is not at all the case. Rather, the metaphor serves to illustrate certain underlying premises, prominent in current mental health practice, that have implications for the conceptualization of just how counseling and psychotherapy work (Wampold, 2001b). Although a search of the extant literature likely does not result in finding those willing to advocate for these specific ingredients, the implicit assumptions of much therapy research and practice are congruent, at least in part, with this metaphor. In recent decades, outcome research has focused on whether therapy works, and more recently, on *how* it works. This burgeoning research area has not been without its share of disagreements and multiple perspectives.

Ahn and Wampold (2001) conducted a meta-analysis of 27 component studies to examine the alleged benefits of specific ingredients of therapeutic approaches. These studies added or removed components of treatments believed to be efficacious in the treatment process. The findings of the meta-analysis provided no evidence that the aggregated effect size was significantly different from zero, suggesting that specific ingredients are not responsible for treatment outcomes. In reaction to this published finding, one researcher claimed that the results of their meta-analysis were limited in their usefulness due to a limitation of the studies selected. This critique noted that client and therapist variables, often highly relevant to treatment outcome, were left out of the

evaluation of interventions and subsequently called for further research to evaluate the client-therapist-intervention match (Maltzman, 2001).

Empirically supported treatments. The Empirically Supported Treatment (EST) is one among many ways psychology has grafted in the medical model. Originally called Empirically Validated Treatments (EVTs), therapeutic approaches supported by empirical research for their utility in treating specific disorders have been the focus of a growing research movement in the last decade. In the early 1990s, the APA appointed the Division 12 Task Force (1995) with the responsibility of compiling a list of treatments for DSM disorders that were supported by empirical research (Chambless & Hollon, 1998). Nevertheless, problems remain with such an endeavor—one that boasts over 100 treatments of varying efficacy, references to training opportunities and treatment manuals. This movement presumes to push for emphasizing these ESTs in all psychology training program curricula. However, several theoretical approaches deal in areas that could never hope to be empirically observed, quantified, or coded. For example, psychodynamic or existential approaches are not as conducive to segmentation into measurable factors. Such theories, not coincidentally, are virtually nowhere to be found among the ESTs, which instead are dominated by cognitive and behavioral approaches (Bohart, O’Hara, & Leitner, 1998).

The conceptual foundation of the EST provides a particularly poignant example of the influence of the medical model within the field of psychological practice. Wampold (2001b) drew attention to the patterning of the EST research program after its counterpart from evidence-based medicine. The Division 12 Task Force originally patterned criteria for screening potential supported treatments after the Food and Drug

Administration (FDA) criteria. Placing therapeutic treatments under the same scientific lens that requires comparison of treatment and placebo groups in the medicine approval process became the ideal in psychotherapy outcomes studies hoping to pinpoint ‘best’ treatments. Standardized treatments complete with manuals replaced medication, and the medical model became the basis for hundreds of efficacy studies (Wampold, 2001b).

While research support for therapeutic approaches is prized, not all agree that such support is as convincing as it might seem. Examination of more than four decades of data led authors to conclude that little support exists for: differential effectiveness of therapeutic approaches; psychopharmacological superiority over psychological interventions; or the usefulness of diagnostic classifications for the course and outcome of treatment (Hubble, Duncan, & Miller, 2001). Garfield (1998) cautioned that while seeking empirical support for therapeutic approaches is important, the way the ESTs have been presented tends to minimize the variability that both the client and therapist bring to the session, and also de-emphasizes therapist skill. He further surmises that with the increasing pressure of third-party reimbursement providers, as well as intensified focus on efficiency and accountability of interventions, psychology will be choosing among two possible routes. The first followed the current EST model, by matching specific prescriptive techniques to psychiatric disorders; the second emphasizes instead the empirically supported performance of individual practitioners themselves (Garfield, 1998). Duncan (2002) argued that the validated treatment movement equates the therapy client with their presenting problem, and further sets up a treatment that is seemingly isolated from the client’s own resources for change and growth.

Of the areas reviewed for this study, the EST movement received the most attention in the counseling psychology-specific literature. One review focused on the implications for counseling psychology training and called for inclusion of certain aspects of the EST program in practica and other training, while simultaneously cautioning that the unique values of counseling psychology must not be sacrificed in the process (Waehler, Kalodner, Wampold, & Lichtenberg, 2000). Among these values potentially threatened by the EST movement the authors included: respect for diversity issues; de-emphasis of diagnostic labeling; attention to career issues; psychoeducation; focus on developmental concerns; and inclusion of prevention. They further called for training programs in counseling psychology to stay alert to the establishment, through the EST movement, of standards and guidelines that might impact training, and to critically examine the merits and limitations of the movement. Taking the matter one step further, many of these same authors published in 2002 the results of their efforts as part of a Special Task Group of Division 17 (Wampold, Lichtenberg, & Waehler, 2002). This group was proposed and formed in 1996 in response to the issues surrounding empirical support of psychotherapeutic treatments, with three principal aims: to increase awareness of the current empirical status of interventions in counseling psychology; to increase training in empirically supported interventions; and to increase public appreciation of the empirically supported interventions that counseling psychologists have to offer. What resulted was called Principles of Empirically Supported Interventions (PESI), seven guiding principles that aid in reviewing research support for counseling and therapy interventions. It remains to be seen whether this parallel movement to that of Division 12

will find a foothold among counseling psychology practitioners, and as of yet no further research has been published focusing on the PESI.

Manualized treatment. In recent years the promotion of ESTs has correlated with an increased effort to produce manuals for treatment based on varying therapeutic approaches. These manuals, like technical instruction books, are constructed with a focus on a specific diagnosis or presenting problem, and present a set of techniques informed by a theoretical school that are presumed efficacious in the treatment of the disorder. The medical model continues its influence here in a logical progression, from the right treatment for the problem, to the right way to apply that treatment. The metaphor invites comparisons to programs of treatment and medications for specific physical diagnoses, recovery plans that partner with prescriptive approaches based on different illnesses, and so on. Critics of manualized treatment have argued that treatment manuals fit poorly with the reality encountered by everyday practitioners (Havik & VandenBos, 1996) or that they stifle practitioner innovation and creativity (Davison, 1998), while others have countered that while imperfect, manuals are helpful tools that are best applied with flexibility (Beutler, 2002) and modified by the complexity of the problems being presented by the client (Scaturo, 2001). Like treatment manuals, protocols developed by managed care organizations have been utilized increasingly in attempts to maximize benefits, minimize costs, and enhance effectiveness of treatment. As with empirically supported treatments, the assumption that technical applications account for the benefits of therapy underlies development and use of these protocols (Shueman & Troy, 1994).

Closely related to the discussion of specific ingredients above, treatment manuals and related protocols are driven by technical specificity of therapist interventions,

believed to be the primary ingredients responsible for change (Lambert & Ogles, 1988). One research study that surveyed practitioners found that attitudes about treatment manuals were widely varied, and that two general categories emerged including practitioners who were opposed to the manuals' effect on the process, and those who believed them to help ensure positive outcomes (Addis & Krasnow, 2000). Another study assessed the attitudes of cognitive-behavioral therapists toward manuals using a 58-item survey (Najavits, Weiss, Shaw, & Dierberger, 2000). The results showed a very positive response to manuals, that respondents had used them and found them helpful, and that the majority of respondents did not concur with critiques of manuals from the literature. The results were limited, however, by sampling only cognitive-behavioral therapists from a national conference, since the cognitive behavioral school is chief among those contributing to ESTs and utilizing manuals to practice and conduct research.

Prescription privileges. Another area within which the medical model has become especially influential is the ongoing movement toward prescription privileges for psychologists. This movement has been called the most controversial issue to face psychology in decades (Heiby, 2002). The literature reviewing the issues involved in such a move is characterized by a multiplicity of opinions and perspectives, and the ongoing debate is one that will likely continue to affect practitioners everywhere. Yet surprisingly, a search of the literature turns up nothing examining the implications for the specialty of counseling psychology. As with any debatable issue, the positions taken by psychologists represent a variety of stances, concerns, endorsements, and arguments. It is perhaps unfair to force a dichotomy here, but for the sake of review, the two general sides of the debate are summarized as they appear in the literature.

Proponents of prescription privileges (often written “RxP”) invite psychologists to consider the issues at hand carefully. DeLeon and Wiggins (1996) raised a commonly encountered argument when they contended that RxP is a logical outgrowth of the field that reflects the continual maturation of the profession. They suggest that there are several ways to attend to the difficulties posed by training demands and interprofessional relations. Additionally, they argue that this next frontier of psychology is one that will continue to enable practitioner to serve society, as has always been the goal. As such, psychologists need not be frightened by the difficult issues raised by RxP, but rather consider them carefully while moving toward a better system of mental health delivery (Pachman, 1996). Among the strongest arguments are those that contend psychologists will do a better job than general practitioners do prescribing psychotropic medications, and that the need for the expertise of psychologists is a needed addition to the psychopharmacological delivery system.

Opponents of RxP also argue the issue from a variety of positions. Sanua (1996) presented a view that adopting the medical model ideology by pursuing RxP is a mistake and moves the field further away from the already disregarded psychosocial foundations. Further, he suggested that the push for RxP for psychologists threatens the identity of the profession and the values on which it was constructed. DeNelsky (1996) listed among other concerns the negative impact on the way in which psychology is practiced, the influence on training and education of future psychologists, the impact on the marketing of psychological services, loss of hard-earned gains relative to other service-delivery professions, neglect of other important issues facing the field, and a shift to dual emphasis on medication and psychology. Hayes, Walser, and Bach (2002) pointed out

that the potential threat to the professional and scientific identity of psychology is an issue that appears to concern scientist-practitioners more so than basic scientists, as the former group has been the one to most resist RxP. Opposition to RxP is also based on predictions that psychology is simply following in the same steps psychiatry did a few decades ago, and that the prescription pad will become the therapy of choice (Hayes & Heiby, 1996). Albee (1998) suggested that the fight for prescription privileges is little more than psychology's desperate attempt to survive current changes within the healthcare industry, a position that is inescapable due to past and present embracing of the medical model.

Other scholars suggested that psychology must carefully explore the potential consequences of seeking prescription privileges. For example, Bush (2002) proposed that RxP may have adverse effects on the collaborative relationship between psychologists and physicians. The results of his small survey of practitioners suggested concerns about diminished referrals from physicians, and impaired communication and collaboration. Klein (1996) argued that recognizing the efficacy of medication is a welcome step for psychology, but presents concerns about the lack of national standards of training and education for psychologists and how that would impact any attempts at overall movement toward RxP.

Few empirical examinations of the RxP issue have been conducted, limited as suggested earlier by a lack of clarification of themes, and inability to get to the depth of philosophical underpinnings upon which issues such as this one rest. Richardson (1996) surveyed clinical and counseling psychology graduate students about their attitudes concerning RxP. The results showed little that was conclusive, other than that there was a

mild desire among the majority of respondents for RxP. Another study surveyed opinions from psychologists in Maryland, as well as compiling past opinion surveys (Sammons, Gorny, Zinner, & Allen, 2000). The authors concluded from the results that strong support for RxP and a consistently high endorsement level was apparent among their sample, and argued that moves toward such privileges were highly appropriate for the psychological field. Researchers in California surveyed 302 PhD and PsyD clinical psychology students and found that nearly 70% agreed that efforts should be undertaken to obtain RxP, while a similar majority considered it to be a natural step in the progression of the field (Tatman, Peters, Greene, & Bongar, 1997). Similarly, a study of psychology interns and directors of training found that 72% agreed that the APA should continue to support prescription privileges (Ax, Forbes, & Thompson, 1997). However, other studies have produced differing results. Boswell and Litwin (1992) found that only a quarter of their sample of 582 hospital-affiliated licensed psychologists agreed or strongly agreed that the APA should advocate for prescription privileges, while nearly half were opposed. In another study, results from 421 clinical psychology graduate students showed a variety of responses and generally indicated little to no consensus (Luscher, Corbin, Bernat, Calhoun, & McNair, 2002). Further, the results suggested that the most pertinent issue for all respondents was a consideration of the impact prescription privileges might have on the profession of psychology. The authors concluded that opponents and proponents both agreed that the issue was one that merited careful consideration.

Such discussions and empirical results as these show that opinions about prescription privileges are at best highly varied. The results also demonstrate that

unfortunately many in the field have yet to become familiar with the issues, think through the implications, and consider the debate on more than a casual level. Again, noticeably absent are any discussions in the literature relevant to the specific implications for the specialty of counseling psychology.

Contextual Factors

A number of contextual factors have contributed significantly to the medical influence in psychology. To some extent or another, these have been consistent themes even in times past and continue to be relevant today (Nye, 2003). These contextual factors offer some explanation as to why the medical model has the stature and impact that it does today.

Health care. One particularly burgeoning area of research and discussion is that which examines the integration of psychological services more fully into the overall health care system. Broskowski (1995) calls for psychologists to consider that the real opportunities of the future of service delivery will come within the broader context of general health care, and further discusses implications for training and practice of psychology. He argues strongly against brushing aside standardization of psychotherapeutic practices as “cookbook” psychology, instead calling for more profession-wide consensus about treatment that falls in line with the overall health care system. In discussing the implications for psychology training, Broskowski states the following:

More emphasis should be placed on models...that view anxiety, depression, and many forms of maladaptive behaviors as episodic conditions requiring brief

intervention and subsequent repeat interventions...much like primary care providers currently view the common cold and minor physical ailments. (p. 161)

The perspective adopted by Alcorn (1991) sees the alignment of counseling psychology and the healthcare industry to be a potentially positive one. He suggested that the goals of counseling psychology and those of the health field are well aligned, yet wonders about the lack of assertiveness by counseling psychologists within that field. Speaking to the adoption of certain models implicit in such an integrative alignment, Alcorn cautioned that in spite of its inherent weaknesses the medical model has done much good and has been of significant benefit to humankind. He also argues that the medical field itself—specifically the disease-health paradigm—is beginning to change, including moving away from strict organic causal models and treatment approaches, to prevention and health promotion, among others.

Managed care has played a major role in securing the medical metaphor's influence in counseling and psychotherapy today. Kiesler (2000) reviewed statistics showing that not only does managed care account for a majority of those insured, but of those 88% do not enjoy fully integrated mental health care services. He saw integration of mental health services with the larger health care system as a positive direction for the profession, and encouraged psychologists to mold research, training, and education to fit these coming changes. However, even in the medical field itself there are those who question the utility and examine the limitations of the medical model, and suggest alternative models for the medical field to employ (e.g., Larson, 1999; Sweeney & Kernick, 2002).

