

Call Me Doctor II. Perspectives in the United States on Holding a Doctoral Degree in Psychology

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In the United States, the big issue concerns the distinction to be drawn between those with a Ph.D. and those with a Psy.D. degree. For many years, all psychologists obtained a Ph.D. and prepared primarily for teaching and research rather than doing psychotherapy or psychological assessment.

I personally had only one course in assessment and devoted only two weeks to use of Rorschach—yet I could have gone out as a qualified “expert” in psychological assessment after receiving the doctorate and passing the licensing exam. Then came the creation of a professional-focused degree --- the Psy.D. (Doctor of Psychology). This is the degree that you were granted. This is now the primary degree granted to those in the USA who wish to do psychological assessments and/or psychotherapy.

Medical Profession in the United States

Restrictions and economics. The Flexner Report in the early 20th Century restricted use of the term “Doctor” in the field of medical education. The term could not be used by those who graduated from nontraditional medical schools (only the Allopaths could be called “Doctor”). Virtually all medical schools that served women and minorities were put out of business. These restrictions led to a major reduction in the number of doctors being educated. As a result, a major shortage of doctors soon developed. This, in turn, led to a significant increase in the price of medical care and subsequently to support for health care insurance by doctors (this not previously being the case).

Subcultures and pecking order. At the top of the pecking order are the specialists, and in particular those doing surgery. At the top of this highest order are those doing neural surgery. Then comes the other specialists, headed by the oncologists. We have those specializing in one part of the human body (Urologists, Ear/Nose/Throat, Pediatricians, Pedologists, etc.). Further down the hierarchical list are those who do not specialize. At the top are those engaged in Internal Medicine.

Below them are the family medicine doctors and those focusing on child medicine (pediatrics). At the bottom of the “Totem pole” are the psychiatrists, who dare to consider mental illness as important as physical illness. There is even a sub-hierarchy among psychiatrists. Those who treat mental and emotional issues with drugs are acting like “real doctors” and are applying “real science.” Conversely, those doing psychotherapy (“talking cure”) are not being “real” doctors and are practicing some sort of mumbo-jumbo that isn’t really “scientific.”

Beyond the Physician

At this point, we leave the world of “medical doctors” but still find the label “doctor” available to some members of the medical profession. Specifically, there are a few non-physicians who have earned the title “doctor.” These are those in the medical community who have earned a doctorate in nursing. It is

worth noting that these senior-level nurses are usually not called “Doctor.” They may have acquired major power in a hospital system, but not the status awarded to those called “Doctor.”

We then come to the many professions in medicine that do not require an earned doctorate. These professions include Physician Assistants and Nurse Practitioners. Originally, many of these women and men had provided important medical services to those wounded in war (Vietnam). It was not unusual for these armed forces veterans to be more experienced and gifted in treating major injuries and accompanying trauma than their civilian counterparts (with “doctor” attached to their name plate).

Close on the hierarchy are the registered nurses (and then those assigned other nursing titles). There are then the “orderlies” and other members of the medical community who are allowed to touch patients. This “touching” restriction seems to be central to the assignment of status in a medical community. For example, medical technicians come to medicine with significant (and critical) knowledge and skills in specific areas (such as radiation and phlebotomy). They might even have a doctorate in their field. However, they are lower on the medical totem pole.

What do we do with those engaged in the “soft” stuff of medical treatment? There are social workers and psychologists (who may have a “Doctorate”). They certainly “do not deserve” to be called “doctor” – but often are allowed to use this title as a way to “reassure” their patients/clients that they are receiving “legitimate” treatment from these practitioners. Recently, a new term has emerged that appears to be bridging the gap between the “soft” and “hard” domains of medicine. This term is “behavioral medicine” and is provided by practitioners who are specially certified in behavior-oriented psychological services to patients/clients. These services range from nutrition and health-related habits to stress management and even the treatment of trauma. There are no white coats for these folks, and currently not much status in the healthcare community.

While the services offered by those engaged in behavioral medicine have proven to be quite valuable in the reduction of recovery time and reduction in occurrence of certain illnesses (thus resulting in cost saving), behavioral medicine is still considered an adjunct service in most health care systems and is likely to “come and go” depending on the proclivity of those in charge of the health care system. Reimbursement for these behavioral medicine services is also not assured, leading to an even more vulnerable position (and lower status) for those providing these services.

It is finally time to identify those at the bottom of the medical hierarchy. They are engaged in nontraditional medical practices. Those whom the authors of the Flexner Report tried to put out of business as “quacks”. These engaged in chiropractic, naturopathy, Asian medical practices (such as the use of acupuncture), and certain physical therapy practices (such as those offered by the Feldenkrais practitioners). Funding for these services is controversial in many countries, even though evidence-based medical studies often find these services to be effective. The reticent acceptance of these nontraditional practices is often evident in the assignment of a specific term to these valuable services. This term is “complementary medicine.” It suggests that these nontraditional services should stand alongside (“complement”) traditional medical services rather than operate on their own as adequate (and successful) sources of medical treatment.

Osteopathy

There is an even more important change and challenge related to the acceptance of alternative medical practices and the use of “Doctor.” We are now finding growing acceptance of a school of medicine called “osteopathic medicine” (to be distinguished from traditional “allopathic medicine”). This holistic school of medicine is now preparing a majority of “doctors” for practice – particularly in the field of family medicine. These graduates from “less prestigious” (and often foreign) schools of medicine have introduced a more diversified perspective on medical strategies and tools that complement their more holistic (biopsychosocial) orientation to medical diagnosis and treatment. A majority of physicians have been trained in osteopathy in many 21st-century medical systems. These nontraditional medical practitioners are called “Doctor” and are often not distinguishable from other “doctors” by patients.

Osteopaths have some status in the medical hierarchy, though not much if they are serving as family physicians. While these doctors might not have a high level of status, they often have considerable power. This comes from the critical role they play as “gatekeepers” in the referral of their patients to specialists for focused treatment. Most medical reimbursement policies now require that a patient first meet with a family or internal medicine doctor before being seen by (and reimbursed for services provided by) a medical specialist. Thus, osteopathic doctors might not have the status of their allopathic colleagues or the specialists to whom they refer patients; however, they have the economic power of referral. A specialist certainly does not want to get on the “wrong side” of a referring osteopathic physician (regardless of how the specialist feels about that “damnable, intrusive osteopathic stuff”).

We find other people in the medical world who also have significant power but not much medical status. These represent the managerial culture (rather than professional culture) in contemporary healthcare. (Bergquist, Guest and Rooney, 2002). We find administrators at the top of this managerial hierarchy (as in all traditional organizations). We then go down the list to department managers, administrative staff, receptionists, billing clerks, etc. They are not called by degree title (be it “doctor,” “masters,” or “bachelorate”); nor are they “allowed” to wear the traditional medical regalia (white coat and perhaps a stethoscope hanging around their neck). Those at the top of the managerial pecking order might have acquired an MBA degree or even an administrative doctorate, but they are rarely allowed to use this title.

Psychological Profession in the United States

The psychology profession in the United States has always lived in the shadow of medicine—at least in the domain of clinical psychology. However, psychology at the doctoral level has also lived in the shadow of academia. While virtually every other professional field has a “practitioner” degree that distinguishes it from a degree focused on research, scholarship, and teaching, the field of psychology for many years had only one degree (Ph.D.) that was awarded both to those running rats in a maze and those doing psychotherapy or clinical assessments. In the field of medicine, there is a practitioner doctorate (Doctor of Medicine: M.D.) alongside an academic degree (usually Ph.D.) in a specialized research area such as epidemiology and neurobiology.

Academic and Professional Training

If this wasn't bad enough, the doctoral programs in most universities were geared toward the preparation of researchers and teachers—not clinicians. As I have already noted, I was ill-prepared to provide clinical services when graduating with a Ph.D. degree from a major US university. Fortunately, I soon decided to follow the traditional academic track and became a young assistant professor of psychology. However, after several years, I left the academy and eventually became primarily an organizational psychologist.

It seems that my doctoral program also did not adequately prepare me for this work. I knew nothing about consulting contracts or stages in the consulting process. As an Assistant Professor of Psychology, I knew something about change theory and such psychological concepts as resistance, motivation, and self-fulfilling prophecy. My training as an organizational consultant came from my enrollment in an organization development program run by NTL (the National Training Laboratories). I suspect that many clinical psychologists of the time also looked for independent training programs that taught them about therapeutic strategies, as well as how to contract with a client/patient. By the 1960s, it became clear to those serving in a leadership role at the American Psychological Association (APA), as well as many leading academic and clinical psychologists, that something had to change. This concern came to a head in the 1970s, when consensus emerged from several notable APA conferences that a new practitioner-oriented degree was needed. The Doctor of Psychology (Psy.D.) was born.

