

## A Brief History of Practice—Expanded

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**Note:** Robert J. Resnick, PhD, was president of APA in 1995. This presidential address was presented at the 104th Annual Convention of the American Psychological Association, Toronto, Ontario, Canada, August 1996.

Psychology can trace its historical antecedents to the Greek philosophers, particularly Plato and Aristotle. Plato saw a separation between the mind and the body, whereas Aristotle believed the mind was a functional interaction of the body and experience. Early psychology was a mental philosophy that included the study of the mind as well as people's "animal nature." Thousands of years later, psychology redefined itself as the science of behavior, and the emergence of psychologists as scientists (not practitioners) occurred slightly more than 110 years ago. Wilhelm Wundt is generally credited with the beginning of psychology as a science. He was a physiologist and philosopher who believed that psychology was the study of immediate experience. It should be noted that William James created his laboratory a bit earlier at Harvard University, but James's lab was exclusively for demonstration purposes and not ongoing research.

The earliest "schools" of psychology were essentially experiential. There was structuralism, which utilized experimental introspection to look at conscious experience, and then there was functionalism, which emphasized the function rather than the content of consciousness. Behaviorism negated subjective conscious experience in both its content and function as it sought to study what was observable and measurable. Shortly thereafter, Gestalt psychology moved the study from behavior alone to behavior with experience from a holistic view, and under Freud, psychoanalysis was promulgated to study biological urges, unconscious processes, and conflict in human behavior as its subject matter. A proliferation of theories—learning, behavioral, and dynamic—soon followed.

In 1892, the American Psychological Association (APA) was founded by a group of philosophers, educators, physicians, and a psychologist or two. Psychology's roots were firmly embedded in the discipline of philosophy. Many of the early significant names in psychology never considered themselves psychologists because they studied sensation, perception, and other intrapsychic events. Membership continued to grow in this new organization until about 1901, when APA membership dropped slightly and then leveled off for two to three years. This was due, in part, to the first "walkout" in 1898, when members were not allowed to form a division of philosophical psychology and, in 1901, formed the American Philosophical Association (Hilgard, 1987). Psychology was moving away from and indeed leaving much of its roots in philosophy and evolving into psychophysics, animal behavior, and human assessment. As these new areas of psychology were embraced, the membership in APA began to increase once again. An interest in measurement was noted as early as 1896 when an APA committee was formed to adopt standards. The Committee on Physical and Mental Tests, as it was

known, may have been the first venture into “practice” but had no impact on psychology’s evolution ( [Sokal, 1992](#)).

In December 1906, the Committee on the Standardization of Procedures in Experimental Tests was charged with identifying standardized instruments for groups and individuals, both applied and technical. This committee, like its predecessor, had difficulty defining its agenda and was disbanded in 1919. With the advent of World War I, Robert M. Yerkes, the then-president of APA, mobilized psychology. Although the APA Council of Representatives was divided on mobilization (so what else is new!), APA and Yerkes moved forward and established 12 working committees. One committee, chaired by E. L. Thorndike, was on selection and induction within the surgeon general's office for the U.S. Department of the Army. The Army Alpha Test of Intelligence, the first published American intelligence test, was developed largely through the efforts of Robert M. Yerkes, E. L. Thorndike, and Lewis Terman. More than 42,000 officers and 1.75 million recruits were administered this instrument. In 1917, what may be the first published diatribe by psychiatry against psychology occurred ( [Cornell, 1917](#)), initiating what would become an unwavering adversarial stance against the autonomy of psychological practice. Post-World War I did have a positive impact on psychology, as there was an abundance of students, jobs, funds, and faculty as well as new departments and buildings. The first world war took psychologists out of pure academia and put them into psychological assessment in ways no psychologist had ever contemplated before! It is of historical interest to note that four days before the founding of the American Association of Clinical Psychology (AACP), on December 24, 1917, the War Department adopted the Army Alpha Test of Intelligence. The measurement of mental abilities had significantly and irrevocably expanded the boundaries of psychology to include practice.