Desire to be science. Among the significant contextual factors influencing the medical model's adoption by psychology has been a desire for psychology to be seen as a science, equal in rigor and methodology to sciences such as physics, biology, and physiology. Speaking of psychology, Cohen (1993) stated, "The use of nosological classifications, esoteric terminology, and statistical procedures gives the appearance of objectivity, free of biases of culture or class" (p. 511). Laungani (2002) wrote that psychiatry also has felt this pull to be perceived as a legitimate profession among the other medical enterprises, a pull that certainly affects the entirety of applied human and social sciences. Others point out that in the struggle to convince other fields of psychology's legitimacy, the recent advancements in biological research are a welcome sight (Bailey, 2002). In this sense the desire to be seen as a science facilitates quick adoption of those models that are well received by the outside world. Bailey cautioned, however, against the possibility that "...in our haste to ease everyone's anxiety (and most of all our own), we have greatly oversimplified people's problems" (p. 46).

Duncan (2002) asserted that in spite of the directions counseling and psychotherapy are moving—those being specified treatments for specific disorders—the research does not support such a move. He argued, in fact, that the medical model itself is not the problem, but rather the privileging of the medical model even in the face of its inability in the research to show that specific treatment is responsible for change, that one treatment is better than another for a specific problem, or the model's inability to predict outcome by diagnosis or type of treatment, among others.

Certainty model. The medical model is also particularly alluring because it represents a universal, objective lens through which psychological problems are seen

with purported certainty. Perlman (1982) aptly states, “The appeal of the medical model then is, at least in part, that it provides a safe haven from the uncertainty that is the human condition” (p. 33). It clearly structures the relationship between patient or client and professional, and serves as protection from the unwanted anxiety, fear, responsibility, and freedom that accompany acknowledgment of such uncertainty. Additionally, the medical model provides an illusion of scientific certainty, aided by the use of clinical instruments, classifications, diagnostic labels and numbers, technical treatments, and so on. Only after these seemingly objective domains have been explored does a medical model allow for the ‘softer,’ more subjective attention to social, non-organic factors (Pardeck & Murphy, 1993).

Western culture. Among the most significant contextual factors that must be addressed when discussing the influence of the medical model in psychology is that of culture. Psychological healing practices are not only influenced by the culture of which they are part, but conversely they themselves influence the culture. Perhaps the medical model is so prevalent in society because the culture welcomes it, understands it, and believes in its rationale. Wampold (2001b) suggested that “healers would have a difficult time convincing patients of a practice that was inconsistent with current epistemological and meta-physical systems” (p. 70). For example, the reductionistic, deterministic ‘fix-it’ mentality of the West—as opposed to other cultures’ conceptions of health and suffering—is particularly influential in molding the practice of psychotherapy. The medical model is also consistent with a dualistic Western intellectual tradition (Pardeck & Murphy, 1993), and the model’s influence is prevalent in the media, psychopharmaceutical advertising campaigns, and public perception (Gussin & Raskin,

2000). Bailey (2002) points out that in spite of its flaws and limitations, the medical model itself has immensely helped in the effort to combat and remove the stigma of mental illness.

The relationship between culture and the medical field is a reciprocal one; both exert influence, and are influenced by, the other. Wampold (2001b) suggests that it would be virtually impossible to look back throughout the history of civilization and not find healers and medicine playing a central role. He further proposes that healing practices cannot accurately be understood as separate from the cultural context of which they are part. Such a relationship also exists between psychology and culture (Cushman, 1995). Although different perceptions surely exist on individual levels, it appears to be a safe generalization that at least within the Western, U.S. culture, the medical model of healing is socially accepted, and is endorsed by consumers as a reflection of the values of the culture of which they are part.

Language. One reason it may be so difficult for psychology to separate itself from some of the assumptions of a medical model is found in the language of our profession. The way we speak of things often reveals, if not implicitly influences, the underlying assumptions upon which our perspectives and profession rest. Words like *therapy* (meaning the treatment of illness or disability), *disorder*, *diagnosis*, *symptoms*, *treatment*, and *clinical* are medical terms and are adopted into the clinical practice of psychotherapy (Perlman, 1982; Wampold, Ahn, & Coleman, 2001). Further, psychology speaks of *syndromes*, *mental illness*, *mental patients*, *mental hospitals* and other terms that pervade the medical model of psychology (Kihlstrom, 2002). Even in this dissertation the impossibility of escaping these is evident.

Patton (1992) discussed the difficulty in clarifying what is meant by *help* in the description of psychology as a helping profession. He argued that in earlier years, psychology defined such as that which provides benefit to another. More recently, however--although a seemingly subtle distinction--‘help’ has come to be understood to mean ‘psychological treatment,’ or in some case has been altogether replaced by the latter. The distinction, he suggests, is one that places responsibility on an expert to bring about or produce change in another person, so as to align with what the expert views will be a more productive or acceptable result.

Economics. An equally large, if not larger, external factor is that of economics. Research, training, and service-delivery all represent endeavors with economic implications, whether in costs to the professional or to the public. Government funding, substantial support of the pharmaceutical industry, and third-party reimbursement from insurance companies are a few of these economic influences. Professionals are able to command higher fees by putting the conditions they treat on a level equal to other biomedical conditions, and in particular psychiatrists are able to see more patients in less time by prescribing medication instead of utilizing nonmedical approaches—an advantage psychology also wants for itself (Cohen, 1993; Laungani, 2002). Bailey (2002) likewise opined that with the big business of healthcare and specifically the financial backing of the pharmaceutical industry, “It is little wonder that the marketing of the chemical imbalance paradigm has raced ahead...” (p. 45).

Recent legislation has called for a priority ranking of diseases for the disbursement of available health care funding (Broskowski, 1995). Under such a system, diseases with serious consequences that also have demonstrably effective treatments are

given highest priority; those with little consensus or without known effective treatments are relegated to the bottom of the list. Further, even for known ‘effective’ treatments, proposed plans give preference to those deemed most cost-effective (Broskowski, 1995).

The health care marketplace is discussed as a chief contributor toward changing ideologies and goals by Patton (1992). He cited the struggle for economic parity that drives many of the decisions of the psychological profession, and cautions that striving for further economic benefit at the expense of other important considerations can and will be damaging to the profession. Among these are what he perceived to be a lack of long-term planning, collaboration among those in psychological and other roles, and the increasingly utilitarian nature of psychology.

These and other contextual factors contribute significantly to the medical influence in psychology. To understand the medical ideology’s influence, it is important to understand the cultural and contextual foundation upon which the profession is currently situated. This review of such factors then leads to the question of where Counseling Psychology has situated itself, and upon what values and assumptions it was founded.

Values of Counseling Psychology

The field of counseling psychology was formed upon foundations that differed in emphasis and philosophy from the then-prevailing models endorsed in fields such as psychiatry and clinical psychology. Important to its identity were ideals valuing development, education, client assets, prevention, and intervention. Gelso and Fretz (1992) summarized five unifying themes of counseling psychology and described them in terms of their contribution to forming the unique identity of the specialty as a whole.

First, counseling psychology focuses on clients functioning more within a ‘normal’ range, on persons with intact rather than more severely impaired personalities. Second, the discipline looks to place particular emphasis not on pathology per se, but on client strengths and assets, resulting in a positive focus for interventions that call actively upon the help seeker. Third, counseling psychology has relied on relatively brief interventions, especially as compared with then popular dynamic approaches that demanded high levels of client time and duration commitment. Fourth, the specialty has chosen to widen its focus from a narrow individualistic view to one more encompassing of social and environmental influence. Finally, the fifth unifying theme places important emphasis on the vocational and educational spheres of person functioning, areas considered by the founders of counseling psychology to have been neglected and ignored, but nonetheless crucial to understanding and aiding overall human functioning.

Counseling psychology has been defined as an approach that is defined by a relationship, which relationship holds the true power of the interventions and techniques applied in efforts to help and aid (Tyler, 1961). In this manner, the client is essentially an active partner, and thus the purpose of counseling is to facilitate personal growth and development by enabling and empowering the client to use his or her personal assets and resources (Tyler, 1961). Howard’s (1992) assessment of the values of counseling psychology found among the top fourteen such ideals as: respect for the individual; the importance of interpersonal relationships; a focus on growth and development rather than on pathology and remediation as preferred lenses for viewing problems; multiple ways of intervening; prevention; influence of the environment; and holistic approaches to mind-body-environment issues. Considering these and others’ writings of the values of

counseling psychology, a question remains about how the influence of the medical model on the practice of counseling fits or does not fit these, and what impact continuing to fall in line with medical ideologies might have on the counseling psychology specialty as it was and is currently known.

Wampold (2003) wrote of counseling psychology, "...We have roots in development rather than pathology, yet we hunger for parity with clinical psychology, adopt the language of medicine...desire prescription privileges, and envy those who bask in the scientific aura of the medical model" (p.542). Patton (1992) presented threats posed by the push for uniformity with the medical institution. He cautioned that counseling psychology, a distinct specialty with unique contributions, must address these threats as they may affect continued viability of the discipline. For example, he suggested that counseling psychology should hold fast to values that emphasize seeking to be of benefit to clients, rather than those that place priority on economic profit generation. Inherent in the move toward medicalization are challenges to the identity, and therefore viability, of counseling psychology itself (Patton, 1992). Part of the foundations upon which counseling psychology was built was the recognition of the importance of the resources and assets of the clients, of their strengths and areas from which they could aid themselves as part of successful counseling. Yet, as one author suggested, following the medical model toward full integration with the health care field implies a mistrust of clients' wisdom, resources, and ability to play an active role in their own treatment (Duncan, 2002).

In a discussion of the foundational counseling psychology model, developed at the Greyston Conference in 1964, Sprinthall (1990) lamented that the discipline has

turned its focus away from the original areas of distinction that made counseling psychology unique and provided the profession with a way to make valuable contributions to the psychology field in general. He noted that in spite of limited and problematic research support for the medical model, and increasing evidence of developmental and preventive models, counseling psychology appears to be headed toward the medical model and away from the foundations once idealized (Sprinthall, 1990). Concerns such as this one, published in *The Counseling Psychologist* in 1990, should surely have warranted some commentary and discussion, if not clarification of where the discipline was headed, but surprisingly little response to expressed concerns such as this one are evident in a search of the counseling psychology literature.

Summary

It becomes clearer, after the review presented here, that the opinion pieces and few descriptive studies are an important acknowledgment of the influence of the medical model in the field of psychology. These scholarly works are valuable in that they encourage critical examination of an important issue and give voice to alternative ways of conceptualizing counseling and therapy. However, they are limited by a lack of organization and disagree on salient themes. Also these studies at times lack richness and depth, instead preferring cursory statistical examinations of broadly measured opinions and attitudes. Lastly, such research and scholarly work is difficult for the field to acknowledge and address on any general level. There is little agreement, much debate, and specifically in the counseling psychology literature a disappointing dearth of discussion. This study was directed at meeting the apparent need for some organization of themes, some added richness and depth of exploration, and some investigation of what it

is that professionals in counseling psychology think and feel about the medical model. Therefore, this study employed a qualitative methodology to examine counseling psychology training directors' attitudes concerning the influence of the medical model in counseling and psychotherapy, and particularly as pertaining to the specialty of counseling psychology.

Method

This study employed a qualitative research strategy, based on transcribed interviews of participants, designed to access their views, perceptions, reactions, attitudes, opinions, thoughts, and experiences. In this method of study the researcher attempts to understand these aspects in depth and organize the rich information received in meaningful ways such that the research question(s) can be addressed. Denzin and Lincoln (1994) stated, "...Qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them" (p. 3).

Assumptions of Qualitative Research

A principal objective of this study was to gain insight into the deeper views and experiences of the participants. Qualitative research is a method, or collection of methods, that facilitates this end by allowing for a more in-depth examination than might be obtained through positivistic empirical methods. Especially relevant to the stated purpose of this study, a qualitative method aims to describe and understand the phenomenon under investigation in ways perhaps previously not understood by the researcher, participants, and readers (Kazdin, 1998).

Participants

The participants in this study were 14 training directors of Counseling Psychology Ph.D. training programs. These training directors are those that serve as program faculty leaders and should be differentiated from those that supervise and administrate in counseling centers. Additionally, only training directors from APA-accredited counseling psychology programs were invited to participate due to a desire to maintain some

uniformity and consistency among the interviewee pool. Training directors participating in this study represented all regions of the United States and Canada. Their age range was 37 to 62 years, with a mean of 48.1 years. Eight were male and six were female. The range of years they had served as training directors ranged from 1 to 15, with a mean of 4.1 years. Their programs were housed in a variety of departments and colleges including education, psychology, and human development. Participants were identified through use of a current list of program training directors, and a total of 70 were solicited by email contact. It was believed that training directors would provide rich information and articulate clearly their views on the influence of the medical model in the practice of counseling and psychotherapy. The operative assumption in selecting directors was that they possess knowledge and experience in both the academic and practice side of psychology, and that in their professional roles they have often encountered the various influences of the medical model—and that as leaders in the field they would have a perspective on and investment in the issue.

Kvale (1996) suggested that in theory, one should interview as many subjects as is necessary until the desired knowledge is fully obtained; he loosely quantified this, suggesting the number of interviews needed in qualitative designs tends to fall somewhere around 15 plus or minus 10. In the case of this particular study, a point of saturation and redundancy was reached at 14 interviews.

Procedure

After initial contact, those training directors that indicated a willingness to participate were provided ahead of time with information regarding the procedure and expected time length of the interview. Additionally, potential participants were informed

about the nature and purpose of the study, and helped to understand their part in the research. All interview responses were held confidential so as to protect the shared views of interviewees. Those that accepted were presented an opportunity to provide their informed consent to participate in the study.

Data Collection

A semistructured interview format was utilized to collect the data for this study. Appendix A contains a list of examples of questions that were used in the interviews. Each interview was conducted by the principal investigator, one-on-one over the telephone. Interviews were digitally recorded to facilitate subsequent transcription, analysis, and interpretation. The researcher utilized a general list of possibly relevant questions in order to ensure that the interviews reached their intended depth and that larger topic areas were not missed in the conversation. This guide did not, however, dictate the format or process of each interview; instead the researcher and interviewee interacted in a type of conversation similar to counseling, with the investigator using minimal encouragers, open-ended questions, and rephrasing as tools to help ensure as complete an understanding of the interviewees' perspectives as was possible (Kvale, 1996).

Each interview lasted between 30 and 45 minutes. Participants answered demographic questions, and interviews were preceded by a briefing and followed by a debriefing. The briefing served multiple purposes, including those of defining the situation for the interviewee, stating the purpose of the interview, obtaining consent to record, and addressing general questions. The debriefing allowed for discussion of any unresolved issues, provided opportunity for clarification, addressed any anxiety or

tension experienced, and provided the interviewee with a chance to provide feedback on the interview and research process (Kvale, 1996).