The Psy.D. Degree

Under considerable pressure from APA and regional agencies that authorize institutions to grant degrees, those graduate institutions that wished to prepare psychologists for professional services were encouraged (and often required) to offer the Psy.D. rather than the Ph.D. This new professional degree became the mandated doctorate awarded by most independent graduate schools of psychology (which had been created and had grown exponentially during the 1970s). Universities retained the authority to grant the Ph.D. degree, while some of them branched out and decided to offer a clinically oriented Psy.D. program.

These changes in degree offerings were not of much help to those wishing to become organizational consultants or provide psychological testing. There were a few graduate schools that conducted a Psy.D. (or Ph.D.) program focusing on organizational psychology. But not many. Programs that specialize in psychological assessment were even fewer in number. The medical field in the United States did indeed cast a shadow over the field of professional psychology. Virtually all attention was directed toward an area of psychological practice that is adjunctive (and often subordinate) to medicine: clinical psychology and related mental health issues.

By the 1980s, the world of psychology had become populated with clinical psychologists. Those doing research, scholarship, and teaching in the field of psychology were now a distinct minority in APA membership. Independent graduate schools that offered Psy.D. degrees now enroll most of those seeking to become psychologists. We also witnessed the emergence of many career options for those wishing to address mental health issues. As I shall note shortly, the field became not just much larger

but also much more diversified regarding degree options. Masters degrees were offered in Marriage and Family Therapy and in Clinical Social Work. Soon, as we shall see, there were many other options.

There is one other important point to be made about degree programs and licensing in the United States. A major policy regarding authorization has created many headaches among those trying to regulate the field and those seeking to be certified as practitioners. In the United States, regulation of all professions occurs at the State rather than the National level. Each state has its own regulations and its licensing tests (though national tests are often available). One does not automatically get approved in another state, even with extensive experience of licensed practice in the original state. This provides a major challenge for those who are in transition between states.

While each state established its own regulations, there are some commonalities. Licensing requirements typically include an approved supervised internship and passage of a state-run examination. It is also common for a ghost to hand over the licensing requirements in all states. This ghost concerns the restraint of trade. The original purpose for granting licensing, which was assurance of quality and elimination of "quackery," has remained at the public level. However, behind the scenes, we find that licensing is being used to control the number of practitioners at any one time in a profession.

It is interesting (and perhaps disturbing) to note that licensing exams (and more generally, the granting of licenses) are often market-driven rather than related primarily to assurance of professional quality. There is a tendency in many licensing domains for there to be lower pass rates on the exam (and lower granting of licenses) when there are many practitioners in the field, than when there is a scarcity of practitioners. There is little data to determine the extent to which this change in levels is common in many other countries; however, this restraining practice is certainly present in many American professions, including psychology.

Professional Recognition of Psychologists

Overall, being addressed as "Doctor" and passing a licensing exam carries significant implications related to expertise, authority, responsibility, and social status. One needs an advanced degree and then licensing if the intention is to work in a medical institution or provide mental health services.

Degrees in Clinical and Nonclinical Fields

If one wishes to work in a medical facility (especially a mental institution) then a doctorate (Ph.D. or Psy.D.) is required. At the Masters Degree level, there is a strong preference (even requirement) that one has obtained a Masters in Social Work (MSW). Increasingly, there is a preference for those who have been awarded an MSW with a clinical emphasis (MCSW). Those psychologists who have been awarded an educational doctorate (Ed.D.) usually need not apply for a job in the mental health field, though they are fully accepted and heavily recruited to provide counselling (and sometimes psychotherapy) services in school systems.

Those with an M.A. or M.S. in psychology are not eligible for mental health jobs unless they are licensed (even if their program is clinically oriented). Those who have obtained not just a Masters Degree in Psychology but also a license to practice as a Marriage and Family Therapist (MFT) can be quite

successful in offering not just marriage and family therapy but also general psychotherapy--though this is usually considered to be formally outside their domain of expertise. Those with an MFT are usually unsuccessful in finding work in a medical facility. However, those with a specialization in behavioral medicine are now often sought, though support and funding for behavioral medicine services are still wavering in many hospital systems.

Giving Psychological Advice

It is also not appropriate (or even legal) to provide psychological services in a clinical setting with a doctorate outside the fields of medicine, psychology, and education. Even giving psychological advice via a public medium (such as radio or television) is frowned upon by those with degrees and licenses in the field of mental health. We can look back, for instance, on the speaking and writing done by Joyce Brothers, who had been a successful contestant on a major TV quiz show. Joyce Brothers was trained as a research psychologist at Columbia University and was awarded a Ph.D. She was to become a widely read and influential interpreter of psychological research findings for practical use. Her column in *Good Housekeeping* probably had a greater impact on the lives of American families than any esteemed article published in a peer-reviewed APA journal.

Dr. Brothers was exceptionally skillful at presenting complex ideas in a way that “ordinary” people could understand—yet she didn’t “water down” the findings. Despite contributing in a major way to the consumption of psychological findings, Dr. Brothers was viewed unfavorably. The negative reactions were founded not just on the fact that her doctorate was not in clinical psychology, but also on the less rational foundation of envy for her popularity and an elitist assumption that psychological findings are only for those who are qualified to read and interpret them in an obscure journal.

An even more unsettling tale can be told about another disseminator of psychological insights. This person was Laura Schlessinger. Known as Dr. Laura, this syndicated “helper” often offers outlandish advice and has been rightfully criticized for being of no real help to those needy folks who phone in for her assistance. However, this was not always the case. When she first was “on the air,” Laura Schlessinger tended, like Joyce Brothers, to offer sensible advice based on credible psychological research.

However, Dr. Schlessinger’s degree was not in psychology. Like Joyce Brothers, Laura Schlessinger received her doctorate from Columbia University. Her Ph. D. was in physiology. However, unlike Dr. Brothers, Laura Schlessinger also studied for and obtained a Marriage and Family Therapy (MFT) license in California. Apparently, the MFT was not enough. Laura Schlessinger’s critics declared that she should “not be allowed” to convey psychological advice. This requires a Doctorate in Psychology. So, “Dr. Laura” emerged, who was now in the business (like “Dr. Phil”) of providing entertainment (and generating ratings) rather than being of “real” assistance to those who seek her advice. We can obtain advice from many sources when we are struggling with a difficult personal issue. Our spouse, friends, pastor, family doctor, and a whole host of other well-meaning people are welcome to tell us what to do. In fact, we now know that we often receive a shot of feel-good neurochemicals when given advice. However, we are not supposed to take advice from those on the radio, TV, Sirius XM, and many social media sites who are not fully credentialed!

Clinical Alternatives

With a strong need for competent mental health practitioners in most US communities, there are now other models of clinical psychology authorization. Some states acknowledge Licensed Mental Health Service providers (LMH), while Licensed Professional Clinical Counseling (LPCC) is gaining considerable credibility in many states. Both of these licenses require at least a Masters Degree in Psychology with a clinical focus. One other alternative to traditional master's and doctoral-level credentialing is now found among those seeking a sub-professional license as a Psychological Associate (PA). Much like the MFTs, these who are PAs have obtained a Masters Degree in a clinically related field of psychology and passed a licensing exam (after a rather lengthy internship). PAs do clinical assessments and conduct psychotherapy sessions. Like the MFTs they find very few restrictions (other than lower credibility accompanied by lower fees).

Those with degrees in art therapy (Bachelors or Masters), vocational therapy (Bachelors or Masters), or recreational therapy (Bachelors) are welcome in medical settings, as are those with an advanced (Masters or Doctorate) degree in Rehabilitation Counseling. Mental health facilities that treat drug abuse patients will seek out Licensed Clinical Alcohol and Drug Abuse Counselors (typically with a Masters Degree). It should be noted that some mental health jobs are available for those with an AA or BA degree in a mental health-related field. They can work as Psychological Associates (PA) (after completing a PA licensing program) or as aides on the wards of residential mental hospitals.