### **Practical Psychology, Internships, and the First Patient**

It is important to recall that Lightner Witmer not only established the first psychological clinic at the University of Pennsylvania in 1896 but also published in Pediatrics ( [Witmer, 1896](#)) his commitments to practical psychology as the examination of physical and mental conditions of school children and to the study of defective children. According to [Witmer's \(1896\)](#) published case study, which may have been the first psychological case history, of a “feeble minded” child who had “mental defects as the result of severe convulsions while teething” (p. 466), Witmer's therapy (instruction) lasted three hours a day, for five days a week, for four years! At the termination of treatment, the child could write all of the alphabet, read several words, add and subtract up to six, and sing 12 songs. However, he could not understand simple concepts like body temperature. The patient was 11 years old when the treatment ceased. From the description and treatment, it appears that this first patient was a mentally retarded child who was given educational remediation. Witmer wrote an article entitled “Clinical Psychology” in the first issue of The Psychological Clinic in 1907. The new discipline frequently worked with learning disabled children and mentally defective children and believed that the practical work of psychology would be connected with “school system(s) examining and treating the mentally and morally retarded children or . . . with the practice of medicine” ( [Witmer, 1907](#), p. 5). Witmer coined the term clinical psychology, stating that

he borrowed the word clinical from medicine because "it is the best term I can find to indicate the character of the method which I deem necessary for this work. . . . The term clinical implies a method and not a locality" ( [Witmer, 1907](#), p. 8). He believed that the methods of "clinical psychology are needed whenever the status of an individual mind is determined by observation, experiment or pedagogical treatment" ( [Witmer, 1907](#), p. 9). Witmer believed that clinical psychology could discover relationships between cause and effect in individuals who were mentally retarded. Consistent with this view, in 1908, the first formal internship at the Vineland Training School (in New Jersey) began under the supervision of H. H. Goddard. In 1909, the Chicago Juvenile Psychopathic Institute initiated its internship program, but it lasted only five years. It is of historical significance because juvenile delinquency was the environment for what appears to be the first programmatic transition from mental testing to the utilization of psychological skills and training to remediate social problems ( [Laughlin & Worley, 1991](#)). Early internships usually offered no stipends, only room and board. And it appears that the early practice of psychology was essentially child school psychology, as described in these early writings, and was advanced further by the American translation of Binet's work on intelligence in France.

With the growth of this new assessment psychology, and as early as 1911, the low status of psychologists at some state institutions was being discussed as well as the lack of appropriate training by some users of psychological tests. In 1915, the APA Council of Representatives passed a resolution to "discourage the use of mental tests of practical psychological diagnosis by individuals psychologically unqualified for the work" ( [Wallin, 1960](#), p. 302). In 1916, at the APA annual convention, discussion was held about these problems, and a roundtable was held at the next annual convention in Pittsburgh, Pennsylvania, to consider the advisability of forming an autonomous clinical psychology organization. The purpose of this new group, AACP, was to define, establish, and promote standards in the field of clinical psychology ( [Routh, 1994](#)). A "business" meeting was announced for this new organization, which produced stormy debate with severe opposition to the formation of a competing organization. Opposition to AACP continued for two years, primarily on the issue of whether the organization would be autonomous or a section of APA ( [Wallin, 1938](#)). A conference committee was formed to report back at the 1919 meeting, and the fledgling AACP became the Section of Clinical Psychology (SCP), APA's first division, for largely undocumented reasons ( [Wallin, 1960](#)). By 1921, sufficient pressure by the applied psychologists had been exerted to form the Division of Counseling Psychologists within APA's SCP ( [Hilgard, 1987](#)).