Interviews were conducted utilizing a variety of different types of questions. Kvale (1996) outlined eight main types of interview questions for use in semistructured interview situations. *Introducing questions* begin conversation of a topic by soliciting rich, spontaneous descriptions of the phenomenon. Building from these, *follow-up questions* extend given answers, and facilitate further exploration and elaboration. *Probing questions* ask for deeper description, further examples, and depth of content. Further operationalizing of responses is accomplished by use of *specifying questions*. *Direct questions* directly introduce topics or dimensions, and usually come after the interviewees have given their spontaneous responses and indicated what they believe to be the central aspects of the phenomenon. Conversely, *indirect questions* may query in a projective way about other people or objects outside the interviewee with respect to the same phenomenon. *Structuring questions* aid the flow of the interview. Lastly, *interpreting questions* attempt to clarify meaning, understanding of content, and the interviewee's interpretations. In addition to these, Kvale (1996) also includes *silence*—a non-question, but a critical part of the interview conversation nonetheless. He further suggests shorter questions and longer subject answers, and a continual process of the interviewer attempting to verify his or her interpretations of the interviewee's responses.

Data Analysis

Analysis of qualitative data is conducted with the primary intent of summarizing and bringing as much significant meaning as possible to the interviews experienced by the researcher and the interviewees. It is the bridge between the interview, where the

interviewees tell their initial stories, and the final story that the researcher communicates to an audience (Kvale, 1996). Interpretation is not a process that comes exclusively as a final step of the research, but is, to some degree, a part of the interview process itself as responses are interpreted and further questions formulated in turn (Seidman, 1998).

After the completion of the interviews the next step in the analysis was transcribing digital recordings of interviews. The subsequent steps in the analysis applied to the qualitative interview text gathered in this study were a synthesis of hermeneutic methods informed by Kvale (1996), designed to provide as meaningful an interpretation as possible of the different views shared. This use of multiple methods was reflective of the endeavor not to uncover objective reality but rather to achieve in-depth understanding of a phenomenon, and represented a strategy that added complexity, rigor, and richness to interpretation (Denzin & Lincoln, 1994). The basic components of this interpretive process were as follows:

1. An unfocused overview of the text. This was achieved through initial attempts to review the recorded interview material with as few presuppositions as possible, with the end goal of approximating closely the subjective intended meaning of the interviewee responses.
2. Successive readings of the material for further interpretations. This process was a spiral (Polkinghorne, 1984) and reflexive (Hoshmand, 1989) one in which the researcher worked to reveal deeper levels of meaning from the text of the interviews.
3. Finding language that accurately conveys the findings. At this point, the interpretations that were made were effectively communicated in such a manner

as to avoid losing any of the rich depth of meaning. Here the ultimate goal was precise description of the meaningful themes (Jackson & Scharman, 2002).

Along these lines, the analysis of the interview material was conducted in the following manner. First, the researcher broadly reviewed all of the transcripts to initially identify themes that stood out. This process consisted of a broad reading of the transcribed interviews and notation of salient meanings as they related to the questions of interest. As part of this clarification process, the researcher also attempted to make the transcript more amenable to analysis by removing superficial material (e.g., repetitions, transitions, tangential directions, and digressions). The emerging themes were recorded and condensed where appropriate to succinct statements. As themes re-appeared throughout, notations were made of their frequency and strength, so as to compare and draw out the most salient themes by the end of the analysis. As the themes emerged, the researcher continually returned to the interview data, re-evaluating throughout the entire analysis stage with repeated spirals of the hermeneutic circle. Themes that continued to be supported in further readings of the interviewees' responses were retained, while those that did not have broad support were removed. At this point in the analysis the dissertation advisor serving as auditor reviewed selected themes found in the initial phase, as well as the overall analysis process, for methodological soundness and validity. Together the faculty auditor and researcher continued by coming to a consensus about themes, and only those agreed upon by both were included in the final report. Additionally, to further ensure reliability of the qualitative analysis, participants were given the opportunity to review findings and comment on the accuracy and consistency of these with their own perspectives. Initially the researcher and auditor agreed to contact

three participants; following the audit check both agreed that contacting five would sufficiently meet the purpose of the reliability check. Five of the interviewees were emailed the emergent themes of the interview data and were asked to provide any feedback and corrections that might enhance reliability. Respondents indicated that the themes were consistent with and accurately represented their experience. Two of the respondents requested that divergent perspectives be included among the results.

Philosophical Assumptions

This type of analysis had underlying philosophical assumptions, as is the case with any attempt to conduct scientific research. Qualitative interpretation is difficult to define clearly as it has no distinct, singular foundational paradigm (Denzin & Lincoln, 1994). Differing from quantitative, empirically-driven research, qualitative research is characterized by more subjective, phenomenological, and relational elements. Qualitative researchers hope primarily to better understand the subject matter at hand (Denzin & Lincoln, 1994). Because of the subjective nature of this type of research, care was taken at all points in the procedure of the study to ensure accurate, meaningful communication of the significant themes reported by the interviewees, and to avoid simply verifying the interviewer's presuppositions (Gilbert, 2001). Also important in this type of research are the assumptions the instrument brings to bear upon the entire process. As such, it should be noted that the instrument in this research study—the interviewer—gave particular attention to his own biases, opinions, and assumptions throughout the process to prevent as much as possible 'tainting' of the interview data acquired. It is also important to note that without the person of the interviewer, including his views and perceptions, the interview would not be possible. Achieving a balance between allowing oneself to be part

of the interview process without overly influencing it is a key task of the qualitative researcher. In this study, the method used was purposefully selected from among the variety of qualitative methods available, due specifically to its suitability for the questions of interest.

Assumptions of Researcher

The assumptions of the interviewer and author of this study about the medical model are worthy of consideration. As my experience in the practice of counseling and psychotherapy has been limited to this point of my graduate education, I cannot claim to have dealt extensively with the influence of the medical model. Many of my own opinions have been formed through research, reading, and observation of the profession in general. However, they are far from complete and therefore are not cemented or believed to be wholly accurate. My bias in conducting the study was that the medical model's influence is pervasive and at some levels inescapable. I also perceived that although certain aspects of the medical model are less than desirable in psychology, others provide structure, means of communication, and some grounding where often none is available otherwise. It was also my assumption that I would find a variety of views on the medical model from counseling psychology training directors, particularly with respect to the specific areas of influence I have reviewed. In the diversity of responses I didn't expect to find entirely positive or negative reactions, but reasoned and integrated views that recognized the implications of the model for the practice of counseling and psychotherapy.

Results

Interviews were analyzed utilizing the process outlined in the above method section. The following seven themes emerged from the analysis of the interview data.

Theme 1: Psychology can't afford to be dogmatic or deny reality, yet must critically examine the influence of the medical model

The participants were asked questions addressing the influence of the medical model on the practice of psychology. Responses varied, at times widely, in general reaction to medical model influence, including strong positive as well as strong negative opinions. However, participants universally agreed and often spoke directly to the need for continued critical thinking and examination of the medical influence on the psychological profession. The reality of often pervasive medical influence was acknowledged, as was the need to know the language of the medical model. This was balanced by agreement that the medical model should not be the sole ideology driving practice and research. Respondents talked about the need for Counseling Psychology to maintain an independent perspective. Participants shared the following views, illustrating this broadly supported theme:

Participant B: We can't ignore the world that's around us... But at the same time I think—and this is where the difficulty is—I think we can't be just driven by the medical model. I think that's what I think is happening. I think we get driven so that everything becomes in that frame; the interventions we teach, the kind of supervision we do, the focus in the research...so that our viability as a unique profession within psychology—Counseling Psychology—becomes less clear.

Participant L: Since it is kind of such a dominant model I think you need to know it. That doesn't necessarily mean you need to like it.... Or stop being involved in the process in terms of offering alternate views to that system. Because who knows what the future is going to bring.... It's the kind of thing that I would hope Counseling Psych stays fully informed about, and yet is always there as this other voice. Saying, here are the strengths and weaknesses of the system, and it really doesn't address this, this, this, and this.

Participant H: I think it's really important that we're aware of it, that we understand it, that we have experience with the medical model, but I think it's critical for us to remain independent thinkers, to advocate for positions in opposition of that model when it helps our clients or our patients.

Participant C: Our training interacts with the medical model in some way, regardless of whether we want it to or not. I do think that Counseling Psychologists should have a clear understanding about what is the medical model, have a clear understanding about how the medical model is or is not practiced within our discipline and in our training programs. And how is it that we can critically think about aspects of the medical model that are helpful to us and aspects that are inconsistent to our particular mission.

Participant M: I think it is a relevant topic for discussion, because other people that hold money think that it is. And we will need, and our students will need to operate in that kind of an environment.

Participants also reported that psychology needs a balanced perspective on, and cannot afford to be dogmatically rigid about, the medical model influence. Such rigidity was believed to mesh poorly with lived experience and the constraints of practical and economic realities.

Participant H: I think that for one thing we lose legitimacy as a profession when we start spouting too much about the negative aspects of all that medical stuff, and how conforming to it is somehow degrading to people.... I mean, the truth of the matter is, if people want to not engage at all in anything related to the medical model, then they should work at Starbucks because that's where they're going to end up working.

Participant G: I think years of practice have allowed me to soften my opinion, that we don't want to just reject everything about the medical model outright

Participant D: I think the medical model is not without its utility. I think the problem we get into is too much dogma in our field. I'm [age], I've been in this field for 25 years. We don't have the luxury of being so dogmatic when people's

mental health is at stake. And I think we need a balanced view of the medical model.

Participant E: The managed care that I deal with, you have to prove “medical necessity.” That’s what they call it. It means deficits in functioning. And people come in feeling very anxiety-ridden and depressed about their vocational situation or their marriage or whatever, but they don’t meet DSM criteria—is that a medical necessity or not? Some psychologists just say, “I don’t see what I’m doing as medical and so I’m not gonna be involved in that.” But I think that the public expects it, and the profession is deeply entrenched in it, and it’s not likely to change.

Theme 2: Counseling Psychology has a lot to offer—so get in the game

The participants spoke, often with notable passion, about what Counseling Psychology has to contribute to the broad contexts of healthcare and mental health services. They shared opinions about the impact that can be had when Counseling Psychology brings its unique values and contributions to the medical arena, rather than sitting on the side and complaining. Many shared dissatisfaction with a perceived tendency to talk often about things like medical model influence, but to have little action to show for so much reaction. The following participant comments illustrate this theme:

Participant M: I do believe that although we’re relatively small, that the quality of the people that are involved with Counseling Psych is really quite high.... I think

we've got some angles that we can probably exploit a bit more than we have, and my hunch would be that the community—the broader treatment-oriented community—would have some receptive ears to that, or to those ideas.

Participant K: I think psychology needs to organize and influence the healthcare system.... And I think we need to be in there as players. One thing that has frustrated me about psychology as a whole, and certainly about Counseling Psychology within psychology, is how we moan about problems with the system, but we're not involved and we just moan about it after the fact....I think particularly Counseling Psych has a lot to contribute. And I think where we really can contribute is in terms of wellness, in terms of prevention. I mean, that's our tradition. And it's something that's sorely needed within the healthcare system.

Participant F: So I think what we're doing in Counseling Psychology is really important. I mean we are looking at multicultural issues; we're looking now at social justice issues, which I think is so wonderful. And I think if we can keep trying to spread the word, I think we can have an impact. I think it takes a lot of courage for practitioners to hold that line because the medical model is so strong out there. But I'd like to see us keep trying.

Participant D: I think Counseling Psychology is an enormously important field. I'm incredibly proud of being a Counseling Psychologist. I think we've led the way on a lot of things that have now become mainstream....I think that the focus

on positive aspects of people's lives, on health, on fostering positive development is really something that psychology can add to the mental health community. And I think that we need not lose that.

Participant C: I think that our values are of respect for diversity, are values for positive well-being and how we can promote healthy, normal adjustment in people, a value of looking at contextual factors. ... Those are not included within the medical model. And I feel that that is a unique contribution of counseling psychology that I would hate to lose, something that psychiatrists and clinical psychologists do not necessarily have.

Participant A: So I think we're actually ahead of the game, if we don't get distracted and if we actually work to validate what that perspective can provide the field. If we don't try to be little physicians, and if we impact the third-party payers and those who fund treatment to recognize what effective treatment is or even what effective prevention is, and how cost effective that can be, then I think it could bring about a change; because I think the medical model is collapsing under its own weight.

Theme 3: The tension between medical model influence and the values of Counseling Psychology has increased

At several points throughout the interviews, respondents directly cited, or indirectly alluded to, what seemed to be a perceived shift over time of the values of

Counseling Psychology. They highlighted the impact of medical influence and economic factors, and talked about a notable difference between the state of the profession at present and what once was, decades ago. Some spoke about their training in Counseling Psychology and how it was more strongly oriented in opposition of medical influence than perhaps in today's training. Others referenced "historical roots" when talking about Counseling Psychology and points of tension with the medical ideology. The following participant statements illustrate this theme:

Participant B: Counseling Psychology has over a 50 year long history of really developing those kinds of things. And I see now the pressure—the pressures through managed health care and other things, such as empirically supported treatments, etc.—to push us more, to push us away from that; and there is a greater similarity now between clinical and counseling psychology than I thought there was 25 years ago or so.

Participant M: I think historically what we have been about is aiding people in going through normal, developmental, or otherwise adjustment-related challenges that they encounter.... So that's been I think a point of tension, and probably more so these days than historically.

Participant J: I'm not sure there's that consensus [in Counseling Psychology] that there was maybe 20 years ago.

Participant D: Well, I think that actually psychology has embraced the medical model for the most part, with some voices not embracing it. But in embracing it, we have adopted a whole language—a set of ideas, a set of concepts, that practitioners feel compelled to use....And I think Counseling Psychology naively went along with this medical model approach and passed up on a lot of its strengths.

Participant N: I think that's going to be the biggest change over the next 10-15 years in psychology. In terms of the practice I think we're eventually going to move away from what we do now and more towards psychiatry. I think, by the time I retire, I think prescription privileges are going to be in most of the states. And I think we're going to rely on it too much, and I think we'll rely on medicine too much, and I think we're going to be more money driven than therapeutically driven... I'm glad I'll be retired when that happens. Because quite frankly I see it as sad.

Theme 4: The medical influence on research is a two-edged sword—we need to think complexly about our science

Interview questions assessing opinions about Empirically Supported Treatments (ESTs), Evidence-Based Practice, and other psychological research produced a general theme of caution about the way the medical model influences research on practice, outcomes, and treatment. Participants desired to see treatment research become more broad, more practically applicable, and allow for greater complexity. Participants also

cited concerns about cultural diversity and individual differences that may not be adequately addressed in treatment research. Many expressed the view that research on treatment is important, and even necessary, but not sufficient. Participants also expressed concerns about the ways in which research on practice could be misused or misapplied. The following statements illustrate this theme:

Participant C: I think—about empirically supported treatments—I think that it's been influenced by the medical model because of the emphasis on psychopathology and its de-emphasis on the importance of increasing positive well-being....We do need some empirical data to support the interventions that we're doing. But we need to think about these complexly.