Pastoral Counsellors

Then there is the matter of human service professionals—called pastoral counsellors—who are working in religious institutions. Like those working in educational institutions, these professionals are often grudgingly accepted by their counterparts with “regular” work in secular institutions. These pastoral counsellors who have obtained a pastoral counselling degree (usually at the Masters or Doctoral level) are reluctantly accepted in large part because they provide a significant amount of the psychotherapy in the United States. Pastoral counsellors are chosen by their clients because of the alignment of their own religious beliefs with those of their pastor. It is also a matter of cost. Pastoral services are typically offered at no charge or a very low fee is charged to members of the counsellor’s congregation. Therapy costs are low or even non-existent because the Pastor receives a regular salary derived from parishioner donations. It is disturbing to note that a significant amount of pastoral counselling is being done by pastors who have received no training in the use of psychotherapeutic services, nor education regarding forms of psychotherapy.

I have consulted with a major religious organization in the United States to address this specific issue. In this particular church, a large amount of time is devoted by pastors in small congregations to these pastoral services. Part of the challenge concerns not just preparation in the provision of clinical services but also dual relationships (discouraged or forbidden in many mental health fields). One of the pastors whom I interviewed noted that he was working as a pastoral counsellor with one parishioner who had anger management issues. This volatile gentleman also served on his parish board and often erupted during board meetings. Quite a dilemma!

License Not Needed

The matter of credentialing is not necessarily needed by professional psychologists if they are working in nonmedical and nonclinical fields, such as those doing organizational consulting work or serving as personal coaches. However, in many states, those professional psychologists without licenses often can not call themselves a “psychologist.” However, they can identify their degree on resumes and books. While they can’t call themselves psychologists, they can include information concerning their advanced degree in psychology.

All of this is a bit confusing and even ironic for not only the “psychologist” but also the general public. Fortunately, this issue of not being able to call oneself a “psychologist” if not clinically licensed is not necessarily a problem for many non-clinically trained psychologists. These professional psychologists often stay far away from the field of clinical psychology and psychotherapy. They wish to avoid the “stigma” of being called a “shrink.” They prefer to call themselves “consultant”, “coach” or “counselor.”

There is another irony associated with the certification of professionals to provide clinical services. It seems that the licensing exam is usually geared primarily to the acquisition of clinically based knowledge. Yet those who have received education and training that is not clinically based must pass this exam if they are to call themselves “psychologist.” In California, it has become even more restrictive. One can’t get licensed anymore unless the title of one’s degree includes the word “clinical.”

Blizzards and Doctorates

We who live in the United States seem to be confronted with blizzard conditions when seeking to find personal nonmedical assistance or when searching for the right career in the human services. The blizzard is produced by the significant influx of new professional human service professions and degrees, the profusion of sometimes conflicting regulations, the appearance of voluminous licensing requirements, and the stifling abundance of restrictive laws concerning the scope of practice.

Amid this human service blizzard, we are looking for some stability, certainty, simplicity, clarity, calm, and consistency. These are desirable conditions that counter what has been identified as VUCA-Plus conditions (volatility, uncertainty, complexity, ambiguity, turbulence, and contradiction) (Bergquist, 2025). These desired conditions can readily coalesce around the term “Doctor.” In a swirling blizzard, we might be looking for something we understand (at some level) and upon which (hopefully) we can rely. “Doctors” come to the rescue and lead us out of the swirling human service blizzard of the mid-21st Century in the United States. Nothing but “Doctor” makes sense (at least as founded in long-standing lore and tradition).

Scope of Psychological Authority

As we explore the power held by the doctorate among psychologists in the United States, we can turn to the formal power and authority associated with the title “Doctor.” The formal power that is assigned in the United States can be identified by asking several fundamental questions concerning authority: who can prescribe medications, commit someone to a mental health facility, conduct psychological testing, and offer psychotherapy services.

Medications

First, who can order medications? This is a granting of authority that cuts deeply into the medical profession. The traditional answer is that only physicians (and perhaps physician assistants and nurse practitioners) can prescribe. However, there is a growing trend to allow some psychologists with significant knowledge and training in the area of psychopharmacology to prescribe. This trend arises from recognition that some psychologists are knowledgeable about medications (and their impact on human functioning) than are primary care physicians (who do most of the prescribing). It is not usual for a psychologist to offer advice regarding prescriptions to the physician working with one of the psychologist's clients/patients.

As in the case of all important matters of authority, the grading of prescription privileges is determined at the state level in the United States. New Mexico was the first state to pass a law extending prescriptive authority to psychologists in 2002, followed by Louisiana, then Illinois, Iowa, and Idaho more than a decade later. Other states, such as California, support the notion that knowledgeable psychologists can serve as important consultants to physicians regarding prescriptions (especially regarding psychoactive drugs) – but still reserve prescription rights to physicians.

Commitment

There is a second medically related question regarding authority: Who can commit patients? An important distinction must be made between involuntary commitment and voluntary commitment. Typically, a medical professional must ultimately authorize the involuntary commitment of someone to a mental hospital or psychiatric ward of a general hospital. This commitment often requires judicial approval in a court, and evidence must be provided of a severe mental disorder.

This “disorder” is often identified –and warrants protective commitment--as a result of some actions taken that could hurt this person or other people. Suicidal behavior (enacted or seriously threatened) could be the triggering event, as could the observation or “legitimate” reporting of behavior that is bizarre, “non-normal,” and considered in some way to be dangerous. Psychologists and other mental health providers can recommend the commitment, but a medical professional must sign the papers. “Doctor” has no valence in this setting.

Voluntary commitment is much more common than involuntary. Mental health challenges such as severe depression, suicidal thoughts, manic episodes, and recurrent psychiatric episodes (e.g., hearing voices) can lead one to seek inpatient treatment at a hospital. While there is no need for a professional mental health worker to sign any commitment papers, a psychiatric evaluation will inevitably be done when a “patient” first enters the hospital. This evaluation will usually be done by a psychiatrist or other physician with mental health credentials.

Psychological Testing

Some other important forms of authority do not reside in the medical domain and are based on the awarding of a psychology-related doctorate (and obtaining licensing as a psychologist). The most notable of these assignments of authority concerns the interpretation of results from certain

psychological assessment instruments. While those without psychological doctorates can administer these tests, the formal evaluation and reporting of test results must be done by a licensed psychologist. This is the one major domain in which psychologists tend to rule. Medical professionals must defer to the work done by and outcomes generated by assessment-based psychologists.

In brief, psychological tests are used in the workplace (hiring and placement, licensing and development), in schools (determining intellectual abilities, mental health issues, and learning disability), in medical settings (brain damage, anxiety), and in mental health settings (diagnosis and treatment assignment). It should be noted that many psychological tests are not in any way regulated—and therefore are not considered “serious” or “credible” by many licensed psychologists or, as a result, by many other members of the mental health professions. Those used for “developmental” purposes are usually not regulated by a national association or government agencies. However, they may be regulated by the company offering the test (such as use of the Myers-Briggs Type Indicator: MBTI). While the “serious” assessment tools are usually norm-referenced (empirically based), those that are less “serious” are often based on a psychological theory (such as the basis of MBTI on Carl Jung’s personality types).

Many of the regulated psychological tests are considered “serious” (even though there may not be a good reason for anyone to accept their validity). The Minnesota Multiphasic Personality Inventory (MMPI), which is widely used in mental health settings, must be interpreted by a qualified mental health professional.” This usually means a licensed clinical psychologist (or psychiatrist with appropriate training). In the case with many of the “IQ” tools used in educational settings, interpretation can only be done by a “trained” psychologist. In some states, this assessor of IQ must be a licensed psychologist. In some states, a qualified “psychometrician” can provide the interpretation.

In general, the American Psychological Association (APA) tends to dictate the terms for use of psychological instruments. The “bible” of psychological testing was produced by APA in association with several other testing organizations. Called *Standards for Educational and Psychological Testing* (APA, 2014), this document provides strict guidelines regarding the administration of psychological tests and offers the following information regarding who can use specific tests (APA, 2014, p. 142):

A number of professional organizations have code of ethics that specify the qualifications required of those who administer tests and interpret scores within the organizations’ scope of practice. Ultimately, the professional is responsible for ensuring that the clinical training requirements, ethical codes, and legal standards for administering and interpreting tests are met.