In 1919, there was an APA initiative, through SCP, to establish a certification procedure. The title "consulting psychologists" was introduced to identify psychologists who were qualified to offer services to the public. However, only 25 psychologists were ever certified, and in 1937, certification was discontinued. The admirable objective of the SCP to certify the competence of members was never realized. With the failure of APA to meet practitioners' needs, other independent organizations were established, perhaps led by the New York Association of Consulting Psychologists (ACP), which formed in 1921 and adopted the first professional code of ethics in 1933. Then, in 1936, APA appointed the National Committee for Affiliation and Association of Applied and

Professional Psychology. Among its accomplishments was the creation of the American Association for Applied Psychology (AAAP). ACP, the disenfranchised SCP, and other groups became AAAP. There were four original sections: clinical, counseling, educational, and industrial psychology, with military psychology being added in 1944. AAAP was initially autonomous from APA, but most members continued their dual membership. In 1938, AAAP became affiliated with APA. AAAP ceased functioning and disbanded in 1946 because of new user-friendly revised APA bylaws that included practice and reorganization into the present division structure ( [Hilgard, 1987](#)).

### **The First Professional Degree**

Interestingly enough, in 1925, Loyal Crane published in an APA journal a description of the first professional degree. He described the degree and called it a doctor of psychology, to be written as Ps.D. During the four-year program, there would be exposure to "familiarization courses" found in portions of a classical medical curriculum along with psychological testing and psychotherapy. Fifteen percent of the second year and smaller portions of the third and fourth years were devoted to psychopharmacology. What a visionary! This degree also required at least one year of practical clinical experience before one could offer services to the public. I note in passing [Crane's \(1925\)](#) comment that "with occasional noteworthy exceptions, the attitude of the medical profession towards practicing psychologists is one of tolerant condescension" (p. 228). In a 1935 article entitled " [The Psychologist in Private Practice](#)," Casselberry wrote that the service rendered in private practice is "diagnosis using tests and questionnaires; a modified psychoanalytic procedure; re-conditioning and training; suggestion; relaxation; and instruction in diet, proper breathing, posture and voice placement and control" (p. 232). Casselberry suggested that such methods would be addressed to "warped and inferior personalities, social maladjustment, cases of nervousness, timidity and bashfulness; fears, phobias, and complexes, marriage maladjustment, vocational maladjustment, juvenile delinquency, and child training; hysteria neurasthenia and psychasthenia" (p. 58).

### **Professional Practice**

In 1944, there was a series of articles published in the Journal of Consulting Psychology that examined the professional practice of psychologists. [Kinder \(1944\)](#) wrote of working in a state psychiatric unit for children where she envisioned the establishment of an assessment and play therapy program. She noted that psychological assessment was the primary activity and that those who were associated with the play therapy program did so as a secondary activity. [Wechsler \(1944\)](#) viewed the duties of a psychologist in a city public psychiatric hospital as defining patients' intelligence, special abilities, or disabilities and aiding in the psychiatric diagnosis with psychological measurement. He did not promulgate the psychologist as a therapist. Similarly, [Wittman \(1944\)](#), in her discussion of psychological services in state hospitals, did not address the issue of treatment and psychotherapy but also emphasized assessment. [Rapaport \(1944\)](#) surveyed private psychiatric hospitals and found that psychologists were underrepresented in these facilities and that no therapeutic work was done by psychologists on either a full- or part-time basis. Rapaport noted that there was no clear pathway for psychologists to follow to become psychotherapists. He also stated that

many psychologists felt that psychiatrists did not want psychologists to practice psychotherapy because psychiatrists didn't want competition. Indeed, even in the first newsletter (June 1936) of the Pennsylvania Association of Clinical Psychology, the lead article was "Concerning Clinical Psychologists and Psychiatrists" and discussed issues of distrust. Thus, during APA's first 50 years, practice for psychologists was essentially testing.

### **Reorganization, World War II, and the Veterans Administration**

Anticipating the outbreak of hostilities, APA formed the Emergency Committee "to prepare the profession . . . for a great national crisis" (Hilgard, 1987, p. 756). The committee was a joint venture of APA and AAAP and began meeting a year before the United States declared war. It was this joint committee that endorsed the reorganization of APA, and the Intersociety Constitutional Convention met in May 1943 and hammered out a new APA with 19 charter divisions. APA and AAAP approved the reorganization in September 1944 to take effect in September 1945, and AAAP disbanded.