Participant N: I think the treatments that they're coming up with, the validated treatment stuff, right now they're under very tight conditions. I think you could broaden them out. My concern isn't necessarily about the treatments as much as it is about the people using them. I think that because of insurance companies...or whatever kind of external influences there are, that people are just going to follow the model without looking at the individual. And I'm a firm believer that people are going to be much more complex, I think we're going to find, than what a lot of these treatments are coming up with.

Participant M: You know if we say that this person because of their diagnosis needs to be treated in this particular way, I think what we might end up doing is

constraining the therapist....I think we kind of miss the mark if we take this purist, medical model approach and try to make it fit within what goes into a psychotherapeutic encounter.

Participant D: It's very, very complicated as you know; hotly debated. I think a case could be made for empirically supported treatments in some conditions, and a case could be made for allowing greater creativity. I think that the nature of the empirical support is what's really fundamental. Are we going to discount 70 years of Rogerian therapy, or Psychodynamically-oriented therapy because it doesn't have a rigorous treatment manual? I would say no.... And you know, I've been very impressed with some of the empirically supported treatments. I think as they expand epistemology I think they could be very effective.

Participant A: Science needs to enter in there, but it can't be naïve science. And the empirically validated stuff—I think it was a good start, it was an important thing to do, but I think now where we are, I'm not sure that I'm all that invested in it. I like the evidence-based approach a bit more; the danger with that tends to be that anything can count for evidence. And if we go that route, then we're just playing another game.

Participant K: I think evidence-based practice is another one of those that if we don't get involved, it's going forward. This train has already left the station. So if we don't get involved in evidence-based practice, we're just going to have to live

with whatever decisions they make.... And so I think this is an opportunity for our profession to step up instead of just complaining and putting our heads in the sand, and then having to live with whatever is decided.

Theme 5: Medical model focus on pathology is reductionistic and restrictive

The first question asked in each interview sought broad, initial reactions to and opinions about medical model influence on the practice of psychology. Nearly all respondents first mentioned areas of diagnosis and pathology and talked about implications of these. A common theme emerged in the form of disdain for pathologizing people, for reducing human beings to a label and focusing on pathology at the expense of the whole person. This theme was broadly supported regardless of whether the participant had a positive, neutral, or negative overall reaction to the medical model. The following statements represent that theme:

Participant A: You know, once you can label something then we maybe feel more comfortable with it. But I'm not sure it really helps the outcomes a whole hell of a lot. You know, it's a complicated and complex world, and simplifying it is not always a positive thing to pursue.

Participant F: Instead of seeing people in a positive light and working with them towards growth, you're working to cure something that is wrong with them. And of course managed care and the need for evidence-based treatments is driving it a lot.... Rather than pathologizing [people] I really prefer to take a stance that's

more growth-oriented, and working with people to develop different coping strategies. The medical model is just completely opposite that kind of approach.

Participant E: [The medical model] is constricting. It kind of pigeon-holes people, and it's subject to confirmatory bias, and it focuses on deficits rather than on strengths.... It also forces public opinion to focus on symptomatic issues and to expect the same kind of outcomes as you do for medical treatment, when in reality most people go to therapy for problems of living.

Participant I: I think one disadvantage that I see in students that we're training is because they have a diagnostic understanding of a person they feel like they know more than they do. They see it as an endpoint. And I see it as a beginning point. And it's an "A-ha! Detective, I've found it, and here it is: we have an Anxiety Disorder, Not Otherwise Specified." Great. It's like, alright, now what are you going to do with it? And how does that apply to this person?

Participant M: There's an assumption that there are these accurate categories within which we can place people; and I don't think the research backs that up. I don't think the research has been done across the, whatever it is now, four- to five-hundred different kinds of mental disorders that can be diagnosed. I don't think we've got a body of literature that supports that those categories are in fact true representations of a latent, diagnosable category.

Participant D: My son went to [hospital name], outpatient, just to see people in the day program. The first hour he met the psychologist, the psychologist told him he had a personality disorder. And my son said, “I don’t think my mom’s gonna like the fact that you diagnosed me after one hour.” I mean, he knew enough to say that. And this psychologist, who I’ve never met, said, “Oh you could bring your mother in here, I’ll go through the DSM with her point by point. She won’t be able to refute it.” Can you imagine how hurt I was, and angry?

Theme 6: Preparing students for the “real world” medical influence on practice while trying to teach values of Counseling Psychology is at times a balancing act

Another broad theme that emerged in the analysis was that of the medical model’s influence and impact on training. This was seen as present in a variety of forms, from having to include DSM and Psychopathology courses in training curricula, to the need to prepare students to be conversant in medical language and capable of adapting to a variety of possible professional settings. Participants cited points of tension that arise in accomplishing training in Counseling Psychology while attempting to provide broad preparation and addressing real world pragmatic issues. Many respondents spoke about opportunity costs involved with incorporating training elements at the expense of other areas of importance to Counseling Psychology. The following participant comments illustrate this theme:

Participant D: We’re a counseling program, and as a counseling program we have less of a focus on psychopathology than would a clinical program.... So one of

the problems is that our students need to really know the medical model, but yet we critique it very strongly. For a less sophisticated student it's very complicated and difficult to deal with that.

Participant L: You have a limited amount of time to do supervision, and so you have to weigh what you're going to spend that time on. I know that I deliberately choose many times not to over-focus on the diagnosis. It's like, "Give it your best shot, we'll maybe talk about it a little bit and if it's not quite right I might make some suggestions." But I'm not going to spend a whole lot of time on it, because it really does take away from them learning good counseling skills.

Participant F: I teach our doctoral practicum, I teach my students their Foundations of Counseling Psych course. And I watch as they get confronted with medical model stuff.... There's a lot of pathologizing that goes on. And of course once they get out into field pracs... they're really being pulled in the direction of thinking and talking more clinically. So I think we teach them core stuff, but we maybe don't reinforce it when it gets to the practice level enough.... In Counseling Psych programs I think that we are actually teaching the words about our philosophy, but I don't know that we're backing it up when our students get into practice.

Participant C: The types of practicum sites or applied sites that our students receive training from often adopt a medical model. So if we aren't clear about

what it is—how it influences our training, what we need to do to prepare students to either fit within a medical model, or to challenge the medical model, or to adjust it—I think that that would be a disservice.

Participant A: I think we actually have to strike a balance. Students have to be aware of the DSM and be conversant in it. They need to be aware of psychopathology and how it's operationalized—at least in the medical community, psychiatric community, and all too often, the psychological community. So they need to be able to think in those terms, communicate in those terms, accurately diagnose within that system.

Participant N: I think that students become confused, too, because of where the field is, because I think we're kind of confused. I think, for example, you've got some faculty who are much more linearly based, and more empirical support based. And you've got others who don't necessarily like to train people in one or two main theories. And so I think the students leave, and can leave—not all of them—but I think some of them do leave without a firm root in either direction.

Theme 7: Cautious about Prescription Privilege: Are we trying to be physicians or psychologists?

Participant attitudes varied widely in response to questions about psychology's pursuit of prescription privileges. Respondents cited a number of different factors and issues to consider, including training, economics, need for services, and impact on the

role of psychologists. Emerging from among the array of opinions was an attitude of cautiousness, and some concern about how obtaining prescription privileges might distort or muddy the role that psychologists currently have in the broader healthcare context. Concerns about this impact did not necessarily equate to an overall unfavorable opinion of prescription privilege, but were expressed by those strongly in favor and those strongly against alike. The following statements illustrate this theme:

Participant K: [Prescription privilege] has been one that I've been opposed to, which is surprising because you'd think I'd be right on board. I think that is probably the more dangerous to our profession in terms of muddying who we are, and really distorting the role of psychology in the mental healthcare system.

Participant I: I think that it dilutes what we do as psychologists. I don't think we should try to be everything to everybody. I think that this is a good example of where we should draw the line and say that this isn't an area where we're going to try to establish some turf for ourselves. On the other hand I think there's a place in the rural communities and underserved populations for being open to different models. But I think psychology in general and APA is ill-advised to move in that direction.

Participant F: I think there's some dangers. Because I think it further medicalizes our thinking. I think there are psychologists who would just kinda go that route and forget about psychotherapy.... It would be convenient for the client; it would

be less expensive for the client to get their meds at a therapy session and stuff like that. I think there's advantages. But I think it also is seductive, for people to start thinking of themselves like doctors.

Participant D: I'm ambivalent about it. I think it should be an option for some psychologists who want it as a post-doc training experience. I don't think it should be for all pre-doc psychologists because I don't think every psychologist wants to do prescription.... A lot of psychologists may have wanted to be doctors; I was one of them actually. It's probably an interesting study to do—how many people who, in psychology, really wanted to be physicians and couldn't hack Organic Chem.

Participant J: I think if we go with prescription privileges, then like I said it requires a different body of knowledge than most Counseling Psychology programs are providing at this time. I think if that comes to be, then we're going to lose more of our foundation. I think what will happen is, that training component will come in and take over other aspects in our training programs.

Participant A: You know, we've got—again, personal opinion—too many psychologists who maybe wanted to go to medical school instead of graduate school in psychology and they want to be little doctors.... I don't think people really have enough time and are able to keep up with what we know about psychology. And what we know about contextual influences, what does and

doesn't work from a counseling or psychotherapeutic perspective, and then to go on and try to be physicians and really try to play at that medical model, I think it's just misguided. And I think that reliance on the medical model makes that a fairly easy transition for some folks.

Participants also wondered about the motivations for pursuing the ability to prescribe medications. While they were aware of, and in some cases strongly in favor of certain arguments for prescription privilege—such as the growing need in rural or underserved areas, the ability to do a better job at prescription than some medical doctors, and the ability to provide services more efficiently—respondents also expressed the view that the appeal of economic gain might also be a significant factor.

Participant N: I think clinicians are going to—I think their heart is in the right place when it comes to medication—but I think what they're going to start doing is just start moving to the money.

Participant M: I think there are people in the medical community that just frankly don't want a piece of their pie cut into, and people in the psychological community that frankly want to cut into a piece of the prescription pie. And it's a big old fat pie of cash. I can see a lot of incentive for wanting to hang onto it, and a lot of incentive for wanting to get into it.

Participant L: I mean, the argument seems to be, gosh, we've got these people and they can't be served, there aren't enough psychiatrists to go around. And that may be true. But in the back of my mind I still think it's probably an economic move. That isn't necessarily bad, but I've just...if I wanted to prescribe, I would've gone into medicine.

Participant N: What's going to happen, then, is it's going to create a dual system. And that dual system is going to be those that get the training and those who don't, and if you're a client, who are you going to go to first? So everybody's going to either have to get the training, or everybody's going to have to not get the training and live with a 2-tier system somehow. Which is what we have now, we have psychiatry and psychology. But the psychiatry makes the money, and the ones in psychology with prescription privileges are going to be the ones that make the money.

Discussion

The range of attitudes, views, and opinions obtained from participants indicated the complexity and expansiveness of the topic of medical model influence in psychology. Initially apparent in the analysis was a bell-curve phenomenon of sorts, where opinions varied about medical influence: some were strong advocates for embracing medical model influence, while others were strongly in opposition to or favored rejecting the medical ideology in psychology. Most of the respondents appeared to be somewhere in the middle of these. Despite this breadth of opinions, several themes surfaced that were broadly supported by participants, and that appeared regardless of contrasting or differing viewpoints on more specific aspects of the medical model. It is important to note that participants themselves exhibited the same behavior for which they advocated in the first theme: they demonstrated critical thinking, careful examination, and a willingness to grapple with what is an inherently complex matter. As such, the interviews were not characterized by simplistic medical model bashing, but instead revealed professionals who were passionate yet realistic, whose views were largely characterized by balance, and whose opinions have been shaped by years of experience in research, training, and practice. Participants also discussed medical model impact not only in terms of the general profession of psychology but also as specifically relevant to Counseling Psychology.

Regardless of their overall opinion, respondents uniformly expressed a disdain for some implications of applying a medical model to practice. However, the participants also identified and spoke about positive influences of the medical model. For example, some referred to the benefit of having a common language across treatment contexts;

others spoke about the impetus to show positive outcomes for therapy as a result of the push for accountability; and many indicated that in some form or another, the medical ideology has allowed for psychology to have greater interface with the public.

This generally balanced view of the medical model that emerged in the analysis contrasted at times with the statements of individual respondents, some of whom expressed a perception that Counseling Psychology generally has a harshly critical view of the medical model. Some participants expressed frustration with Counseling Psychology's rigid adherence to its values in the face of conflicting realities, while others surmised that their own opinions might be more moderate and balanced than would be found among other Counseling Psychology training directors. However, at least in this particular set of interview data, that perception did not appear to hold true. Such a contradiction may be indicative of uncertainty about just what is the overall attitude, or 'feel' among Counseling Psychologists regarding the medical model. Or perhaps it implies that many in Counseling Psychology feel that others have a much harsher view of the medical model than do they, when in fact that perception may be more of a group artifact—complicated by varying reactions to specific aspects of medical influence. This apparent contradiction of perceptions within Counseling Psychology is seen elsewhere as well. In a fairly recent volume of *The Counseling Psychologist*, one author posited that counseling psychology generally “eschew[s]” (p. 498) and feels “disdain” (p. 499) for the medical model (Chwalisz, 2003), while in the pages of the same publication another author suggested rather that Counseling Psychology is “ambivalent” (p. 542) or only concerned about the medical model's appropriateness (Wampold, 2003).

The first theme that emerged reflected a view that psychology (generally) and Counseling Psychology in particular need to maintain an independent perspective in the broader medical context, and continue to evaluate with a critical eye those aspects of the medical model that are particularly impactful, in positive or negative ways. Respondents spoke strongly at times, and sarcastically at others, about a tendency of some in psychology to be dogmatic and ideologically rigid about the medical ideology and its influence on practice, and suggested that such an attitude causes more problems than it solves. This is not to say that respondents didn't have clear views about negative implications of the medical influence, nor that they advocated for mindless accommodation; but rather suggests that they preferred a position of balance wherein critical examination meshes with practical constraints..

Respondents also agreed that it is important for Counseling Psychology to think about, reflect on, and talk about medical model influence. But again, some were quick to point out that such talk is not by itself enough (see theme 2). Many participants insisted that it would be a disservice to students in Counseling Psychology if the medical model were completely ignored or summarily dismissed. The phrase, "need to know it" and similar such phrases were found often in the interview data. Similarly, respondents often referred to a softening of views that comes with experience in the field. Respondents highlighted the importance of challenging medical influence where necessary, without denying the fact that psychology interacts with the medical model—regardless of whether or not it would be preferable to do so.

The second theme follows almost as a direct implication of the first—that rather than complaining about the medical model, Counseling Psychology needs to recognize

the impact that it can have and take that influence to the broader medical and mental health paradigms. An implication seemed to be that all talk and no action does not accomplish much. Some participants were notably more passionate about this potential for influence than were others; however, all interviewees indicated a desire to see Counseling Psychology continue to work at making an impact, and to infuse values for education, development, cultural differences, prevention, focus on strengths, treating the whole person, and more into the broader, general field. Respondents indicated also that psychology as a whole has a lot to offer the healthcare context, mental health system, and broad medical field.