Acting much like a labor union that is in the business of protecting its members, the American Psychological Association is active in securing the boundaries of practice (in essence, restricting trade). This association actively blocks the engagement of those outside the psychological profession in the administration of tests and the interpretation of results from these tests. At the same time, APA is an active facilitator in the coordination of collaborations between psychologists who are engaged in assessment with other mental health professionals (as well as educators, human resource professionals, and general physicians). For instance, the following is stated in the APA guidelines (APA, 2020, p. 3):

The purpose of the American Psychological Association (APA) Guidelines for Psychological Assessment and Evaluation (PAE) is to assist and inform psychologists of best practice when psychological instruments, including psychometric tests and collateral information, are used within the practice of psychological assessment and/or evaluation. As the discipline of psychology has expanded, the application of psychological assessment has also developed in response to new areas of practice. Integrated medical and primary care, online assessment and scoring, and global initiatives are examples of these new areas. Since the last publication of test user qualifications guidelines (APA, 2001), neuropsychology, forensic psychology, cognitive science, consulting, industrial/organizational, integrated health, and other fields have evolved into more defined and recognized specific areas of practice with developing professional practice guidelines, standards of practice, and identified consistency with the APA Ethics Code.

Thus, in the domain of psychological testing, the label “doctor” often makes a difference—especially when coupled with specific training and expertise in the use of certain “serious” psychological tests.

Psychotherapy

The fourth area of authority is perhaps the most important—and most controversial. The question to pose is: who can call themselves a “therapist” or “psychotherapist”? Typically, the word “psychotherapist” is reserved for those with a clinical psychology doctorate and license, while the word “therapy” is used in a specific context to designate someone doing psychotherapy (rather than someone doing “therapy” of a different sort, such as physical therapy or even basic medical treatment. All of this is quite straightforward—but then it gets messy. For many years, those with an MA or MCSW degree have declared themselves to be “psychotherapists.” And now the host of other mental health practitioners are (rightfully) calling themselves “psychotherapists” since, under their own mandate, they are in fact doing psychotherapy.

We find once again that there is something of a blizzard swirling around the heads of not just those who seek to regulate use of the term “psychotherapy,” but also those who are seeking out a “legitimate” psychotherapist. Yet again, the title of “Doctor” often helps those seeking these services to identify someone who is truly “qualified” to provide “expert” services. The prospective client/patient enters the therapy office looking for the doctoral diploma hanging on the therapist’s wall.

Similarly, the befuddled regulator will sometimes turn in exasperation to the title of doctor. They will declare that someone who has earned a doctorate is somehow more qualified to do psychotherapy than someone without a doctorate. This even means that someone like me with minimal training as a psychotherapy and even less as an administrator and interpreter of results from a “serious” psychological test is better qualified with my Ph.D. in Psychology to do psychotherapy than someone with a MCSW or MFT (but not a doctorate) who has acquired more than 20 years of training and firsthand experience in conducting psychotherapy session.

Respect

In addition to the formal authority associated with the title “Doctor,” there is the informal power that comes with Respect. In many ways, the respect associated with this title holds greater, consistent

weight than does the formal authority, especially given the blizzard of roles and regulations found in the contemporary world of American human services.

Title and Costume

The most tangible manifestation of respect for the title of “Doctor” comes in the use of this title when addressing a person who has earned this esteemed degree. While the title is automatically assigned to a physician when they are operating in a medical center (rather than on the golf course or at home), the title of “Doctor” is *usually* embraced by psychologists when they are operating in a clinical role. While these traditional clinical psychologists have abandoned the white coats of their medical colleagues, and of course have no stereoscopes to drape around their necks. The male clinicians do tend to wear coat and tie, while their female counterparts will dress in an understated dress or slacks.

Those clinical psychologists who seek to reduce the hierarchy associated with quasi-medical engagements may abandon this title. They ask their clients to call them by their first name, just as they rarely identify the person they are serving as a “patient.” Beginning with the “democratization” of psychotherapy by those following the practices of Carl Rogers, the psychotherapists who steer away from psychodynamic (psychoanalytic) perspectives on therapy are likely to go by their first name and wear more informal attire than their psychodynamic colleagues – though they still tend to abide by the 50 minutes therapy “hour” and the private therapy office. We find more informality regarding the use of title among those therapists engaged in behaviorally focused approaches (e.g., cognitive-emotional therapy) and among those inclined toward humanistic approaches (e.g., narrative therapy).

Most importantly, those without a doctorate will never (or very rarely) use their awarded degree as a title. Shirley Smith, who has earned a Masters Degree and has practiced as an MFT for many years, would never call herself “Master Smith.” It would be even less likely that David Johnson, with his Bachelors Degree and license as a Mental Health Service provider, would call himself “Bachelor Johnson.” The only indication of degree earned is to be found in the initials that follow their name, such as “Shirley Smith, M.A., MFT” or “David Johnson, B.S., LMH”.

Fees

There is another salient way in which Respect is manifest. This concerns the fees that can be charged. Those with a “Doctorate” are likely to earn at least 1/3 more and often twice as much as their clinical colleagues without doctorates. The current fees range from \$100 to \$200 per hour. The rate that is charged depends in part on location (related to local cost-of-living) and available options for reimbursement of client/patient’s payment. For those who offered psychoanalytic services, the fees tend to start at about \$150 per hour and rise to at least \$250 per hour in major urban areas and when therapy is being offered by prestigious psychoanalysts. The costs are even higher when consideration is given to the frequent scheduling of multiple sessions each week by traditional analysts.

Fees range widely for psychologists who are working outside the clinical world. Fees are often charged on a per-day rather than per-hour basis. It is not usual for an esteemed organizational psychologist to charge \$1,000 to \$2,000 per day for their services. These fees, of course, are being paid by an organization rather than an individual client—hence can be much higher.

The fees for those doing psychological assessments typically range between \$125-200. However, a full assessment process can cost \$1,500 to \$5000. A neurodiagnostic battery of tests (often provided in conjunction with a medical assessment of brain damage) can range between \$500 and \$1,500. These tests are often given as part of a broader assessment involving brain scanning and other medical tests, thereby driving the total costs of the neurological assessment much higher.

What about those without a doctorate? Clinical fees might begin below the \$100 threshold and rarely raise higher than \$150 per hour. As I have noted, those doing assessments typically must have a doctorate (especially those doing neurological assessments). Those working outside the clinical field who have a Bachelors or Masters Degree will rarely find work as a psychologist in an organizational setting. Those with MBA degrees are preferred. Other practitioners without a doctorate may get a job working in a specialized field (such as art or occupational therapy). They typically are in a salaried position within an organization (such as a mental hospital or rehabilitation setting).

One additional sector must be considered regarding the work done by psychologists. They might be employed in an educational setting. School psychologists earn an average of \$75,000 per year. Faculty members with earned doctorates earn the same amount as most other faculty—the range being quite wide (\$50,000 to \$185,000), with an average of \$103,000 in 2024. The salary of school psychologists and faculty members without a doctorate will be at the lower end of the scale. This is one sector in which there are some advantages associated with moving into an administrative position (especially for those without a doctorate). While salaries for school administrators are not much higher than for those teaching in their schools, college and university administrators tend to start at \$100,000 and rise to as much as \$200,000. The average administrative salary is around \$135,000 per year.

Gender

Finally, there is one disturbing factor regarding the conferring of Respect on someone with a doctorate in psychology. There is often a differing engagement of respect associated with gender. Women are more likely to make use of their doctoral title than are men. I rarely use my title when interacting with other people in a professional setting, whereas my female colleagues frequently make use of their doctoral title. Sadly, women often must document their academic achievements—the assumption being that they are not as “well educated” as men. This difference also tends to show up in the use of degree and license related initially following their name. There is more often a display of initials following the name of a psychologist who is a woman than is to be found with men. Hopefully, this discriminatory difference in the use of degree titles is fading away.

Responsibility

If one is to be responsible and find respect as a psychologist in the United States, then several responsibilities must be fulfilled.

Reports

First, there is paperwork. This is a particularly important responsibility in a clinical setting. However, responsibility also must be assumed in virtually all areas of professional psychology. Reports must be prepared whether conducting an assessment, providing psychotherapy, engaging in organizational consultation, or serving as a school psychologist. Notes are usually taken, and a formal written description of the outcomes (and often the original diagnosis and ongoing processes) must be prepared.

The report is prepared even if it remains confidential (as is the case with most psychotherapy reports). For those doing psychotherapy and school counselling, the report is prepared as a record for the therapist/counsellor's use in preparing for future work with a client/patient. It is also prepared as a source of legal protection for the therapist/counsellor if a suit is brought against the practitioner (all too common today). A report on the diagnostic assessment of the client/patient's status is particularly important for mental health service providers to prepare if they are requesting third-party payment for their work with a client/patient. This report is delivered to the third party.