The new APA was almost immediately concerned with competence, and several initiatives were begun to ensure and expand competent psychological practice. The APA Council of Representatives created the American Board of Examiners in Professional Psychology in 1946; accredited and developed the 1947 scientist–professional training model; approved clinical, counseling, school, and industrial–organizational psychology programs and internships; and promulgated state certification and licensure statutes.

World War II brought further refinements in the military induction testing procedures. The war also caused large numbers of mental casualties called "war neurosis" or "battle fatigue." Thus, military care during and after World War II was instrumental in providing the opportunity for nonphysician providers, mostly psychologists, to receive training and supervision in psychotherapy. After World War II, the Veterans Administration (VA) was faced with a serious shortage of properly trained therapists and worked with APA to expand training opportunities. Fortunately, AAAP, before it disbanded, was largely responsible for having U.S. Civil Service Commission Announcement 405 issued in 1945, according definitive professional status to clinical psychologists in the VA system. This helped to accelerate the thinking of the federal government and hastened the creation of the VA training programs. Such training was well ahead of the practice of mainstream psychology and provided the single greatest impetus to add psychotherapy to services offered by psychologists. Shortly after World War II, psychotherapy was viewed as a legitimate part of the psychological profession and was enhanced further by the 1949 creation of the National Institute of Mental Health and its funding of graduate training in psychology. The change in emphasis from assessment to treatment was not met with unequivocal acceptance by the profession, as this was seen by some as a new and dangerous divergence from traditional psychology and, indeed, was the view embraced by psychiatric competitors as well. But, by the early 1950s, the VA was the prominent training organization having responsibility for almost half of all psychology interns (Laughlin & Worley, 1991). In 1953, George Goldman established at Adelphi University a postdoctoral program in psychotherapy. In the process of advertising this program, it



came to the attention of the Nassau County Neuropsychiatric Society that a suit had been filed against Goldman and Adelphi University for practicing medicine without a license and for establishing a medical school without a license (G. Goldman, personal communication, March 1991). Goldman and Adelphi University prevailed because the practice of psychotherapy was not found to be a medical specialty. However, years passed before psychotherapy was seen as a part of mainstream psychology. Such consensus developed over time as there was and is not complete agreement about what, where, and how psychotherapy should be taught.

It is especially important to pause and reflect on the history of practice to this point. Practice is approximately 50 years old and owes much of its modern configuration to the first and second world wars and to the federal government, which was and is not constrained by state law or interprofessional territorial issues. Practically from the beginning, psychiatry and psychology were adversaries because they were indeed competitors. A historical footnote: William James, while he was APA president but not under those auspices, appeared before the Massachusetts state legislature opposing the medical professionals' bill limiting the practice of "mental therapy" to licensed physicians. He accused the Massachusetts medical group of being anticompetitive. The bill was killed. This was in 1894 ( [Fowler, 1991](#)).

Two other movements were important to psychological practice but are mentioned only in passing. The first occurred between World War I and World War II. Outside of academic programs, psychologists were finding employment in hospitals and clinics but were very slowly embracing the transition from assessment to psychotherapy. The transition to intervention, however, was aided by the child guidance clinic movement in the 1920s. The second major force was the "Great Society" under President Lyndon B. Johnson and the 1963 community mental health centers movement, which again opened career ladders for psychologists as psychotherapists.

### **The Regulation of Practice**

After World War II, psychologists also became more interested in independent practice, and the next major step in this history of psychological practice was certification and licensure. There were many psychologists who wondered about the necessity of credentialing psychologists, but the process began in 1945 with certification of school psychologists in Connecticut and the first licensing act in the Commonwealth of Virginia in 1946. In that same year, recall that because of concerns regarding what constituted the practice of psychology, the American Board of Examiners in Professional Psychology was created by APA with a grant of \$2,000. The need to protect the public from unqualified providers superseded beliefs about the wisdom or necessity of certification and licensure. The regulation of practice psychology moved forward (unevenly), and in 1976, Missouri became the 50th state, along with the District of Columbia, to credential and regulate psychologists. In many jurisdictions, the practice of psychology would be beset by obstacles placed by organized medicine, psychiatry, or both attempting to exert varying degrees of control over the practice of psychology. In some states,

licensure was gained only by compromising and permitting medical board involvement in the licensing procedure.

