

# Anti-professionalism within Clinical Psychology: The Japanese Association of Clinical Psychology in the 1960s and 1970s

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## 1 Introduction

### 1.1 Purpose

Anti-professionalism is among the important lines of thought that has grown out of the independent living movement and the movement for the liberation of people with disabilities since the 1970s. For example, concerning the independent living of people with disabilities, Takehiro Sadatō states that “it goes without saying that the common motivation behind the concept of independence is the ‘anti-professionalism’ line of thought which maintains that there is a connection between rehabilitation facilities run by professionals, including medical personnel and social welfare staff, and the promotion of the non-welfare and dependence of people with disabilities” (Sadatō, 1993, p.19). These movements criticized the planning and management of facilities and provision of services under the leadership of professionals, and along with emphasizing the receiving of services as consumers in some cases they also demanded the affirmation of people with disabilities living active lives just as they are.

On one hand, in the leading research citing anti-professionalism there is a tendency to tacitly assume this is anti-professionalism adopted by people with disabilities themselves (Mishima, 2007; Tanaka, 2005; Sugimoto, 2001; etc.), but in fact there has also been anti-professionalism pursued by professionals, that is, a movement among professionals to reflect on their own conduct and adopt the perspective of people with disabilities. Specifically, an academic association improvement movement has been active within several academic associations from the 1970s onward, originating at the 66<sup>th</sup> Annual Meeting of Japanese Society of Psychiatry and Neurology held in Kanazawa in May of 1969. Even before the Kanazawa meeting, as a precursor to this initiative there had been movements critical of the introduction of an association authorized board certification system that proposed the “cultivation of skilled doctors who have received adequate training” (Japanese Society of Psychiatry and Neurology, 1968, p.381), and of the introduction of “orders for the preservation of public peace” through the revision of the Criminal Law. In other words, as Mikio Tomita asserts when he states that “[at the Kanazawa meeting] conflict over the dismantling of the medical office course system [i.e. criticism of hierarchical systems/organizations

in medicine] and conflict over the dismantlement/criticism of the Mental Health Law system [criticism of the policy of orders for the preservation of public peace] were debated where they intersect” (Tomita, 1989 (2000), p.17), in the foundations of the association reform movement within the Japanese Society of Psychiatry and Neurology there was a latent awareness of these issues from the two perspectives of securing the status of doctors and protecting the human rights of patients. And with the members of the Psychiatry National Joint Struggle Committee, a group formed as a result of the Kanazawa meeting, at their center, initiatives such as the investigation of mental hospitals that had caused problems, criticism of dangerous experimentation on human beings and lobotomies, and a general resolution opposing the new establishment of orders for the preservation of public peace were also implemented.

In this paper I want to shed light on the association reform movement of the Japanese Association of Clinical Psychology, which, among the reform movements of various associations related to psychiatry in Japan, developed a particularly thorough self-criticism. The Japanese Society of Psychiatry and Neurology’s reform movement, too, was indeed not unaware of the oppressive nature possessed by the professionalism of psychiatry, as is evidenced by Ozawa Isao, a leading member of the Psychiatry National Joint Struggle Committee, having said, “Psychiatry throws people into mental hospitals by attaching scientific labels such as ‘schizophrenia’” (Ozawa, 1975, p. 128). But the Psychiatry National Joint Struggle Committee that promoted the association reform movement, “while it was almost completely victorious over the “Kōza faction” [the Japanese Communist Party (Left Faction)] and the Democratic Youth League of Japan in terms of theoretical thought and discourse, when it came to actual practice the power relationship was reversed” (Ozawa 1975, p. 9). And as Ozawa later put it when he said that “up to now our movement has been focused on one thing: turning mental hospitals from detention centers into places of treatment, nothing more, nothing less” (Ozawa 1989, p. 919), the problem was taken to be poor conditions at mental hospitals, and the professionalism of psychiatry was not comprehensively rejected.

The purpose of this paper is to follow the historical development of the association reform movement of the Japanese Association of Clinical Psychology and elucidate how clinical psychologists[1] perceived the oppressive nature of their own professionalism and conducted a comprehensive reexamination of the work of clinical psychology. In concrete terms, with a focus mainly on the 1970s, this involves describing the process by which, through a comprehensive reexamination of psychological tests and psychological treatments, the professionalism of clinical psychologists came to be comprehensively rejected. In this paper I examine how the clinical psychologists who participated actively in the association reform movement came to critically reexamine their own professionalism from the standpoint of their clients, or how they went beyond

relating to them as “professionals” and, turning their attention to the overall lifestyles of patients and people with disabilities, sought ways to better “live together”.