In the case of assessments and organizational consultations, the report (or at least a portion of it) is given to the client/patient. This report is an integral part of the service being rendered. Borrowing from the work of Chris Argyris and Don Schon (two psychologists engaged in organizational development), the psychological engagement should be guided by a commitment to "action science" (Argyris, 1985). Information collected and observations made by the psychologist are shared with the client/patient. The new information and observations will challenge assumptions made by the client/patient and "unfreeze" views of their current behavior. The client/patient is encouraged to reflect on the information and observations. This sets the stage for new learning and new behavior.

Lifelong Learning

Reflection on current assumptions and engaging in new learning is relevant not just for a client/patient, but also for the psychologist. A "Doctor" is expected to be open to lifelong learning, keep up with advances in their field, and engage in ongoing monitoring of their own performance. This typically means that psychologists in the United States must accumulate a certain number of continuing education hours each year if they are to retain their license. In most states, at least 36 hours of continuing education per year are mandated. Usually, at least 24 of these hours must be allotted to clinically related issues, while 3 of the hours must concern the ethics of clinical practice.

Even if someone with a doctorate is not licensed as a psychologist, they are expected to keep up with their field as long as they are actively involved in their work as a psychologist. This means not only reading current literature but also attending conferences in their area of specialization and meeting with colleagues in a variety of settings. While professional psychology can be an isolating occupation (services conducted in private offices and reports prepared confidentially for a client/patient), it is also an

occupation that requires active engagement in a world of ever-changing evidence, insights, and clarifying models and theories. There is little tolerance for the psychologist with a doctorate who is living on an intellectual island without access to the work of others in their field.

Those with doctorates in psychology are not alone when it comes to lifelong learning expectations. There are often continuing education requirements for those human service providers without a doctorate who wish to retain their license. Typically, at least 20 hours of continuing education must be completed every year (or 40 hours over two years). As in the case of continuing education for those serving as licensed psychologists, this continuing education must be clinically related (usually with some coursework related to ethics).

Supervision

While continuing education responsibilities concern sporadic lifelong learning regarding general and enduring issues in psychological practice, there is also the matter of what is now often called “just-in-time” learning. This means important learning that can occur when one meets with a supervisor once a week or “on-call”. New learning and new insights can occur in a supervisory session regarding specific psychological issues that are of immediate concern for the psychologist being supervised or are brought up by the supervisor to challenge the existing perspectives and practices of the supervisee.

Supervision is usually only required of the newly minted psychologist—especially one who is earning hours of practice required to obtain licensing. This requirement is usually confined to those doing work as a psychotherapist or school counsellor, though training in clinical assessments will inevitably come with supervision and guidance. The supervision can be quite extensive in the case of many upper-tier psychotherapeutic (and especially psychoanalytic) training programs. The trainee must themselves often receive psychotherapy (as a way not only to personally experience the therapeutic process but also to address their own psychological barriers in preparation for being an effective therapist).

This requirement of supervision makes perfect sense regarding the preparation of competent therapists. However, there is an ongoing controversy concerning the value of supervision for all psychologists at all stages of their professional career. Should supervision be required after one is licensed, and even after several years of successful practice? Should this form of “just-in-time” learning at least be encouraged? Is this a matter of ethics? Should the title “Doctor” come with a commitment to being open to assistance from other professionals?

Some form of supervision is required for virtually all newly minted mental health workers. It is typically not required for those starting their work as an organizational consultant, though psychologists who are new to the field of organizational consultation will often first serve on a consulting team rather than going it alone. It is rare for those doing work as an organizational consultant to seek out supervision during their career. They might offer a case presentation at a regional or national conference and receive some feedback on this matter; however, the best approach is to work in a team. This is the one advantage of organizational consulting (when contrasted with psychotherapy): teams are acceptable (even desirable) in organizational work while the clinician is supposed to go it alone--unless engaged in

couples therapy or family therapy, where it is acceptable for co-therapists to participate in this often-complex therapeutic process.

Ethics

The ethical standards to be found in any human service field are complex and nuanced regarding specific conditions and specific kinds of relationships established between a human service provider and their client/patient. However, there are several themes and concerns that always seem to surface in any book about or discussion concerning ethical practices. For instance, in one of the most often referenced books about *Ethics in Psychotherapy and Counseling*, Kenneth Pope and Melba Vasquez (2016) focused on such standard ethical issues as the appropriate relationship between provider and client/patient (especially regarding sexual relationships), confidentiality, supervision (ongoing and emergency, administrator and use of psychological tests, availability between sessions, and record keeping.

Pope and Vasquez also addressed legal issues such as informed consent, required disclosure, liability, and malpractice. Important emerging and controversial ethical issues concerning the use of teletherapy, Internet therapy, and other emerging technologies were also considered. Of greatest importance is the consideration given to matters of ethical reasoning by Pope and Vasquez. In a world of VUCA-Plus, there is little of value in just trying to “play by the rules” and a simple referencing of ethical codes and regulations will be inadequate when dealing with the volatility, uncertainty, complexity, and ambiguity, of provider/client relationships, or with the turbulence of human services needs (e.g. impact of viruses) and frequent inconsistencies of mid-21st Century regulations (e.g. transgender counseling).

The state of ethical compliance in the human services is not made easier by the absence of a Hippocratic oath in psychology (or virtually any of the other human services). There is no ceremony to solemnly swear to abide by some code of conduct and some set of values (which would bring psychotherapy and clinical psychology into the spiritual realm).

Disclosure

A specific ethical issue challenges the practices of all mental health workers. This is the so-called Tarasoff provision that requires a breaking of confidentiality when there is a risk of harm to one’s client/patient or other people. A therapist may need to take appropriate action, which could include breaking confidentiality if their client/patient expresses a threat to harm themselves (e.g., suicidal thoughts) or another specific person (e.g., assault or violence). Furthermore, if a family member informs the therapist that the client/patient seriously intends to harm someone, the therapist may need to disclose information to protect that person. Therapists must also report child abuse, child sexual assault, and elder abuse to relevant public offices, such as Child Protective Services.

Operating In One’s Domain of Training and Competence

There is one final ethical matter that must be addressed by someone doing psychotherapy—and more generally by anyone in the United States who is engaged in professional psychology. They must operate only in areas where they have acquired expertise. Having completed a doctoral program does not allow one to offer services in all areas of psychology. This ethical issue has become more salient as the field of

professional psychology has become more finely differentiated in the United States and as new areas of specialization have emerged.

For instance, those trained as clinical psychologists might be inclined to expand their practice by offering services as a life coach or health coach alongside their clinical services. This expansion is not looked upon favorably by those who are monitoring either the clinical or coaching professions. This is especially the case if the clinician has received no training specifically as a life or health coach. Even if they have received this training and are “certified” as a life coach by an organization such as the International Coaching Federation (ICF), the therapist is expected to separate their clinical and coaching practices. Each is to be independently promoted and even run out of a separate business entity.

Many schools of psychotherapy (especially those with psychodynamic orientation) require extensive training and supervision before being able to use a title designating their practice in this specific area. Not everyone can call themselves a “psychoanalyst,” and specific schools of psychoanalysis usually require that those in their school designate their orientation when “hanging out their sign” (e.g., “Jungian psychoanalyst”). Historically, there has been an ongoing debate in psychoanalysis regarding whether the analyst should also have been awarded a medical degree. Those without a medical doctorate are called “lay analysts” and often charge less and sit lower on the totem pole than those with a medical degree, even though their medical knowledge is rarely used in this psychoanalytic practice. The one area in which their medical degree is engaged concerns the prescription of medications (such as those which reduce anxiety). While psychoanalysts have traditionally discouraged the use of anxiety-reducing medications by their patients (“pure” treatment requiring the leveraging of insights via anxiety), an alliance is growing between psychoanalysis and psychopharmacology among many contemporary analysts.

Expectations of Expertise

We can now turn to the client/patient’s perspective on the services being rendered by a psychologist or other human service provider.

Initial Impressions

As I have already noted, this is where the title of “Doctor” can make a real difference in the United States (and elsewhere in the world). Typically, the person seeking psychotherapeutic services will look for the doctoral diploma on the wall when first entering a therapist’s office, as will the person requesting an assessment or counselling with their troubled teenager. The request for organizational consultation by a corporate executive will usually come with a request that the consultant submit their resume (unless they are well known). The executive is often looking for both a degree and a record of previous consultations.