Related to this theme, when participants talked about the impact that Counseling Psychology can have, many of them made mention of Bruce Wampold and his work in this area (e.g., Wampold, 2001a). Those who mentioned Wampold's work praised his contribution and held it out as an example of ways that Counseling Psychology can have an impact. Others referred to the number of Counseling Psychologists in the leadership of APA and indicated a belief that the quality of people involved in Counseling Psychology is very high. Also of interest, some expressed disappointment over things that are happening currently in the healthcare and mental health arenas that are seen as new and contemporary when in fact Counseling Psychology has advocated for the same since its inception. For example, several interviewees mentioned the recent growth of Positive Psychology as evidence of a need for Counseling Psychology to be more vocal.

Participants referred often to a perceived change in the views on medical model influence, particularly in Counseling Psychology. This third theme appeared to be the product of some reflection by interviewees about their own background and training, as

well as their knowledge of the historical roots of Counseling Psychology, combined with their awareness of some changes and shifts in attitudes represented in present day. A few participants expressed concerns about the impact the medical influence continues to have, while others advocated for positions of flexibility and openness to change. Many cited economic impact as a key force in this change.

Several references were made to historical roots of Counseling Psychology as though the ideas of the past are no longer as prevalent or strong at present, and respondents expressed a view that tension between medical influence and traditional values of Counseling Psychology has increased not because of more rigidity but in fact because of more practical concerns and perhaps less ability to simply ignore medical influence as may have been possible several decades previous. Some indicated that this is a result of consistent pressure from the medical model influence to push away from traditional Counseling values toward more of a medical focus. Current professional dialogue on this matter reflects the theme found in this study. In a recent special issue of *The Counseling Psychologist*, Smith (2006b) suggested that Counseling Psychology has not backed up the rhetoric about the medical model and deficit focus with research and action. She suggests that the discipline “has ‘hooked its star’ almost exclusively on multiculturalism” (p. 141), in recent years, meanwhile more steadily accepting the medical model and disregarding the strength-based focus that was a root of Counseling Psychology.

Respondents also spoke not just about past trends but about future ones as well; some expressed fears and concerns, many saw opportunities for positive change, and

others commented about the difficulty of predicting where Counseling Psychology specifically, and psychology generally, might be heading in the next 10-20 years.

The fourth theme addressed participants' general opinions about empirical support, research on the practice of psychology, and impact on treatment approaches. Few mentioned manualized treatment but all addressed empirical support in some fashion. Generally, reactions to increased accountability and efforts to provide a scientific basis for psychotherapy treatment were favorable, with some more or less in favor of the recent movements in psychology. However, respondents also expressed the view that such science can't be naïve or simplistic, due to the complexity of the subject matter.

Participants expressed concerns about the restrictiveness and pathology focus of the Empirically Supported Treatment movement, and expressed opinions that often such research efforts miss what is actually helpful about the therapeutic encounter. Many were pleased with the direction being pursued at present (Evidence-Based Practice), in that this area appears to be one of broadening, rather than further narrowing. This perception fits with the intent of EBP to move beyond the oft-debated restrictiveness of ESTs (e.g., Messer, 2004). However, even with recent positive developments, participants were generally cautious about the medical influence on psychology research and offered opinions about not just the tools (treatments) themselves, but also about how they are used, and by whom, and for what reasons. For example, some expressed concerns about insurance companies and policy makers, others expressed caution about the rigidity of treatment protocols and the appeal of complexity management, and others cited a disconnect between the ivory tower feel of empirically supported treatments versus what happens in the real world with clients who are complex human beings.

Despite the variety of views and opinions offered, the fifth theme of hesitance about and disdain for pathologizing people was broadly supported. Those who were more in favor of medical model influence referred to this as one of the bigger pitfalls of a traditional medical approach, while those who were strongly against the medical model cited it often as the chief reason for their adoption of the attitudes they held. Also of note, “diagnosis” and “pathology,” or variants of these words, were by far the most common and consistent among initial reactions to the medical model at the beginning of each interview. Respondents expressed concerns about medical influence shaping a view of people toward a negative, problem-focused, illness mentality that in turn impacts practice. Some saw the areas of DSM diagnosis and focus on pathology as the area of most significant disconnect between Counseling Psychology and the medical model, and indicated that this problematic area also underlies many other points of tension with the medical ideology. However, participants also talked about having to teach courses in psychopathology, needing to train students in DSM terminology, and in general about the need at times to be conversant in those areas in order to be an effective practitioner in today’s world.

The sixth theme related to the points of tension caused by friction between medical model influence and Counseling Psychology training. Participants agreed that the impact on training comes largely from having to prepare students to enter the larger professional field where they might encounter a variety of models, approaches, and influences. Some expressed concern that it takes a sophisticated student to be able to accommodate, for example, the critiques of the medical model they get in a theory class concurrent with a required course in DSM diagnosis.

A few of the respondents spoke to the difficulty of infusing values of Counseling Psychology that take hold beyond just the academic training institution and follow a student out into practice. Respondents also spoke about having limited time in supervision and clinical training and having to balance a focus on such things as basic counseling skills and relationship formation with attention to the details of proper diagnosis, treatment planning, and other more medically-influenced elements of practice. Some indicated that an unfortunate result of this point of tension is that at times students can become so preoccupied with looking for and identifying symptoms, checking DSM criteria, and implementing a matching treatment that they miss developmental factors, client strengths, or factors related to cultural diversity.

The seventh and final theme, of cautiousness about acquiring prescription privilege and the impact on the role of psychologists, was based on considerable attention paid to the topic by respondents. One interesting finding was that there appeared to be no predictor of whether or not a person might be in favor of or against RxP. For example, two of the respondents who were most strongly for and against the medical model, broadly speaking, were also most strongly in opposition to and in favor of RxP, respectively. A few respondents made comments like “you wouldn’t expect that from me” or “you might find that surprising” in explaining their stance on RxP.

While attitudes varied about prescription privilege, almost all the participants expressed opinions about the possible negative impact on training and indicated a desire to keep pharmacological training out of predoctoral curricula. Also of note, several participants talked about the potential distortion of the role of a psychologist that might come with also taking on the role of a medical doctor. A general view that seemed to be

expressed was the caution that psychologists can't be everything to everybody.

Additionally, many of the participants wondered about the motivations for pursuing RxP; they expressed awareness of arguments in favor of doing so (and in some cases expressed those arguments themselves), but also indicated that for some the motivations might be mostly economic. Reactions to this economic motivating factor, when it was discussed, were mixed.

A few other findings of interest came to light during the analysis of the interview data that were not included among the broad themes but merit some discussion. One of these was a tendency by interviewees to qualify or excuse views expressed as “just an opinion.” Considering that the interview was conducted expressly with the purpose of gathering opinions and attitudes, the tentativeness expressed about certain opinions that occurred in several interviews was a somewhat puzzling phenomenon. Part of it may have been due to the complexity of the issue, with compelling arguments available for or against aspects of medical model influence. Phrases such as, “On the other hand,” “At the same time,” and “However” were observed quite frequently in the interviews, often as participants thought out loud and attempted to address all sides of an issue or communicate a variety of viewpoints. At other times, though, participants seemed nervous about whether or not their opinion might be representative of their department or profession (“That may well be a minority opinion,” “They're my opinions, I don't know how well they represent the field or not, they're just my opinions.”); or unsure about whether they knew enough to even offer an opinion, and seemingly apologetic for the impact their opinion might have (“That's my own personal view, I hope I didn't offend you,” “I hope you have other cynical people or hope I'm not the only one.”).

Another finding of interest was a thread woven throughout many of the points of discussion and included amongst many of the themes. Participants referred often to multicultural factors, individual differences, and the general absence of cultural considerations in the medical model. Many also cited among the unique contributions that Counseling Psychology can make to the broader medical field that of valuing diversity and endeavoring to understand and account for cultural influences. Participants made references to Western culture when discussing the expectations that the public and clients may have. They expressed the view that often people in a Western culture are looking for a quick fix or a metaphorical pill that they can take to rid themselves of distress, and that such a view has been influenced and shaped by the medical ideology. While the multicultural thread was not identified as a theme per se, it was clearly evident as a filter or lens broadly considered by participants in their discussion of the medical model's various points of impact. The following statements exemplify that thread:

Participant L: A lot of the medical stuff doesn't even really consider any of the multicultural stuff. So I think that's a legitimate criticism, and one that just gets glossed over.

Participant D: I think that the medical model really fits within Western, European and North American cultures, and it doesn't fit so well into more collectivist cultures, where there are different forms of healing. So I think that certainly with the diversity of our population, I think the medical model will be increasingly questioned within psychotherapy.

Participant C: I think it's pretty presumptuous that only people who represent Western views are the ones identifying what these disorders are and how they manifest themselves, and then saying that they apply to other regions of the world.

Another thread intertwined throughout many of the themes was that of economic influence. Participants referred often to the power that money wields, to the impact of economic forces when discussing medical model influence in psychology. Many commented about how huge a role economic factors play in, for example, pressures to diagnose and apply empirically supported treatments, finding funding for research, the pursuit of prescription privilege, the impact of the psychopharmaceutical industry, and the burden to show cost-effectiveness of therapy. Some opined that economic factors are what has led psychology to adopt the medical model more at present than it perhaps has done in the past. They felt that money constituted a pragmatic concern, one that could not be ignored, and that often the money is on the side of the medical community.

Limitations of the Study

The present study had limitations that should be considered in any interpretation of its findings. Participants voluntarily responded to the researcher's email invitations and perhaps represent those among the larger pool of training directors who are at the poles of the continuum in such conversations. Initially, training directors from APA-accredited Counseling Psychology doctoral training programs were randomly selected for invitation, but quickly the relatively small pool (approximately 70) of persons fitting that description

was exhausted, and subsequent invitations were sent to all such persons. Additionally, respondents were likely to express views that at times may not have been representative of the larger field of psychology in general, in favor of views more generalizable to Counseling Psychology specifically. Some limitations may also be present in the procedure for conducting interviews. The researcher opted for a semi-structured guide in order to attempt to lend flexibility and adaptability to the interviews; as such, it might be argued that not approaching each interviewee with the same structure and procedure could have influenced time spent on certain topics, coverage of relevant areas, or other procedural trade-offs. However, the semi-structured approach also allowed for greater spontaneity, frankness, and natural flow in the participant responses. The study may be biased to the experiences and worldview of educated, middle class European Americans, and was limited intentionally to a specific group. The study may have benefited from including other professionals in psychology—training directors of counseling centers, private practitioners, or students for example—but the nature and scope of the study was limited by practical factors. Further, the process of qualitative research and the hermeneutic inquiry and analysis applied in the present study is a process that is never finished. It is hoped that continued examination is conducted of this topic and further attempts made to understand and represent the rich views and attitudes of professionals in the field.

Suggestions for Further Research

Future research might further explore the attitudes and opinions regarding medical model influence of those who work in healthcare and medical settings, and who have considerable experience dealing with the medical paradigm on a daily basis. Research

might attempt to identify in what ways psychologists in such positions are able to integrate values and aspects of psychology, and how they have advocated for these. The present study included two individuals that fit the above description, but further research could identify an even larger sample as a subset of practicing psychologists. Quantitative studies could build off the research done in the present study by forming survey instruments so as to more broadly assess the prevalence of these views and opinions among psychology as a whole.

A question that was not asked or addressed in the interviews arises here: What is it that is hindering psychologists, or more specifically Counseling Psychology, from doing just what the respondents indicated is needed? Future research might focus on identifying and exploring obstacles to “getting in the game.” Perhaps these could explore practical issues such as economics and power, or perhaps obstacles arise simply because it is easier to observe, critique, and complain than it is to take action. Some in the present study believed that the broader healthcare context is currently receptive and ripe for the infusion of the values of Counseling Psychology. Future research could examine the state of affairs in the medical field, or could look at consumer attitudes to determine if indeed this is the case.

Research might also address the space between science and practice by assessing—qualitatively or quantitatively—the opinions and views of practitioners and academicians, and then comparing the two. Studies could be conducted to determine if indeed attitudes in Counseling Psychology about the medical model are shifting over time, and what factors might be contributing to such a potential shift.

And finally, in keeping with a strong theme of this study, research would be valuable that dedicates efforts to finding ways and channels through which Counseling Psychology might “be in there as players” in the medical system, and how Counseling Psychologists can take their influence to the medical paradigm.

Implications of the Study

Among the questions driving this research study was the following, as suggested above: Does *disdain* or *ambivalence* better capture Counseling Psychology’s attitude toward the medical model? This study would suggest that, for the Counseling Psychology doctoral program training directors that were interviewed, neither is accurate. If we were forced to find one word to characterize the attitude that emerged from respondents in this study, that word might be *balanced*. It is clear that the respondents, at least in this particular sample, did not favor complete rejection of the medical model; nor for that matter did they advocate full accommodation of it. Instead, the themes that emerged were characterized by careful and critical thinking, acknowledgment of competing forces and ideologies, respect for outside influences, and passion for the values of psychology and the sub-discipline of Counseling Psychology. So in a broad sense, a key implication of this study is the clarification, richness, and depth that it provided on the topic, and the contribution it will make to ongoing dialogue and examination about medical model influence on the practice of psychology.

Further, as was discussed in the introduction to the study, the discussion in the literature about the interface between the medical model and Counseling Psychology is sparse. The discipline may be actively engaged in examination of the medical paradigm in training, in practicum courses, in supervision, or in colleague to colleague discussions.

But a survey of the extant Counseling Psychology literature reveals a surprising lack of scholarly work addressing that interface. It is hoped that the present study can spark not only more dialogue, but also action on the part of Counseling Psychologists who believe as strongly as did the participants in this study that the discipline has much to offer.

Other implications of the study include the potential for critical examination of those aspects of the medical model influence that are less helpful—such as over-reliance on diagnosis and pathology-based conceptualizations, as discussed above—and movement towards inclusion of more appropriate alternatives. Professionals involved in Counseling Psychology training might be encouraged to think about the ways in which medical model influence creates points of tension in their own training programs, and increase awareness of the ways that the medical paradigm might be contributing to shifts in the overall values and trajectory of the field. Similar implications exist for practitioners of psychology, who interface regularly with the public and as such encounter medical model impact on cultural factors, client expectations, economic considerations, and treatment guidelines. Several participants commented on the need for psychologists to educate clients and the public, and recognized that the medical model has in many ways increased the breadth of that interface.