Once psychologists were licensed as independent practitioners and were in competition with other provider groups, the need for autonomous recognition under health insurance programs for psychology was necessary. When a freedom of choice statute was proposed, medicine and psychiatry objected. When CHAMPUS was considering direct recognition of psychologists, organized psychiatry vociferously protested. Their arguments focused on the training psychologists receive, stating they were not skilled in physical diagnosis and, therefore, would miss important physical symptoms. Furthermore, psychologists would treat psychotherapeutically, organically based diseases and would be responsible for wrongful deaths. The issue of training standards continued to be raised by psychology's adversaries. However, in August 1968, the APA Committee on Health Insurance held its first meeting with state association insurance chairs, launching the campaign for freedom of choice laws. Notwithstanding the medical and psychiatric opposition, the first Freedom of Choice Acts were passed in 1969 in the states of New Jersey and Michigan. And, in 1974, President Richard Nixon signed the federal freedom of choice bill, eliminating physician referral or supervision from the Federal Employees Health Benefits Act. The intensity of the rhetoric in opposition to third-party reimbursement is well documented in the Congressional Record, the Department of Defense's call for comments on CHAMPUS reimbursement, Congressional hearings on Medicare, and the testimony found in the Virginia Blues litigation ( [Resnick, 1985](#)).

The Virginia Blues was actually two separate suits filed in 1977, one in the state court system to mandate compliance by Blue Cross and Blue Shield of the 1973 Freedom of Choice Act. Three psychologists, including myself, worked with the attorney general's office and ultimately prevailed by a unanimous opinion in the State Supreme Court on the constitutionality of the statute. A separate action initiated by the Virginia Academy of Psychologists and myself was the federal antitrust suit alleging restraint of trade. For more than three years, this suit was bitterly litigated through the district and appellate federal courts. A disastrous lower court opinion was reversed on appeal, with the U.S. Supreme Court refusing to hear the other side's appeal. These two actions are considered by APA and the legal profession to be benchmarks of state and federal case law establishing the autonomous practice of psychology (for further discussion, see [Resnick, 1985](#)). Presently, psychologists are recognized in freedom of choice acts (helped by a 1976 decision by the Health Insurance Association of America endorsing the Model Psychologist Direct Recognition Bill) in more than 40 states, encompassing almost 95% of the psychologists in practice in the United States. Psychologists are recognized directly in more than 30 Medicaid programs and, of course, in 1989 were autonomously recognized under Medicare. Psychologists are also statutorily recognized for hospital practice in 11 states.

Autonomous and expanded practice mandates vigilance and, at times, litigation. Since the "Blues" suits, which identified psychologists as independent providers of services

and competitors of psychiatrists, psychologists have had to use legal remedies when negotiations have proven futile. Armed with the Blues decision, in 1984, psychology was able to force the Joint Commission on the Accreditation of Hospital Organizations to revise its standards to permit psychologists to have staff privileges. In 1990, psychologists won a six-year court battle in California that allowed psychologists to practice in hospitals. And, in 1988, psychologists obtained the right to be trained in psychoanalysis under a settlement with the American Psychoanalytic Association. It almost goes without saying that the health of psychological practice would be very different if APA had not created the Practice Directorate in 1987 and the Special Assessment in 1986.