These requests regarding degree earned do not, of course, guarantee competence; however, when faced with addressing a stressful condition, a prospective client/patient will look for anything that reduces their stress and offers assurance of competency. Physical appearance is important. It is not just a diploma on the wall or an impressive resume. There is also the matter of an office that is filled with high-quality furniture—and perhaps a coach. The resume should be printed on fine paper if provided in

person. It should be well-organized and free of spelling or grammatical mistakes when delivered either in person or digitally submitted. These are superficial matters that relate not at all to the services being presented—yet these matters are important in setting the stage for the psychologist’s display of expertise.

These superficial conditions are even more important to establish for those without doctorates who are providing human services. The client/patient is looking for anything that will assuage their anxiety about putting their life (or at least their psyches) in the hands of another human being. Diplomas should still be put on the wall (even if not doctoral), and degrees awarded should still appear on the resume. There might also be a statement describing the unique nature of the degree and license that were achieved. Certifications are to be displayed, and initials placed after one’s name (even if no one is quite certain what these initials stand for).

Containing the Anxiety

Beyond the initial impression of expertise and competence comes the provision of an anxiety container of anxiety by the provider, be this person a psychologist, psychiatrist or clinical social worker. It is critical that the setting in which these services are provided is safe and conducive to the open exploration of new ideas and insights. If the services being provided are likely to increase levels of anxiety (at least for a certain period). Many years ago, Riane Eisler wrote of the role played by a Chalice (versus a sword) in constructive human interactions. The chalice holds and contains the anxiety (as well as the hopes) inherent in any relationship. We offer a chalice when being attentive to another person’s needs, when appreciative of their strengths and moments of success, and when helping the other person lean and learn into the future.

More concretely, psychologists and other human service providers establish a container and chalice when setting up appropriate boundaries with their clients/patients. This often means establishing a time boundary (e.g., 50-minute hour), when providing services in an enclosed/confidential space and when ensuring that their role in working with a client/patient is constrained (e.g., no sexual relations with client/patient). Even more basically, the human services provider is expected to listen to and respect their client. In recent years, this basic requirement has been reinforced and brought to a focus by those therapists and consultants who engage in narrative therapy (e.g., David Drake) and appreciative consultations (e.g., David Cooperrider).

Even more fundamentally, there is the expectation on the part of clients/patients that their human service provider is an “expert” regarding ethics. In a VUCA-Plus world, the rules might not always be easy to follow. Ethical behavior is often not easy to engage. For instance, is it ever appropriate to meet with a consulting client for a cup of coffee? What should be done if the therapist encounters their client/patient at a movie theater or restaurant? Do they just ignore one another? And what about the client/patient who brings in a slice of the apple pie they just baked—is this appropriate? Can the school counsellor attend their client’s graduation party (they having been instrumental in helping this young person complete their coursework)? It is quite understandable that Pope and Vasquez (2016) devote

chapters in their book on ethics to such topics as “ethical judgement under uncertainty and pressure: critical thinking about heuristics, authorities and groups” and “logical fallacies in Ethical Reasoning.”

Social and Market Exchange

At the heart of the matter regarding reasonable human service expectations is the nature of norms and expectations established by the provider in their relationship with a client/patient. In recent years, those who identify themselves as behavioral economists have drawn an important distinction between what they call “market exchange” and something called “social exchange.” The second of these two exchanges (“social”) occurs when we meet with a dear friend to share some personal problems or offer a party to celebrate our friend’s graduation or job promotion. These “services” are offered at no fee and are reciprocated. We can be helped sometimes, and at other times, provide the help and support. This is what friendships are all about. Our friend or a member of our family doesn’t reimburse us for the cost of the celebration, but they are expected to “return the favor” at some point in the near future.

Psychological and other human services are not based on social exchange. They are based on market exchange. Payment is received for services rendered, and the helping role is rarely reversed. This means that the concerns of one’s client/patient are primary. Focus is NOT placed on the therapist, but instead on the client/patient. The therapist is expected to ask questions, take notes, or in some way demonstrate sustained attention to what their client/patient is saying or doing. Most of the time during a session is taken up by client/patient talk, not by therapist talk—unless the therapist is providing some relevant information. Periods of silence are acceptable. The client/patient is not expected to keep the conversation going (as is often the case with a social exchange).

While the psychologist is quite active when doing an assessment, the focus is still on the client’s performance. Similarly, an organizational consultant might be doing some teaching or demonstrating some mode of constructive interaction—yet the focus must always be on the interests and needs of the client rather than the ego needs of the consultant. Most organizational consultants conduct interviews, observe operations in an organization, and/or review documents before generating a report that summarizes the consultant’s conclusions and recommendations. In this consultative mode, there is a much greater proportion of taking in rather than giving out—this proportion defines what it means to engage in the provision of human services via market exchange.

The other distinguishing characteristic of a market exchange, of course, concerns payment for services rendered. This payment might be made specifically by the person receiving the services or a third party. It should be noted that financial matters are often very difficult to address even when market exchange has been established. How much should be charged? What if the client/patient can’t afford this fee? Can I and should I do pro bono work for worthy causes? What if a client/patient fails to show up or fails to pay? All of this suggests that a ghost of social exchange resides at the heart of many (if not all) market exchanges in the domain of human services. It is not hard to manage a market exchange when it involves the selling of hats or zucchini. It is much more difficult to manage when it involves the treatment of human pain.

Unrealistic Expectations

Several other ghosts linger in the world of human services. Like the confusion regarding social and market exchange, these other ghosts tend to muck up the effective delivery of psychotherapy, counselling, psychological assessment, and organizational consultations.

First, there is the matter of an anxious client/patient obtaining answers to their complex and elusive questions. Why did this happen? Who is to blame? Will this problem be with me (with us) for the rest of my life? Human service providers—and especially those who call themselves “Doctor”—are expected to have answers regarding etiology.

Even if the provider focuses on the actual behavior rather than the causes of the behavior, they are expected to “know” something about the reason why someone is behaving as they are. Is it a matter of personality or the setting in which the behavior is occurring? Will the “old” behavior recur if I change jobs, find a new partner, or stop drinking? Expectations regarding etiological wisdom are even greater for those who are trained as psychoanalysts or provide “depth” oriented consultations. It is even assumed by their clients/patients that if they learn about the reasons why they feel and act as they do, then they will be “healed” and will be free to feel and act in a new way.

Second, an assumption is made that payment for services (market exchange) results in a successful “cure.” Furthermore, the more that I pay for these services, the greater is the chance that I (or our organization) will be “healed.” I pay more for an automobile so that it will provide a smooth ride: I pay more for psychotherapy or organizational consulting services so that I (we) will find a smoother ride in life. While we don’t necessarily expect our friends or other family members to “heal us” (social exchange), we do expect this “miraculous” healing of the person we are paying for services (market exchange).

The payment for cures is often easiest to establish when the bar is set low regarding the cure. Those psychologists and other human service providers who tend to focus on behavioral change are likely to achieve a higher rate of success than those who believe that genuine, long-lasting “cures” require something more than a temporary behavior change. Those who set a higher bar and identify behavior change as nothing more than treating the “symptom” are less likely to find and declare success with their paying clients/patients.

Social Status and Prestige

Where do psychologists and other human service providers stand on the social pecking order in the United States? As mentioned in our previous essay in this series, there is good reason to believe that professional status as often replaced race as an irrational determinant of social status.

Pecking Order

This being the case, then those who hold a doctorate in some professional can be expected to rank fairly high in the pecking order. However, those doing the “soft” work of helping to heal or at least improve the thinking and feelings of other people can’t compete for status with those who do the “hard” work of

healing the physical body of other people. The M.D. is ranked higher than the Ph.D. psychologist, who, in turn, is ranked higher than the Psy.D. psychologist. Those with either of these doctorates will rank higher than clinical social workers or others without doctorates who work in the field of mental health. In general, I would propose that psychologists with doctorates run neck-and-neck with the nontraditional providers of medical services (such as osteopathic and chiropractic practitioners).

Those with doctorates who operate outside the mental health field hold a very confusing and often tenuous rank in the social hierarchy of the United States. First, those doing organizational consulting or coaching are involved in work that many people don't really understand or appreciate. Someone with an MBA will often be accorded greater respect than someone hanging around an organization with a doctorate in organizational behavior. A life coach will take a back seat to a "real" career counsellor. Someone advising about health issues will readily be replaced by a knowledgeable nurse. This social status stuff is very consuming and ever-changing. However, it is important and opens the way once again for someone with a doctorate remaining firmly in place somewhere in the upper third of the rankings.