Participants commented at times that psychology, and specifically Counseling Psychology, perhaps have not marketed themselves as well as they could have. Another implication of the study seems to be that complaining and critiquing alone aren't going to get anything done. As an example of this, the several mentions of Positive Psychology referred to above were often accompanied by remarks about how Counseling Psychology has affirmed the same values for decades but the perception seems to be that the Positive

movement is new and exciting, a welcome shift from deficit-based psychological conceptualizations and treatment. Participants expressed concern about what this trend implies for the marketing of Counseling Psychology's values, and what the discipline has to offer. This study would suggest, echoing a strongly supported theme, that it is time to get in the game rather than sitting on the sidelines. If some of the current moves in the field, such as Positive Psychology or Strength-Based Counseling (e.g., Smith, 2006a) do indeed continue to become the zeitgeist some anticipate them being, then Counseling Psychology would do well to encourage and be a part of such movements. These are the kinds of arenas within which the medical model influence can be critically examined by psychology, and where specific aspects of that influence can be rejected in favor of alternative views. Likewise, other current medically-influenced issues, such as the push for prescription privilege and its implications, or the move toward Evidence-Based Practice, may be receptive to the values, insights, and views such as those shared in this study. Indeed, as was communicated by one interviewee, the "train is leaving the station" in current areas of growth such as these—and it is up to professionals to decide whether or not they wish to board that train and have an impact. This strong theme found in the present study is not without similar voices of support in other current professional discussions: As stated by Kaczmarek (2006), "It is past time for counseling psychology to move beyond rhetoric to a more action-oriented definition...." (p. 94-95).

Finally, a practical application of this research is one of adding to the existing literature base a richness and depth of views, attitudes, and opinions that is missing from much of has been done on the topic. It is hoped that the results of this study will add to the opinion pieces and few quantitative studies that exist on the topic by contributing

sound foundational themes, as well as some organization around a topic that is complex and includes a breadth of discordant perspectives.

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APPENDIX A

Semi-structured Interview Guide—Example Questions

Semi-structured Interview Guide—Example Questions

I am interested in your perspectives on the influence of the medical model in the practice of psychology. Can you describe how you see this influence?

What do you see as the positive influences of the medical model on psychology practice?

What do you see as the negative implications of the medical model for psychological practice?

What has led you to the opinions that you hold?

In your experience as a training director, how has the medical model influenced the training provided to students in your program?

What are your attitudes about and reactions to these areas of the medical influence in psychology:

Empirically supported treatments?

Manualized treatment approaches?

Prescription privilege for psychology?

Illness-based conceptualizations of clients' presenting problems?

What do you see as the implications of culture for the medical model in psychology?

How do the values and philosophical foundations of counseling psychology, as you see them, influence your perspective of the medical model's influence in psychology?

Where do you see counseling psychology currently with regard to these issues? In the future?

Does it matter what we think about the medical model? Is it a relevant topic for discussion, examination? Why/Why not?

Duncan (2002): "the psychotherapist of the future will be a specialist in treating specific disorders with highly standardized psychotherapeutic interventions—empirically validated protocols for DSM diagnoses." What are your reactions to this prognostication?

APPENDIX B

Consent Form

Consent to be a Research Subject

Introduction

This research study is being conducted by Dallas R. Jensen to examine views and attitudes regarding the influence of the medical model on the practice of counseling and psychotherapy. You have been invited to participate because you are a training director at an APA-approved Counseling Psychology doctoral program.

Procedures

You will be asked to arrange a time with the investigator to complete a phone interview. The interview will last approximately 45-60 minutes and will follow a semi-structured format designed to solicit responses about a number of broad areas of medical influence on psychology. The interview will be preceded by a short briefing and followed by a debriefing, where you will have the opportunity to provide any necessary clarification or additional information. The interview will be tape recorded and transcribed for analysis.

Risks/Discomforts

There are little to no risks associated with participation in this study. You may feel some discomfort reflecting on your views about medical influence in psychology. However, it is anticipated that this risk will be minimal.

Benefits

There are no direct benefits for participation in this study. However, it is hoped that your participation will facilitate the summarizing and organization of rich themes and in-depth views, aiding future research as well as training in graduate programs. It is hoped that finding and reporting these themes will lead to increased discussion, thoughtfulness, and consideration.

Confidentiality

All taped interview responses will remain confidential and will not be reported with identifying information. All interview tapes and transcriptions will be kept in a filing cabinet and only those directly involved with the research will have access to them.

Compensation

Participants will be entered into a drawing for gift certificates to APA Books, three of which will be awarded following completion of the interview process.

Participation

Participation in this research study is voluntary. You may withdraw from participating at any point during or after the data collection process.

Questions about the Research

If you have questions regarding this study, you may contact Dallas R. Jensen at (801) 377-2872, drj6@email.byu.edu, or Dr. Aaron Jackson at (801) 422-8031, aaron_jackson@byu.edu.

Questions about your Rights as Research Participant

If you have any questions regarding your rights as a research participant or any other matter pertinent to your participation in the study, you may contact Dr, Renea Beckstrand, IRB Chair, (801) 422-3873, 422 SWKT, Brigham Young University, Provo, UT, 84602, email renea_beckstrand@byu.edu.

I have read, understood, and received a copy of the above consent and desire of my own free will and volition to participate in this study.

Signature: _____

Date: _____

APPENDIX C

Journal Manuscript

MEDICAL MODEL INFLUENCE IN COUNSELING AND
PSYCHOTHERAPY: COUNSELING PSYCHOLOGY
TRAINING DIRECTORS' VIEWS

by

Dallas R. Jensen

Brigham Young University

March 2006

Introduction

Medical and human science paradigms have been closely related for centuries (Smith, 1997). At present the profession of psychology is powerfully affected by the medical paradigm, including the practice of counseling and psychotherapy. The application of theories, techniques, and other principles to helping people with behavioral, psychological, and emotional problems often appears very similar to the manner in which medical professionals treat organic illnesses. The practice of psychotherapy is influenced by the metaphor or ideology of medical practice, due in part to economic, philosophical, and cultural factors. The influence of the medical model is a salient issue deserving of critical examination particularly within the practice of psychology (Duncan, 2002).

Definitions

As a construct central to this study, defining “medical model” warrants some specific attention. Ogles, Anderson, and Lunnen (2001) suggest: “...A *model* is defined as a collection of beliefs or unifying theory about what is needed to bring about change with a particular client in a particular treatment context” (p. 202). Differing conceptualizations exist that focus on various aspects of medicine’s influence on psychology. These include, among others, the following definitions of the medical model in psychology as:

- The belief that mental illnesses are like any other illnesses
- The treatment of specific mental illnesses by specific therapeutic ingredients
- Biological, materialistic, and causal-deterministic explanations of psychological problems

- Practices borrowed from medicine that are superimposed on psychological treatment (Simon, 1994; Wampold, 2001a).

In these and other attempts to define the medical model, it seems appropriate to consider two related themes, namely an ‘etiology’ (causal-descriptive) medical model, and a ‘practice’ (help or treatment) medical model. Such a division has served a pragmatic purpose in discussing the many conceptual variants and applications of the medical model (Kihlstrom, 2002). The focus of this study was specifically on the influence of the medical model on practice, rather than on conceptualizations of and theories about causes of psychological problems.

Current State of the Profession

At present, the profession of psychology continues to grapple with competing ideologies. The medical model is highly influential and drives many aspects of the field. What follows is a brief discussion of some of the areas of psychological practice currently most influenced by the medical model ideology.

The medical ideology potentially begins to have impact the moment a client enters into contact with a counselor or psychotherapist. From the medical model perspective, individuals are not responsible for their problems or solutions, but need only treatment (Brickman, 1982). The problems of clients are seen as diseases or illnesses just like any other. Under this model, one possible result is that clients can be defined primarily by their pathology, disorder, or mental illness—effectively making the mental disorder the person or client (White, 2002).

Further influence of the medical model is found in the diagnosis and classification of disorders. Some have suggested that diagnosis is positioned at the very heart of the

medical model of psychopathology, entailing an expert assessment and decision about what affliction a person suffers from, and from which all other decisions and processes of therapy flow (Kihlstrom, 2002).

Another significant influence of the medical model is evinced in the focus on specific therapeutic techniques as having efficacy relevant to positive outcomes. Much like the pharmaceutical model which looks for the best drug or intervention for a given disease, the specific ingredients and techniques of therapy approaches are believed by some to be responsible for change. This perspective is the foundation of the movement toward manualized treatments and empirically supported treatments (Hubble, Duncan, & Miller, 2001). However, some argue that these critical components are shown to be negligible compared to other more salient, general factors (Ahn & Wampold, 2001).

Researchers have suggested that technical therapeutic interventions and protocol-driven interventions, with their accompanying treatment manuals, are becoming the standard of care in the practice of psychotherapy (e.g., Ogles, et al., 2001). Questions have been raised about their appropriateness and about the implications of following the medical metaphor to this conclusion (Addis & Waltz, 2002). While some have championed their use and benefit to the process of psychotherapy (Wilson, 1998), others have argued that while potentially helpful in some situations, manuals have been around in some form or another for decades and have added little of substance to the profession (Lambert, 1998).

Another current aspect of the profession receiving much attention is the discussion about prescription privilege for psychologists (RxP). Some in psychology believe that such changes are a positive sign of psychology's alignment with the health

care paradigm and are a natural progression for the field (DeLeon & Wiggins, 1996).

Others argue that securing this privilege would lead to a loss of profession-wide identity, raise questions of safety, and disrupt training (Hayes, 1996), or would be incompatible with the philosophical assumptions of a psychology that in its infancy attempted to separate itself from the existing medical practices (Sanua, 1996).

Contextual and Cultural Factors

A relevant contextual factor is psychology's desire to be a science, and thereby enjoy the same position and public regard as do other fields. For many, it seems that adoption of a medical model aids psychology in its efforts to be included with hard sciences such as biology or physics. (Bailey, 2002). This factor is addressed by Leifer (1990), who posits, "The medical model is well suited as ideology because it *appears* to represent the most authoritative and reliable source of knowledge, namely, science, as well as the most benevolent and compassionate branch of science, namely, medicine" (p. 250).

In a conversation with Mullan (1995), Laing suggested, "We use a medical model because that's the tactic that is currently most acceptable to...our society" (p. 259).

Cultural factors play a significant role. Wampold (2001b) suggested that "Indeed, it is impossible to identify historically a civilization in which medicines, rituals, and healers were (are) not central features of the culture" (p. 69). As has been convincingly argued by Cushman (1995) and others, psychotherapy is culturally-bound and contextually situated, and such factors cannot be ignored in an ahistorical, acontextual way without impairing understanding of the profession. The medical model's influence is thus located within a larger culture.

The language used in counseling and therapy, and to a greater extent within the psychological profession, also reflects the influence of the medical model. Kihlstrom (2002) suggested that whether one likes it or not, the language and lexicon of the medical model is pervasive in discussions of mental illness. This language may reveal foundational beliefs and underlying assumptions (Mahrer, 2000; Slife & Williams, 1995). Mahrer (2000) cautioned that the foundational beliefs of our language, if kept hidden and unexamined, can be made to be immune from change and can be implicitly powerful, effectively denying the chance for the creation of alternative models with accompanying alternative language.

A strong contextual force influencing psychology's use of the medical model is the influence exerted by economic forces. Bailey (2002) suggested the "chemical imbalance paradigm" (p. 45), is motivated considerably by the economic influence of insurance companies, pharmaceutical corporations, and the desire for quicker, cheaper, and less frequent treatment than would occur in psychotherapy. Particularly interested are the public, and government policy makers, who see in specific ingredients models the equivalent of a pill to eliminate psychological distress (Hubble, Duncan, & Miller, 2001). The monetary benefits of such a pill are seen as potentially significant relief from constant economic pressures and trying to fit into the overall health care system.

Values of Counseling Psychology

Wampold (2003) wrote of counseling psychology, "...We have roots in development rather than pathology, yet we hunger for parity with clinical psychology, adopt the language of medicine...desire prescription privileges, and envy those who bask in the scientific aura of the medical model" (p.542). The literature is sparse when it

comes to discussing the medical model and counseling psychology. A few visible contributions have provided the impetus and suggestion for further consideration (e.g., Wampold, 2001). One might wonder if counseling psychology is content with the opinions being expressed by those in other areas of practice, or is under the assumption that such issues as these will not impact counseling psychologists the same way they do other practitioners of psychology.

To illustrate the lack of clarity, recent discussion of Evidence-Based Practice included one author who held out the idea that counseling psychology generally “eschew[s],” (p. 498) and feels “disdain” (p. 499) for, the medical model (Chwalisz, 2003). In the same publication, however, another author takes issue and suggests this premise to be incorrect, that instead counseling psychology is “ambivalent” (p. 542) at best or only concerned about the model’s appropriateness (Wampold, 2003). Perhaps Fretz (1980) best summarized this apparent ambiguity about what counseling psychology believes regarding this and other significant issues: “Counseling psychology, it seems, is in the eye of the beholder” (p. 9).

Rationale and Purpose of Study

Some might argue that medical model conversations are the stuff of history, already attended to and handled fully in decades past, or some may question the relevance of discussing the medical ideology when it is so clearly a reality of our field. Duncan (2002) speaks to the pervasiveness and influence of the medical model, and thereby the importance of considering its implications for our professional endeavors:

The end result of our Faustian deal with the medical model: Psychotherapy is now almost exclusively described, researched, taught, and practiced in terms of

pathology and prescriptive treatments... firmly entrenched in our professional associations, licensing boards, and academic institutions. It is so taken for granted that it is like the old story about a fish in water. You ask a fish, “How’s the water?” and the fish replies, “What water?” (p. 45)

The aim of this study was to make the “water,” explicit, and to examine the in-depth attitudes of those who swim in it, with the hopes of clarifying, enriching, and organizing future discussion of the medical model’s influence in counseling and psychotherapy, and the specialty of counseling psychology. The problem, as is presented in the literature review, is one of a dearth of organization—opinion pieces that are highly varied, and a few attempts at empirical examination that lack sound foundational themes, richness, and depth. This study examined and arranged those themes and provided some organization around a topic that includes a wide variety of discordant perspectives. Due to the often controversial nature of the present research topic, a method that has as its strength the ability to capture a multiplicity of views from a complex and often contradictory world was appropriate (Kvale, 1996). It is hoped that finding and reporting the themes that emerged will lead to increased consideration and examination of the model’s influence among psychology professionals.

Method

This study employed a qualitative research strategy, based on transcribed interviews of participants, designed to access their views, perceptions, reactions, attitudes, opinions, thoughts, and experiences. Denzin and Lincoln (1994) stated, "...Qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them" (p. 3). A qualitative method aims to describe and understand the phenomenon under investigation in ways perhaps previously not understood by the researcher, participants, and readers (Kazdin, 1998).