### **Health Care Reform and Managed Care**

By 1990, practice was thriving. Barriers to practice settings and training were crumbling. Psychologists were everywhere. And where they weren't, they were at the door knocking. Health care was accessible to more people than ever. We saw patients, we billed, we were paid. Life was good! However, costs were going out of control—from \$27.1 billion in 1960 to \$675 billion in 1990 ( [Newman & Reed, 1996](#)) and over \$1 trillion in 1993. Cost containment loomed on the horizon as a response to these economic pressures. Out of the HMO movement, which was largely ignored, came a subset of the managed care industry—companies that focused exclusively on mental health services called managed behavioral health care ( [Freeman & Trabin, 1994](#)). In part, psychologists were the victims of their own good work because the media had popularized mental health services and reduced the stigma, which, in turn, increased the demand. In a decade, fee-for-service health care plans went from a dominant 80% market share in 1985 to 20% in 1995. Capitation, integrated care, “one-stop shopping,” and group practices were foreign to psychologists. After all, most psychologists were never trained in the “business” of practice. Approximately 40% of psychologists are in solo practice, and almost 44% of practitioners state that psychotherapeutic services are their primary professional activity ( [Phelps, 1996](#)). Now, psychologists are faced with 68% of insured individuals in a managed behavioral health system ( [Oss & Stair, 1996](#)). There are relatively few psychologists who believe they can turn back the hands of time. Most of them recognize that managed care is neither all good nor all bad and understand that it is a player. There are some very real problems with managed care—serious problems—that will need correcting through negotiation, regulation, and litigation, if necessary. But this is just what psychologists did when they were kept out of the health care system 20 years ago! Psychologists must take an active role in shaping the next iteration of the health care delivery system, and the next, and the next. Psychologists and their patients must be players as well—not just providers! Managed care contracts must have any willing provider statutes as well as direct access (no referral) and point of service options. And care must be clinically driven, not economically driven.

### **A Crystal Ball**

There are 56,000 licensed psychologists who are members of APA (R. Newman, personal communication, July 8, 1996). About half of them define their orientation as cognitive-behavioral or behavioral, and another one fourth identify themselves as



psychodynamic. Psychologists believe that knowledge regarding the interaction of mind–body, psychopharmacology, brief treatments, hypnotherapy, forensic psychology, employee assistance programs, quality assurance procedures, and outcome-based assessment will be very important to psychologists in the future ( [Greenberg, Smith, & Muenzen, 1996](#)). Psychologists add to their numbers annually in large quantities: 2,716 in 1993, the most recent year with complete data (J. Kohout, personal communication, July 23, 1996). And as I mentioned earlier, psychologists can best be described as solo practitioners providing psychotherapy. But as the folk song says, “The times, they are a changing,” and to meet this extingency, practice has evolved and expanded—not taken the place of psychology’s historical practice pattern or venue.

There is a growing consensus and movement to add prescriptive authority for appropriately trained psychologists. Several states have developed or are developing prescription privileges task forces. The Department of Defense’s Demonstration Project has already proven the efficacy of such training. Psychologists continue to offer services in general medical, surgical, and psychiatric hospitals. They have recognized the increasing body of knowledge linking mind–body experience and use the findings in their work with medically ill patients. Their collaboration with primary care physicians in all settings has improved both medical and surgical outcomes. And psychology’s place as a primary health care provider is recognized as more than a mental health specialty ( [Newman & Rozensky, 1995](#)). The recent advances in genetically altered animal organs for human transplantation will be common in less than 10 years and will bring yet another new venue for psychological practice. In my 1995 presidential miniconvention, “To Your Health: Psychology Through the Life Span,” I highlighted how psychological interventions contribute to the overall health of citizens of any age. But as [Newman and Reed \(1996\)](#) pointed out, psychology as a health care profession will be difficult for some both within and outside the profession to accept, but it is a critical step for the well-being of psychological practice. Furthermore, it does appear that psychologists have become more entrepreneurial, forming group practices, multidisciplinary practices, and integrated models of care. Sometimes this movement is elective, and other times it is a matter of simple economic survival for some practitioners and their families. It is never “selling out.”

In conclusion, psychological practice has expanded and is expanding in both settings and services provided. What psychologists have learned from psychology’s history is that they must continue to fight for their autonomy and for the rights of their patients to access services unencumbered. History has also taught psychologists that psychological practice must mature and develop new skills if it is to survive. Increased competition and new systems of health care delivery present many problems but also, like the world wars, bring an opportunity for growth. Psychologists have expanded their competency base and broadened their horizons. And they have done so without compromising their most basic commitment to provide their patients with all the high-quality care they need along with a deep respect for human dignity. Psychologists make a difference in people’s lives. They make a difference.