Degrees and Human Services

With all of this confusion, there are several more general criteria that determine social status in the United States. Status is relatively high when someone has an advanced degree—and when they are NOT doing manual labor. Regardless of the public recognition given to the "blue collar" workers (including the commemoration of "Labor Day") the blue ribbon is still given to "white collar" work—and the human services are considered "white collar" jobs. So are the jobs being done by those with doctorates who teach, consult or administer human service agencies.

On the other hand, the status for those doing human services is not terribly high because, as I have noted, these people are providing "soft" treatments. It is not clear how "treatment" has an impact (especially short-term). It is also unclear how "helpful" the teaching of psychology (or related fields such as sociology and anthropology). Does the understanding of human behavior actually help us solve tough economic and political issues? Don't we need plumbers and home builders more than we need shrinks and societal critics?

Three Images

There is another source of status that can be quite volatile when it comes to those engaged in human services. Status can be threatened or elevated given the reactions of people to the seeming capacity of psychologists and other human service providers to "see" into another person's "psyche" or "soul." While this assumption has no basis in reality, it can produce a fear response that dictates how someone views this human service provider.

Many years ago, a noted psychiatrist (Irving Schneider) wrote about the three images that people hold of someone who does human service work (especially those in the field of psychiatry) (Schneider, 1977). These people can be cast as those who can perform miracles (*Dr. Good*) or as someone who is ineffective ("soft treatment") and perhaps even foolish in trying to do good (*Dr. Dippy*). However, there is also the assumption that human service professionals are powerful manipulators of human emotions

and behavior. They are cast as *Dr. Evil* and are feared, especially if they have an advanced degree. Those with a medical degree are most likely to be threatening (since they can manipulate body as well as mind and heart).

These considerations leave us with a sense that social status is an irrational dynamic when it comes to assigning this status to those in the human service fields. We set status for most people based on their wealth, earning power, and position in the organizational hierarchy. These criteria don't work very well when it comes to assistance with the messy affairs of the human mind and heart. While the hierarchy of those in the field of mental health is pretty much dictated by the medical profession and reinforced by the American Psychological Association and other professional associations in the mental health field, there remains irrationality in the fears and hopes of those seeking these services.

Legal and Professional Privileges

When we move psychological and most human services out of the office and into the courthouse, there are several formal privileges accorded those who are practicing with a license—and especially those who hold a doctorate.

Confidentiality

First, there are important protections against the loss of confidentiality boundaries. Aside from the Tarasoff provision, those doing mental health work usually are not required to divulge confidential information from their work with a client/patient if required to appear in court. This typically includes those doing school counselling. In the case of nonclinical work, the protection is a little less clear. An organizational consultant or person doing life or organizational coaching might be required to report on what they observed regarding illegal actions taken in an organization with which they have worked—though there could be a battle in court about the consultant's or coach's rights and obligations. Those doing assessments are also likely to find that they must report on their findings, especially where a defendant is pleading that they are not responsible for their actions because of mental illness, cognitive incapacity, or emotional breakdown.

In addition to that which doesn't have to be conveyed in a courtroom, there are those matters that can be conveyed. Those with a license—and especially those with an earned doctorate typically have the right to offer hypotheses about the state-of-mind and motive of a defendant. They are often brought into the courtroom precisely for their "expert" opinion. By contrast, a "nonqualified" person is discouraged or even prevented from expressing their opinion about a defendant's psychological condition.

The astute lawyer representing the other side of the argument is likely to say something like: "Who do you think you are making these outrageous assumptions. You are not a licensed therapist!" The judge is likely to throw out or ask the jury to disregard these "nonexpert" hypotheses. Conversely, it is common for both sides to offer expert-based testimony—thus often negating the validity of either set of observations (and demonstrating once again that "shrinks" are working in an area where there is no "truth" or "reality"—there is only Dr. Dippy or an easily-bought Dr. Evil.)

Psychological Test Results

Finally, there is the formal privilege of qualified psychologists (and some other professionals) to bring testing results into the courtroom. While those administering a test might not be required to report on the results (retaining the right of confidentiality), they might be allowed to share the results of their tests if they voluntarily chose to do so—and if the trial concerns serious crimes. In some ways, this is a variant on Tarasoff. The confidentiality rights of a person standing trial for murder or some other dangerous crime are waived. The right of refusal regarding psychological testing is also waived, though, of course, this person can never be required to provide honest answers or perform at an optimal level on a specific test. They also can not demand that test results NOT be reported.

Given the inability to force honesty or hard effort on a psychological test, the administrator of tests for forensic purposes will often use a test that somehow “hides” its purpose. Projective tests (such as the Rorschach or TAT) are often used—leaving open the validity of results from these “soft” tests. There is a legendary use of the Szondi test for many years in criminal trials. This test consisted of 48 photos taken of mental patients with various disorders related to such “illnesses” as sadism, hysteria, and homosexuality. The person on trial was asked to select the two most favorable and the two least favorable pictures. Supposedly, the accused person will “project” their own pathology on these pictures. They will admire the person who has an “illness” related to the criminal behavior for which they are being tried. It is remarkable how widely the Szondi test was used in courtrooms for many years. The validity of this test (and damage done on behalf of this invalid test) approaches that of the 16th and 17th Century Witch trials, where women bound up in ropes were thrown into a body of water to see if they could float (witches apparently could float). If the accused drowned, then they were declared innocent.

Informal Privileges

Several informal privileges are provided to psychologists and other human service professionals in a court of law in addition to the formal privileges that have been assigned. The most important of these privileges concerns credibility. While “shrinks” might be engaged in a profession that is filled with ambiguity, inconsistency, and an abundance of anxiety, they are at least familiar with the elusive dynamics of violence, inhumanity, and greed. They purport to know something about the internal life of those charged with committing a crime. In the land of the blind, the one-eyed prophet is king. Similarly, in the land of those who are blind regarding the motives of evil people, those who have some understanding of an evil person’s inner psyche deserve the attention of those who are asked to judge the actions of the evil (or “insane”) defendant.

The second informal privilege relates closely to the first. If a psychologist knows something about what makes a criminal act as they do, then the psychologist might have some valid ideas to share about how this convicted criminal should be “treated.” It is not just that a psychologist might informally recommend medication given to a patient being treated by a primary care physician. They might informally also be asked by a sentencing judge to suggest what would be the most appropriate and constructive sentence to be meted out to someone convicted of a crime. Should they be sent to the psychiatric ward in a prison? How will their withdrawal from an addictive drug be handled? What about visitations by family members? Is there much hope for this person’s rehabilitation? Most importantly,

should this person be sentenced to death if they are truly “insane”? The psychologist doesn’t play a formal, legally mandated role regarding these difficult forensic decisions. However, the role that they do play can be critical (even lifesaving).

Identity and Career

While licensing and field of practice often overshadow the title of “Doctor” when it comes to formal responsibilities and privileges, the earning of and display of a doctoral degree come front and center when identity and self-image are the issue. While professionals may move around a bit from job to job if they are operating without a doctorate, there is a strong tendency for those with doctorates to use this title throughout their career (and life) and to remain in jobs that enable them to make full use of this title.

Career Settings

To provide a context for this assessment of identity and self-image among those with a doctorate in psychology, I turn to (and modify) a model of career settings first proposed by Michael Driver (1979, a faculty member at the University of Southern California. Driver proposed that one of four “career concepts” (and associated career paths) is promoted in most organizations. I relate their four types to specific organizational settings. These settings, in turn, help to forge one’s career-related identity and self-image.

I identify the first of the four settings as *Steady State* (SS). This is a setting (such as a hospital or human service agency) where one can engage in the same work during most, if not all, of their career. The SS setting is often found in the trades (where one spends their entire career as a plumber or carpenter) and in highly protected (often union-based) jobs (serving in an outdated position, such as a fireman on a train). However, it is also closely associated with the professions and, in particular, with those professions that require an advanced degree (such as a doctorate in psychology). This setting offers someone possible employment in a consistently structured job with clear and consistent job expectations. It also offers the possibility of being recognized for a specific and stable work assignment.