Participants

The participants in this study were 14 training directors of Counseling Psychology Ph.D. training programs. These training directors are those that serve as program faculty leaders and should be differentiated from those that supervise and administrate in counseling centers. Additionally, only training directors from APA-accredited counseling psychology programs were invited to participate due to a desire to maintain some uniformity and consistency among the interviewee pool. Training directors participating in this study represented all regions of the United States and Canada. Their age range was 37 to 62 years, with a mean of 48.1 years. Eight were male and six were female. The range of years they had served as training directors ranged from 1 to 15, with a mean of 4.1 years. Their programs were housed in a variety of departments and colleges including education, psychology, and human development. Participants were identified through use of a current list of program training directors, and 70 were solicited by email contact. It was believed that training directors possess knowledge and experience in both

the academic and practice side of psychology, and that in their professional roles they have often encountered the various influences of the medical model—and that as leaders in the field they would have a perspective on and investment in the issue.

Procedure

After initial contact, those training directors that indicated a willingness to participate were provided ahead of time with information regarding the procedure and expected time length of the interview. Additionally, potential participants were informed about the nature and purpose of the study, and helped to understand their part in the research. All interview responses were held confidential so as to protect the shared views of interviewees. Those that accepted were presented an opportunity to provide their informed consent to participate in the study.

Data Collection

A semistructured interview format was utilized to collect the data for this study. Each interview was conducted by the principal investigator, one-on-one over the telephone. Interviews lasted between 30 and 45 minutes, and were digitally recorded to facilitate subsequent transcription, analysis, and interpretation. The researcher utilized a general list of possibly relevant questions in order to ensure that the interviews reached their intended depth and that larger topic areas were not missed in the conversation.

Data Analysis

Analysis of qualitative data is the bridge between the interview, where the interviewees tell their initial stories, and the final story that the researcher communicates to an audience (Kvale, 1996). Following transcription of the interviews, subsequent steps in the analysis were a synthesis of hermeneutic methods informed by Kvale (1996). This

use of multiple methods was reflective of the endeavor not to uncover objective reality but rather to achieve in-depth understanding of a phenomenon, and represented a strategy that added complexity, rigor, and richness to interpretation (Denzin & Lincoln, 1994).

Along these lines, the analysis of the interview material was conducted in the following manner. First, the researcher broadly reviewed all of the transcripts to initially identify themes that stood out. This process consisted of an unfocused reading of the transcribed interviews and notation of salient meanings as they related to the questions of interest. The emerging themes were recorded and condensed where appropriate to succinct statements. As themes re-appeared throughout, notations were made of their frequency and strength, so as to compare and draw out the most salient themes by the end of the analysis. The researcher continually returned to the interview data, re-evaluating throughout the entire analysis stage with repeated spirals of the hermeneutic circle. Themes that continued to be supported in further readings of the interviewees' responses were retained, while those that did not have broad support were removed. At this point in the analysis an auditor reviewed selected themes found in the initial phase, as well as the overall analysis process, for methodological soundness and validity. Together the faculty auditor and researcher continued by coming to a consensus about themes. Additionally, to further ensure reliability of the qualitative analysis, participants were given the opportunity to review findings and comment on the accuracy and consistency of these with their own perspectives. Initially the researcher and auditor agreed to contact three participants; following the audit check both agreed that contacting five would sufficiently meet the purpose of the reliability check. Five of the interviewees were emailed the emergent themes of the interview data and were asked to provide any feedback and

corrections that might enhance reliability. Respondents indicated that the themes were consistent with and accurately represented their experience, and two respondents requested that the divergence of perspectives about some of the themes be included in the results.

Results

Interviews were analyzed utilizing the process outlined in the above method section. The following seven themes emerged from the analysis of the interview data.

Theme 1: Psychology can't afford to be dogmatic or deny reality, yet must critically examine the influence of the medical model

The participants were asked questions addressing the influence of the medical model on the practice of psychology. Responses varied, at times widely, in general reaction to medical model influence, including strong positive as well as strong negative opinions. However, participants universally agreed and often spoke directly to the need for continued critical thinking and examination of the medical influence on the psychological profession. The reality of often pervasive medical influence was acknowledged, as was the need to know the language of the medical model. This was balanced by agreement that the medical model should not be the sole ideology driving practice and research. Respondents talked about the need for Counseling Psychology to maintain an independent perspective. Participants shared the following views, illustrating this broadly supported theme:

Participant L: Since it is kind of such a dominant model I think you need to know it. That doesn't necessarily mean you need to like it.... Or stop being involved in the process in terms of offering alternate views to that system. Because who knows what the future is going to bring.... It's the kind of thing that I would hope Counseling Psych stays fully informed about, and yet is always there as this other voice. Saying, here are the strengths and weaknesses of the system.

Participant H: I think it's really important that we're aware of it, that we understand it, that we have experience with the medical model, but I think it's critical for us to remain independent thinkers, to advocate for positions in opposition of that model when it helps our clients or our patients.

Participant M: I think it is a relevant topic for discussion, because other people that hold money think that it is. And we will need, and our students will need to operate in that kind of an environment.

Participants also reported that psychology needs a balanced perspective on, and cannot afford to be dogmatically rigid about, the medical model influence. Such rigidity was believed to mesh poorly with lived experience and the constraints of practical and economic realities.

Participant H: I think that for one thing we lose legitimacy as a profession when we start spouting too much about the negative aspects of all that medical stuff, and how conforming to it is somehow degrading to people.... I mean, the truth of the matter is, if people want to not engage at all in anything related to the medical model, then they should work at Starbucks because that's where they're going to end up working.

Participant G: I think years of practice have allowed me to soften my opinion, that we don't want to just reject everything about the medical model outright

Participant D: I think the medical model is not without its utility. I think the problem we get into is too much dogma in our field. I'm [age], I've been in this field for 25 years. We don't have the luxury of being so dogmatic when people's mental health is at stake. And I think we need a balanced view of the medical model.

Theme 2: Counseling Psychology has a lot to offer—so get in the game

The participants spoke, often with notable passion, about what Counseling Psychology has to contribute to the broad contexts of healthcare and mental health services. They shared opinions about the impact that can be had when Counseling Psychology brings its unique values and contributions to the medical arena, rather than sitting on the side and complaining. Many shared dissatisfaction with a perceived tendency to talk often about things like medical model influence, but to have little action to show for so much reaction. The following participant comments illustrate this theme:

Participant K: I think we need to be in there as players. One thing that has frustrated me about psychology as a whole, and certainly about Counseling Psychology within psychology, is how we moan about problems with the system, but we're not involved and we just moan about it after the fact...I think particularly Counseling Psych has a lot to contribute. And I think where we really can contribute is in terms of wellness, in terms of prevention. I mean, that's our tradition. And it's something that's sorely needed within the healthcare system.

Participant A: So I think we're actually ahead of the game, if we don't get distracted and if we actually work to validate what that perspective can provide

the field. If we don't try to be little physicians, and if we impact the third-party payers and those who fund treatment to recognize what effective treatment is or even what effective prevention is, and how cost effective that can be, then I think it could bring about a change; because I think the medical model is collapsing under its own weight.

Theme 3: The tension between medical model influence and the values of Counseling Psychology has increased

At several points throughout the interviews, respondents directly cited, or indirectly alluded to, what seemed to be a perceived shift over time of the values of Counseling Psychology. They highlighted the impact of medical influence and economic factors, over time, and talked about a notable difference between the state of the profession at present and what once was, decades ago. Some spoke about their training in Counseling Psychology and how it was more strongly oriented in opposition of medical influence than perhaps it today's training. Others referenced historical roots when talking about Counseling Psychology and points of tension with the medical ideology. The following participant statements illustrate this theme:

Participant B: Counseling Psychology has over a 50 year long history of really developing those kinds of things. And I see now the pressure—the pressures through managed health care and other things, such as empirically supported treatments, etc.—to push us more, to push us away from that; and there is a greater similarity now between clinical and counseling psychology than I thought there was 25 years ago or so.

Participant M: I think historically what we have been about is aiding people in going through normal, developmental, or otherwise adjustment-related challenges that they encounter.... So that's been I think a point of tension, and probably more so these days than historically.

Participant J: I'm not sure there's that consensus [in Counseling Psychology] that there was maybe 20 years ago.

Participant D: Well, I think that actually psychology has embraced the medical model for the most part, with some voices not embracing it. But in embracing it, we have adopted a whole language—a set of ideas, a set of concepts, that practitioners feel compelled to use....And I think Counseling Psychology naively went along with this medical model approach and passed up on a lot of its strengths.

Theme 4: The medical influence on research is a two-edged sword—we need to think complexly about our science

Interview questions assessing opinions about Empirically Supported Treatments (ESTs), Evidence-Based Practice, and other psychological research produced a general theme of caution about the way the medical model influences research on practice, outcomes, and treatment. Participants desired to see treatment research become more broad, more practically applicable, and allow for greater complexity. Participants also cited concerns about cultural diversity and individual differences that may not be adequately addressed in treatment research. Many expressed the view that research on

treatment is important, and even necessary, but not sufficient. Participants also expressed concerns about the ways in which research on practice could be misused or misapplied.

The following statements illustrate this theme:

Participant C: We do need some empirical data to support the interventions that we're doing. But we need to think about these complexly.

Participant N: I think the treatments that they're coming up with, the validated treatment stuff, right now they're under very tight conditions. I think you could broaden them out. My concern isn't necessarily about the treatments as much as it is about the people using them.

Participant D: It's very, very complicated as you know; hotly debated. I think a case could be made for empirically supported treatments in some conditions, and a case could be made for allowing greater creativity. I think that the nature of the empirical support is what's really fundamental. Are we going to discount 70 years of Rogerian therapy, or Psychodynamically-oriented therapy because it doesn't have a rigorous treatment manual? I would say no.... And you know, I've been very impressed with some of the empirically supported treatments. I think as they expand epistemology I think they could be very effective.

Participant A: Science needs to enter in there, but it can't be naïve science. And the empirically validated stuff—I think it was a good start, it was an important thing to do, but I think now where we are, I'm not sure that I'm all that invested in

it. I like the evidence-based approach a bit more; the danger with that tends to be that anything can count for evidence. And if we go that route, then we're just playing another game.

Theme 5: Medical model focus on pathology is reductionistic and restrictive

The first question asked in each interview sought broad, initial reactions to and opinions about medical model influence on the practice of psychology. Nearly all respondents first mentioned areas of diagnosis and pathology and talked about implications of these. A common theme emerged in the form of disdain for pathologizing people, for reducing human beings to a label and focusing on pathology at the expense of the whole person. This theme was broadly supported regardless of whether the participant had a positive, neutral, or negative overall reaction to the medical model. The following statements represent that theme:

Participant A: You know, once you can label something then we maybe feel more comfortable with it. But I'm not sure it really helps the outcomes a whole hell of a lot. You know, it's a complicated and complex world, and simplifying it is not always a positive thing to pursue.

Participant E: [The medical model] is constricting. It kind of pigeon-holes people, and it's subject to confirmatory bias, and it focuses on deficits rather than on strengths.... It also forces public opinion to focus on symptomatic issues and to expect the same kind of outcomes as you do for medical treatment, when in reality most people go to therapy for problems of living.

Participant I: I think one disadvantage that I see in students that we're training is because they have a diagnostic understanding of a person they feel like they know more than they do. They see it as an endpoint. And I see it as a beginning point. And it's an "A-ha! Detective, I've found it, and here it is: we have an Anxiety Disorder, Not Otherwise Specified." Great. It's like, alright, now what are you going to do with it? And how does that apply to this person?

Participant D: My son went to [hospital name], outpatient, just to see people in the day program. The first hour he met the psychologist, the psychologist told him he had a personality disorder. And my son said, "I don't think my mom's gonna like the fact that you diagnosed me after one hour." I mean, he knew enough to say that. And this psychologist, who I've never met, said, "Oh you could bring your mother in here, I'll go through the DSM with her point by point. She won't be able to refute it." Can you imagine how hurt I was, and angry?

Theme 6: Preparing students for the "real world" medical influence on practice while trying to teach values of Counseling Psychology is at times a balancing act

Another broad theme that emerged in the analysis was that of the medical model's influence and impact on training. This was seen as present in a variety of forms, from having to include DSM and Psychopathology courses in training curricula, to the need to prepare students to be conversant in medical language and capable of adapting to a variety of possible professional settings. Participants cited points of tension that arise in accomplishing training in Counseling Psychology while attempting to provide broad preparation and addressing real world pragmatic issues. Many respondents spoke about

opportunity costs involved with incorporating training elements at the expense of other areas of importance to Counseling Psychology. The following participant comments illustrate this theme:

Participant D: We're a counseling program, and as a counseling program we have less of a focus on psychopathology than would a clinical program.... So one of the problems is that our students need to really know the medical model, but yet we critique it very strongly. For a less sophisticated student it's very complicated and difficult to deal with that.

Participant F: In Counseling Psych programs I think that we are actually teaching the words about our philosophy, but I don't know that we're backing it up when our students get into practice.

Participant C: The types of practicum sites or applied sites that our students receive training from often adopt a medical model. So if we aren't clear about what it is—how it influences our training, what we need to do to prepare students to either fit within a medical model, or to challenge the medical model, or to adjust it—I think that that would be a disservice.

Participant A: I think we actually have to strike a balance. Students have to be aware of the DSM and be conversant in it. They need to be aware of psychopathology and how it's operationalized—at least in the medical community, psychiatric community, and all too often, the psychological

community. So they need to be able to think in those terms, communicate in those terms, accurately diagnose within that system.

Participant N: I think that students become confused, too, because of where the field is, because I think we're kind of confused.

Theme 7: Cautious about Prescription Privilege: Are we trying to be physicians or psychologists?

Participant attitudes varied widely in response to questions about psychology's pursuit of prescription privileges. Respondents cited a number of different factors and issues to consider, including training, economics, need for services, and impact on the role of psychologists. Emerging from among the array of opinions was an attitude of cautiousness, and some concern about how obtaining prescription privileges might distort or muddy the role that psychologists currently have in the broader healthcare context. Concerns about this impact did not necessarily equate to an overall unfavorable opinion of prescription privilege, but were expressed by those strongly in favor and those strongly against alike. The following statements illustrate this theme:

Participant K: [Prescription privilege] has been one that I've been opposed to, which is surprising because you'd think I'd be right on board. I think that is probably the more dangerous to our profession in terms of muddying who we are, and really distorting the role of psychology in the mental healthcare system.

Participant I: I think that it dilutes what we do as psychologists. I don't think we should try to be everything to everybody. I think that this is a good example of

where we should draw the line and say that this isn't an area where we're going to try to establish some turf for ourselves.

Participant J: I think if we go with prescription privileges, then like I said it requires a different body of knowledge than most Counseling Psychology programs are providing at this time. I think if that comes to be, then we're going to lose more of our foundation. I think what will happen is, that training component will come in and take over other aspects in our training programs.