## REFERENCES

- Casselberry, W. S. ( 1935). The psychologist in private practice. *Psychological Exchange*, 4, 57– 58.
- Cornell, W. B. ( 1917). Psychology vs. psychiatry in diagnosing feeble-mindedness. *New York State Journal of Medicine*, 17, 485– 486.
- Crane, L. ( 1925). A plea for the training of psychologists. *Journal of Abnormal and Social Psychology*, 20, 228– 233.
- Fowler, R. D. ( 1991, March). William James: Back to the future. Invited address presented at the meeting of the Southern Psychological Association, New Orleans, LA.
- Freeman, M. A., & Trabin, T. ( 1994). Managed behavioral healthcare: History, models, key issues, and future course. (Community Mental Health Services, SAMHSA Rep.No. 4692). Rockville, MD: U.S. Department of Health and Human Services.
- Greenberg, S., Smith, I. L., & Muenzen, P. M. ( 1996). Study of the practice of licensed psychologists in the United States and Canada. Princeton, NJ: Professional Examination Service.
- Hilgard, E. R. ( 1987). *Psychology in America: A history survey*. New York: Harcourt Brace Jovanovich.
- Kinder, E. F. ( 1944). Work of the psychologist in a psychiatric unit for children. *Journal of Consulting Psychology*, 8, 273– 280.
- Laughlin, P. R., & Worley, J. L. ( 1991). Roles of the American Psychological Association in the development of internships in psychology. *American Psychologist*, 46, 430– 436.
- Newman, R. N., & Reed, G. M. ( 1996). Psychology as a health care profession: Its evolution and future directions. In R. J. Resnick & R. H. Rozensky ( Eds. ) , *Health psychology through the life span: Practice and research opportunities* (pp. 11– 26). Washington, DC: American Psychological Association.
- Newman, R., & Rozensky, R. ( 1995). Psychology and primary care: Evolving traditions. *Journal of Clinical Psychology in Medical Settings*, 2, 3– 6.
- Oss, M. E., & Stair, T. ( 1996, May). 68% of insured in managed care. *Open Minds*, 12, 34– 40.
- Phelps, R. ( 1996). Preliminary practitioner survey results enhance APA's understanding of health care environment. *Practitioner Focus*, 9, 5.
- Rapaport, D. ( 1944). A psychologist in a private mental hospital. *Journal of Consulting Psychology*, 8, 298– 301.
- Resnick, R. J. ( 1985). The case against the Blues: The Virginia challenge. *American Psychologist*, 40, 975– 983.
- Routh, D. K. ( 1994). *Clinical psychology since 1917*. New York: Plenum Press.
- Sokal, M. M. ( 1992). Origins and early years of the American Psychological Association, 1890–1906. *American Psychologist*, 47, 111– 122.
- Wallin, J. E. W. ( 1938). The establishment of the clinical section of the American Psychological Association. *School and Society*, 48, 114– 115.
- Wallin, J. E. W. ( 1960). History of the struggles within the American Psychological Association to attain membership requirements, test standardization, certification of psychological practitioners and professionalization. *Journal of General Psychology*, 63, 287– 308.
- Wechsler, D. ( 1944). The psychologist in a psychiatric hospital. *Journal of Consulting Psychology*, 8, 281– 285.

Witmer, L. ( 1896). Practical work in psychology. *Pediatrics*, 2, 462– 471.  
Witmer, L. ( 1907). Clinical psychology. *The Psychological Clinic*, 1, 1– 9.  
Wittman, P. ( 1944). Psychological service in state hospitals for the mentally ill. *Journal of Consulting Psychology*, 8, 291– 297.

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**Source:** American Psychologist. Vol.52 (4) US : American Psychological Association pp. 463-468.

**Accession Number:** 1997-03698-018 **Digital Object**

**Identifier:** 10.1037/0003-066X.52.4.463