In this steady (and often protected) setting, one can safely take on and use the title of “Doctor.” One can expect this title to be honored. A job is awaiting after being awarded the degree. All of this, of course, requires that the environment is stable and that one’s specific area of expertise will forever be honored. Unfortunately, this is not always the case in a VUCA-Plus world. The implicit agreement (“covenant”) between oneself and one’s society may be broken. Even though one has dedicated themselves to many years of professional preparation (“the lost twenties”), this no longer means that one is automatically guaranteed lifelong employment. It also does not guarantee that one will be consistently honored for their “doctoral” designation. Identity and self-image are in jeopardy in a VUCA-Plus environment. This can lead to disillusionment, depression, and even anger among those who find their “covenant” broken (Cassatly and Bergquist, 2011).

There is also a major challenge for some professionals associated with doing the same kind of work throughout their career. Those in the fields of health and mental health can become bored with their work (unless they are confronted with new health care or mental health challenges). They can also find

a challenging outlet inside their profession (such as serving as a leader in their local professional association) or outside their profession (such as joining an amateur musical group). This identification of a diversionary outlet is often less of a problem for those psychologists who are working outside a clinical setting. Somehow there is always something new to face in a complex organization with which one is consulting or in a coaching session where one is addressing multiple life issues rather than just an emotional malady.

What about those psychologists who are working in a traditional organizational setting? I turn to the second career setting *Linear Incline* (LC). As the name implies, this pathway is identified by an inclined plane. One works in a hierarchically based organization and moves up through the organization, having displayed competency and sustained motivation. A hierarchical organization is required to open the possibility of movement up in the organization and to find many opportunities for career advancement. This LC setting makes it possible for one to be recognized for their work-related accomplishment. As a result of this work, one is given greater responsibility and authority.

Most psychologists with a doctorate are less attracted to this second setting than they are to the first one. While there might be job security in an organization (important given the swirling winds of VUCA-Plus), there is also the politics of organizational life, which can make professional competency no longer of greatest importance. Somehow, the joy of moving up in the hierarchy of an organization is not at the top of the list of motivators for many psychologists. They might take a job managing the human relations or employee assistance program in an organization, but this is rarely life-f fulfilling. Some organizational consultants move over to a position of leadership in a corporation. However, this usually occurs late in the consultant's career. And it often doesn't work very well. As "they" sometimes say: "If you can't manage, then teach management, and if you can't teach management, then try consulting!"

Most importantly, the sense of self for a psychologist with a doctorate is rarely wrapped up in the SS-style organization in which they are employed. They are still more likely to call themselves a "psychologist" than an "IBM'er" or "long-time employee of General Motors." The covenant might have been broken, but not the foundation laid during graduate school of being now-and-forever a psychologist!

The third career setting is quite new. The third setting that I call the *Recursive Spiral* (RS) is one in which there is an upward movement between multiple careers, each of which builds off the previous one(s). This setting is commonly found in fast-moving technology organizations. One moves from one project to another project and may even move from one tech firm to another. This setting comes with diffuse boundaries between jobs and between organizations. It provides the possibility of one's movement into job assignments that make use of one's existing skills and knowledge while also requiring and enabling the acquisition of new skills and knowledge. While this setting provides many challenges (in keeping with VUCA-Plus), it is rarely boring.

This setting is filled with multiple opportunities. There is the ever-present possibility of being given responsibility for embracing an emerging opportunity in one's job. This opportunity supports new learning while building on the foundation of one's current successful work. This third setting is new for most people, including psychologists. What does it mean to keep operating as a psychologist while also

working in new areas? For instance, as I have already mentioned, many psychologists have now begun to provide life coaching services (if they have been trained as a clinician) or as an executive coach (if they have been trained and are working as an organizational consultant). We also find clinical psychologists who are being trained in new neurofeedback procedures and those doing assessments gaining training in the use of new neurological testing procedures or newly validated employee selection-based tests (such as the Big Five). As a prophetic colleague (and esteemed clinician) told me several decades ago: the future will reside not in academic degrees but in certifications!

The RS setting is here to stay. The challenge for psychologists with doctorates is to retain their identity and sense of self as someone providing psychological services while exploring the boundaries of psychology and the intermixing of several disciplines and fields of study (such as neurology and psychology, or leadership and psychology). Some psychologists even declare ownership of a field in which they have just entered. Psychologists in one state, for instance, recently declared that those doing professional “coaching” must have earned a doctorate in psychology (even though coaching touches on many fields). Other psychologists find that they are engaged in a skirmish with professionals in other fields regarding their “right” to provide certain kinds of treatment (for example, neurologically-based treatments).

In many ways, the fourth setting is quite old. Called *Diffuse Opportunism* (DO), this setting was often one in which many women lived—if they were following their husbands from job to job in many different geographic locations. Found not just among military families but also corporate families, the DO setting required that women (and some men) find work wherever they can in a community to which they have just moved. The DO setting might not be easy to find in a closed community (such as a small town) or in an economy where everyone is scrambling to find work. The “outsider” is identified as an unwanted “migrant” and often told to go away. During the 1930s, we find that “transients” (hobos) were found in abundance. While they may have been portrayed in a romanticized manner in song (Woody Guthrie), the world in which they lived was far from being secure or gratifying.

In our own times, we find some psychologists who operate as professional “hobos.” They use their doctorates to move from funded project to funded project. These are often organizational consultants and trainers who work primarily in non-profit or educational settings. The good news for these hobos is that they face the possibility of moving freely in and out of specific job assignments. They are not bound by organizationally dictated expectations regarding role and responsibilities. Furthermore, there is the possibility that they will be recognized for and supported in their initiation of bold new ventures. These ventures can take place both within and outside traditional organizational boundaries. They may yield unanticipated beneficial outcomes. Freedom is alive and well for the DO folks.

The bad news is that there is very little security or stability for the inhabitants of a DO setting. Typically, those working as professional hobos are sometimes successful. This being the case, they are overwhelmed with work and have no time to breathe or spend time with their family. At other times, these hobos have no work. They are overwhelmed with anxiety and must devote an exceptional amount of time to marketing their services. They find little time and have few reasons to breathe or to spend enjoyable time with their family. There is rarely a balance regarding the “right” amount of work in which to be engaged.

Sense of Self

And then there is the matter of identity and self-image. A colleague of mine who makes his living primarily teaching part-time in several graduate schools suggests that he (and others doing this part-time teaching) are operating like migrant workers moving from harvest to harvest. Who is he, and who are the other migrant DO psychologists? What do you tell people when they ask: “So, what is your job?” How do you tell your children that you are a professional psychologist with a doctorate but are right now “out of a job” and are waiting for a new contract to come in? Who am I other than a train-hopping “tramp”? Where is the next train (potential contract), and how do I board this train (get the contract) – especially given my age? And how do I plan for my future years without any retirement plan in place?

In sum, psychologists with a doctorate tend to stick to their profession (steady state). They prefer to do the same kind of work over the lifetime of their career—risking boredom and burnout. They usually are not reliant on a position in an organization (inclined plane). These psychologists tend not to value administrative positions. Greater value is often assigned to moving up in the hierarchy of their professional association. Psychologists with doctorates tend to identify with their profession rather than their organization. Doctoral-level psychologists usually don’t prefer the DO (hobo) setting (unless they are a professional psychologist who is working outside the clinical world). However, they might be found in a Recursive Spiral. However, this shift is usually regarded as merely an addition of new therapeutic skills or adding a new service area to their portfolio. These established professionals are not about to spiral into a new job or new organization, let alone a new profession!

Conclusions

I suggest that there is one tangible way to determine how much a professional psychologist is invested in their identity as someone with a doctorate. This also tends to reveal the career setting in which they now find themselves. The key is to observe how often one makes use of their doctoral title when being introduced to other people. How often do they identify the organization in which they are working or the type of work they are now doing? What do they include in their resume or in their brief bio (description of self)? My prediction in the United States is that 70% of one’s identity is typically invested in the identification of their doctorate. It might be even higher for women. This means that we introduce ourselves and identify ourselves more than half of the time as “Doctor.” That is who we are—most of the time and in most settings. I suspect that this percentage might be much higher in many other countries.

The distinctive culture of the United States has pervaded most other cultures in the world, including in the health care sector. Most of what we have described regarding hierarchies and cultures in the United States holds to some extent for other societies in our 21st-century world. However, several important differences throw important light on assumptions being made about health care services and the meaning and use of the title “Doctor.” The use of “Doctor” is controversial in virtually all countries around the world. In the third essay in this series, Dr. Jim Little specifically considers the use of “Doctor” in another country (Canada).

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