Participant A: You know, we've got—again, personal opinion—too many psychologists who maybe wanted to go to medical school instead of graduate school in psychology and they want to be little doctors.... I don't think people really have enough time and are able to keep up with what we know about psychology. And what we know about contextual influences, what does and doesn't work from a counseling or psychotherapeutic perspective, and then to go on and try to be physicians and really try to play at that medical model, I think it's just misguided. And I think that reliance on the medical model makes that a fairly easy transition for some folks.

Participants also wondered about the motivations for pursuing the ability to prescribe medications. While they were aware of, and in some cases strongly in favor of certain arguments for prescription privilege—such as the growing need in rural or underserved areas, the ability to do a better job at prescription than some medical doctors,

and the ability to provide services more efficiently—respondents also expressed the view that the appeal of economic gain might also be a significant factor.

Participant N: I think clinicians are going to—I think their heart is in the right place when it comes to medication—but I think what they're going to start doing is just start moving to the money.

Participant M: I think there are people in the medical community that just frankly don't want a piece of their pie cut into, and people in the psychological community that frankly want to cut into a piece of the prescription pie. And it's a big old fat pie of cash. I can see a lot of incentive for wanting to hang onto it, and a lot of incentive for wanting to get into it.

Participant L: I mean, the argument seems to be, gosh, we've got these people and they can't be served, there aren't enough psychiatrists to go around. And that may be true. But in the back of my mind I still think it's probably an economic move.

Discussion

The range of attitudes, views, and opinions obtained from participants indicated the complexity and expansiveness of the topic of medical model influence in psychology. Despite this breadth of opinions, several themes surfaced that were broadly supported by participants, and that appeared regardless of contrasting or differing viewpoints on more specific aspects of the medical model. It is important to note that participants themselves exhibited the same behavior for which they advocated in the first theme: they demonstrated critical thinking, careful examination, and a willingness to grapple with what is an inherently complex matter.

Respondents expressed a disdain for some implications of applying a medical model to practice. However, the participants also identified and spoke about positive influences of the medical model. For example, some referred to the benefit of having a common language across treatment contexts; others spoke about the impetus to show positive outcomes for therapy as a result of the push for accountability; and many indicated that in some form or another, the medical ideology has allowed for psychology to have greater interface with the public. This generally balanced view of the medical model that emerged in the analysis contrasted at times with the statements of individual respondents, some of whom expressed a perception that Counseling Psychology generally has a harshly critical view of the medical model. However, at least in this particular set of interview data, that perception did not appear to hold true.

The first theme that emerged reflected a view that Counseling Psychology needs to maintain an independent perspective in the broader medical context, and continue to evaluate medical influence with a critical eye. Respondents spoke about a tendency of

some in psychology to be dogmatic and ideologically rigid about the medical ideology and its influence on practice, and suggested that such an attitude causes more problems than it solves. This is not to say that respondents didn't have clear views about negative implications of the medical influence, nor that they advocated for mindless accommodation; but rather suggests that they preferred a position of balance wherein critical examination meshes with practical realities..

Respondents also agreed that it is important for Counseling Psychology to think about, reflect on, and talk about medical model influence. But again, some were quick to point out that such talk is not by itself enough (see theme 2). Many participants insisted that it would be a disservice to students in Counseling Psychology if the medical model were completely ignored or summarily dismissed. The phrase, "need to know it" and similar such phrases were found often in the interview data. Similarly, respondents often referred to a softening of views that comes with experience in the field.

The second theme follows almost as a direct implication of the first—that rather than complaining about the medical model, Counseling Psychology needs to recognize the impact that it can have and take that influence to the broader medical and mental health paradigms. An implication seemed to be that all talk and no action does not accomplish much. Some participants were notably more passionate about this potential for influence than were others; however, all interviewees indicated a desire to see Counseling Psychology continue to work at making an impact, and to infuse values for education, development, cultural differences, prevention, focus on strengths, treating the whole person, and more into the broader, general field.

Related to this theme, when participants talked about the impact that Counseling Psychology can have, many of them made mention of Bruce Wampold and his work in this area (e.g., Wampold, 2001a). Those who mentioned Wampold's work, praised his contribution and held it out as an example of ways that Counseling Psychology can have an impact. Others referred to the number of Counseling Psychologists in the leadership of APA and indicated a belief that the quality of people involved in Counseling Psychology is very high. Also of interest, some expressed disappointment over things that are happening currently in the healthcare and mental health arenas that are seen as new and contemporary when in fact Counseling Psychology has advocated for the same since its inception. For example, several interviewees mentioned the recent growth of Positive Psychology as evidence of a need for Counseling Psychology to be more vocal.

Participants referred often to a perceived change in the views on medical model influence, particularly in Counseling Psychology. This third theme appeared to be the product of some reflection by interviewees about their own background and training, as well as their knowledge of the historical roots of Counseling Psychology, combined with their awareness of some shifts in present attitudes. A few participants expressed concerns about the impact the medical influence continues to have, while others advocated for positions of flexibility and openness to change. Many cited economic impact as a key force in this change.

Respondents expressed a view that tension between medical influence and traditional values of Counseling Psychology has increased. Some indicated that this is a result of consistent pressure from the medical model influence to push away from traditional Counseling values toward more of a medical focus. Current professional

dialogue on this matter reflects the theme found in this study. In a recent special issue of *The Counseling Psychologist*, Smith (2006b) suggested that Counseling Psychology has not backed up the rhetoric about the medical model and deficit focus with research and action. She suggests that the discipline “has ‘hooked its star’ almost exclusively on multiculturalism” (p. 141), in recent years, meanwhile more steadily accepting the medical model and disregarding the strength-based focus that was a root of Counseling Psychology.

The fourth theme summarized participants’ general opinions about empirical support, research on the practice of psychology, and impact on treatment approaches. Generally, reactions to increased accountability and efforts to provide a scientific basis for psychotherapy treatment were favorable. However, respondents also expressed the view that such science can’t be naïve or simplistic, due to the complexity of the subject matter.

Participants expressed concerns about the restrictiveness and pathology focus of the Empirically Supported Treatment movement, and expressed opinions that often such research efforts miss what is actually helpful about the therapeutic encounter. Many were hopeful about the broadening being pursued at present (Evidence-Based Practice). This perception fits with the intent of EBP to move beyond the oft-debated restrictiveness of ESTs (e.g., Messer, 2004). However, participants were generally cautious about the medical influence on psychology research and about how research results are used, and by whom, and for what reasons. For example, some expressed concerns about insurance companies and policy makers, others expressed caution about the rigidity of treatment protocols and the appeal of complexity management, and others cited a disconnect

between the ivory tower feel of empirically supported treatments versus what happens in the real world.

Despite the variety of views and opinions offered, the fifth theme of disdain for pathologizing people was broadly supported. Those who were more in favor of medical model influence referred to this as one of the bigger pitfalls of a traditional medical approach, while those who were strongly against the medical model cited it often as the chief reason for the attitudes they held. Also of note, “diagnosis” and “pathology,” or variants of these words, were by far the most common and consistent among initial reactions to the medical model at the beginning of each interview. Respondents expressed concerns about medical influence shaping a view of people toward a negative, problem-focused, illness mentality that in turn impacts practice. Some saw the areas of DSM diagnosis and focus on pathology as the area of most significant disconnect between Counseling Psychology and the medical model, and indicated that this problematic area also underlies many other points of tension with the medical ideology. However, participants also talked about having to teach courses in psychopathology, needing to train students in DSM terminology, and about the need to be conversant in those areas in order to be an effective practitioner in today’s world.

The sixth theme related to the points of tension caused by friction between medical model influence and Counseling Psychology training. A few of the respondents spoke to the difficulty of infusing values of Counseling Psychology that take hold beyond just the academic training institution and follow a student out into practice. Respondents also spoke about having limited time in supervision and clinical training and having to balance a focus on such things as basic counseling skills and relationship formation with

attention to the details of proper diagnosis, treatment planning, and other more medically-influenced elements of practice. Some indicated that an unfortunate result of this point of tension is that at times students can become so preoccupied with looking for and identifying symptoms, checking DSM criteria, and implementing a matching treatment that they miss developmental factors, client strengths, or factors related to cultural diversity. Others expressed concern that it takes a sophisticated student to be able to accommodate, for example, the critiques of the medical model they get in a theory class concurrent with a required course in DSM diagnosis.

The seventh and final theme was cautiousness about acquiring prescription privilege and the impact on the role of psychologists. Many participants expressed opinions about the possible negative impact on training and indicated a desire to keep pharmacological training out of predoctoral curricula. Several participants talked about the potential distortion of the role of a psychologist that might come with also taking on the role of a medical doctor. A general view that seemed to be expressed was the caution that psychologists can't be everything to everybody. Additionally, many of the participants wondered about the motivations for pursuing RxP; they expressed awareness of arguments in favor of doing so (and in some cases expressed those arguments themselves), but also indicated that for some the motivations might be mostly economic. Reactions to this economic motivating factor, when it was discussed, were mixed.

A few additional observations about the interview data merit some discussion. One of these was a tendency by interviewees to qualify or excuse views expressed as "just an opinion." Considering that the interview was conducted expressly with the purpose of gathering opinions and attitudes, the tentativeness expressed about certain

opinions that occurred in several interviews was a somewhat puzzling phenomenon. At times participants seemed nervous about whether or not their opinion might be representative of their department or profession (“That may well be a minority opinion,” “They’re my opinions, I don’t know how well they represent the field or not, they’re just my opinions.”).

Additionally, participants referred often to multicultural factors, individual differences, and the general absence of cultural considerations in the medical model. Many cited the unique contributions of Counseling Psychology such as valuing diversity and endeavoring to understand and account for cultural influences. Participants made references to Western culture when discussing public expectations, for example that people may often be looking for a quick fix or a metaphorical pill that they can take to rid themselves of distress. While the multicultural thread was not identified as a theme per se, it was clearly evident as a filter or lens broadly considered by participants in their discussion of the medical model’s various points of impact.

Another thread intertwined throughout many of the themes was that of economic influence. Participants referred often to the impact of economic forces when discussing medical model influence in psychology. Many commented about how huge a role economic factors play in, for example, pressures to diagnose and apply empirically supported treatments, finding funding for research, the pursuit of prescription privilege, the impact of the psychopharmaceutical industry, and the burden to show cost-effectiveness of therapy. Some opined that economic factors have led psychology to adopt the medical model.

Limitations of the Study

The present study had limitations that should be considered in any interpretation of its findings. Participants voluntarily responded to the researcher's email invitations and perhaps represent those among the larger pool of training directors that are passionate or motivated enough to complete an interview on the topic of the medical model. Some limitations may also be present in the use of a semi-structured interview guide. It could be argued that not approaching each interviewee with the same structure and procedure influenced time spent on certain topics, coverage of relevant areas, or other procedural trade-offs. However, the semi-structured approach also allowed for greater spontaneity, frankness, and natural flow in the participant responses. The study may be biased to the experiences and worldview of educated, middle class European Americans, and was limited intentionally to a specific group. The study may have benefited from including other professionals in psychology—training directors of counseling centers, private practitioners, or students for example—but the nature and scope of the study was limited by practical factors. Finally, the process of qualitative research and the hermeneutic inquiry and analysis applied in the present study is a process that is never finished. It is hoped that continued examination is conducted of this topic and further attempts made to understand and represent the rich views and attitudes of professionals in the field.

Suggestions for Further Research

Future research could explore obstacles that hinder Counseling Psychology from doing what the respondents indicated is needed, including practical issues such as economics and power. Quantitative studies could build off the research done in the present study by forming survey instruments so as to more broadly assess the prevalence

of these views and opinions among psychology as a whole, including students or those exclusively involved in practice. Some in the present study believed that the broader healthcare context is currently receptive and ripe for the infusion of the values of Counseling Psychology. Future research could examine the state of affairs in the medical field, or could look at consumer attitudes to determine if indeed this is the case. Studies could be conducted to determine if indeed attitudes in Counseling Psychology about the medical model are shifting over time, and what factors might be contributing to such a potential shift. And finally, in keeping with a strong theme of this study, research would be valuable that dedicates efforts to finding ways and channels through which Counseling Psychology might “be in there as players” in the medical system, and how Counseling Psychologists can take their influence to the medical paradigm.

Implications of the Study

Among the questions driving this research study was the following, as suggested above: Does *disdain* or *ambivalence* better capture Counseling Psychology’s attitude toward the medical model? This study would suggest that, for the Counseling Psychology doctoral program training directors that were interviewed, neither is entirely accurate. It is clear that the respondents in this particular study did not favor complete rejection of the medical model; nor did they advocate full accommodation of it. Instead, the themes that emerged were characterized by careful and critical thinking, acknowledgment of competing forces and ideologies, respect for outside influences, and passion for the values of Counseling Psychology. So in a broad sense, a key implication of this study is the clarification, richness, and depth that it provided on the topic, and the

contribution it will make to ongoing dialogue and examination about medical model influence on the practice of psychology.

Further, a survey of the extant literature reveals a surprising lack of scholarly work addressing the interface between Counseling Psychology and the medical model. It is hoped that the present study can spark not only more dialogue, but also action on the part of Counseling Psychologists who believe as strongly as did the participants in this study that the discipline has much to offer. Professionals involved in Counseling Psychology training might be encouraged to think about the ways in which medical model influence creates points of tension in their own training programs, and increase awareness of the ways that the medical paradigm might be contributing to shifts in the overall values and trajectory of the field. Similar implications exist for practitioners of psychology, who interface regularly with the public and as such encounter medical model impact on cultural factors, client expectations, economic considerations, and treatment guidelines.

Participants commented at times that Counseling Psychology perhaps has not marketed itself well. Another implication of the study seems to be that complaining and critiquing alone aren't going to get anything done. Participants expressed concern about what new trends like the Positive Psychology movement imply for the marketing of Counseling Psychology's values, and what the discipline has to offer. This study would suggest, echoing a strongly supported theme, that it is time to get in the game rather than sitting on the sidelines. If some of the current moves in the field, such as Positive Psychology or Strength-Based Counseling (e.g., Smith, 2006a) do indeed continue to become the zeitgeist some anticipate them to be, then Counseling Psychology would do

well to encourage and be a part of such movements. Likewise, other current medically-influenced issues, such as the push for prescription privilege and its implications, or the move toward Evidence-Based Practice, may be receptive to the values, insights, and views such as those shared in this study. Indeed, as was communicated by one interviewee, the “train is leaving the station” in current areas of growth such as these—and it is up to professionals to decide whether or not they wish to board that train and have an impact. This strong theme found in the present study is not without similar voices of support in other current professional discussions: As stated by Kaczmarek (2006), “It is past time for counseling psychology to move beyond rhetoric to a more action-oriented definition....” (p. 94-95).

Finally, a practical application of this research is one of adding to the existing literature base a richness and depth of views, attitudes, and opinions that is missing from much of has been done on the topic. It is hoped that the results of this study will add to the opinion pieces and few quantitative studies that exist on the topic by contributing sound foundational themes, as well as some organization around a topic that is complex and includes a breadth of discordant perspectives.

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