## 1.2 Methodology

The Japanese Association of Clinical Psychology was founded in June, 1964, and throughout the 1960s and 1970s was the only domestic association covering the profession of clinical psychology. The structure of the association’s organization differed greatly between the 1960s and from the 1970s onwards. In the 1960s, there was a system in which the members were divided into “regular members” and “official members” (the latter being regular members who satisfied certain qualification criteria), directors were chosen from among the official members, and executive directors were chosen from among the directors. In practice members belonging to universities or research institutions comprised the majority of the directors, and “it was a structure in which university people dominated and oversaw the people ‘on the ground in clinical practice’” (Japanese Association of Clinical Psychology Steering Committee, 1970, p. 14). Entering the 1970s, this hierarchy among members was criticized, and the division of members on the basis of educational background and experience was abolished. The actual running of the association was undertaken by the association reform committee (later the steering committee), a group made up primarily of practicing clinical psychologists that was engaged in the association reform movement. The number of members was 1,646 in 1970, 847 in 1975, and from the 1970s onward most of the former directors left the association and the membership declined sharply.

In this paper I draw on the following resources to trace the historical development of the Japanese Association of Clinical Psychology’s association reform movement: 1) the monthly association bulletin *Kurinikaru saikorojisuto* [*Clinical Psychologist*], 2) the quarterly journals published by the association *Rinsho shinri* and *Rinsho shinrigaku kenkyū* [*The Japanese Journal of Clinical Psychology*], and 3) other materials such as books edited by the association. Among these, 1) the association bulletin *Clinical psychologist* contains the most detailed accounts of the organization’s activities, while 2) the association’s journals *Clinical Psychologist* and *The Japanese Journal of Clinical Psychology* and 3) books edited by the association allow for a detailed understanding of the debate over the comprehensive reexamination of psychological tests and psychotherapy.

Along with a literature review using these materials, I also conducted interviews of clinical psychologists who had been actively involved in the Japanese Association of Clinical Psychology’s association reform movement in the 1970s. I undertook these interviews because throughout the 1970s these clinical psychologists devoted most of their efforts to the criticism of perspectives that opposed their own views and a comprehensive reexamination of the work of clinical psychology,

and as a result they left hardly any written documentation concerning how each of them came to be aware of the oppressive nature of his or her own professional status and the concrete triggers and processes involved in arriving at this awareness.

These interviews targeted three medical psychology professionals who participated in association activities before the association reform movement began and later played an active role in this movement. I selected medical psychology professionals as providers of information in conducting the interviews because it was the issues raised by medical psychology professionals that were the source of the pressure felt by the directors/board of directors and that gave the association reform movement its original impetus[2]. When conducting the interviews I read the materials they had produced up to that point in advance, and spoke with each for about two hours. The interviews were conducted between July and October of 2008.

## **2 Initiative to establish clinical psychology qualifications: 1960s**

Consideration of the establishment of clinical psychologist qualifications in Japan began in the 1950s and was led by the Japan Association of Applied Psychology. In the 1960s, the Japan Association of Educational Psychology then released “proposed regulations regarding an institution to recognize clinical psychologists”, created a cooperative system with the Japan Association of Applied Psychology and the Japanese Society of Psychiatry and Neurology, and aimed to set up an institution to recognize clinical psychologists. In 1962 the Association of Applied Psychology and the Japan Association of Educational Psychology were joined by the Japanese Psychology Association in calling for the formation of a preparatory committee for the formation of an institution to recognize the qualifications of clinical psychologists, and in December of 1963 the first meeting of the preparatory discussion committee for the formation of an institution to recognize the qualifications of clinical psychologists (the word “discussion” was later dropped from the name of this committee) was held with the participation of 24 members from 17 associations. According to the “Regulation outline (proposed) concerning recognizing institutions and regulation outline (proposed) concerning recognition” released by the three associations, the purpose of an institution to recognize the qualifications of clinical psychologists was to “advance the psychological knowledge/techniques that should be used in each field, to improve the abilities of those involved in this work, and to work toward the cultivation of places where this work is done, the securing of its position, and the improvement of treatment” (Japanese Psychology Association, 1962, p. 51) by establishing qualifications for clinical psychologists.

Also, during the same period, in connection with the movement to establish a preparatory committee for the formation of an institution to recognize the qualifications of clinical psychologists, in June of 1964 the Kansai Clinical Psychologist Association and the Hospital

Clinical Psychology Association were dissolved and the Japanese Association of Clinical Psychology was formed in their stead. According to the association's ordinances, its purpose was "through the cooperation and linking together of those involved in clinical psychology, to work toward their benefit and the improvement of their abilities, and to advance and develop clinical psychology as a science" (Article 3). Administrative, research, and editing bureaus were set up as lower branches of the organization under the board of directors, and, unlike in any of the other organizations, a professional capacity bureau was established to undertake initiatives concerning employment facilitation, qualification questions, and related issues. In this sense, the Japanese Association of Clinical Psychology was formed as a scientific organization that aimed to develop clinical psychology as a science, and, at the same time, as a professional organization that aimed to benefit clinical psychologists. Following its establishment, too, through various undertakings such as enacting "confirmation of a policy of becoming a driving force behind the preparatory committee for the formation of an institution to recognize the qualifications of clinical psychologists" (Bulletin 1965.7.25: 1)[3] in May of 1965 and taking the lead in implementing supervision training to recognize officially approved supervisors, this organization would go on to clearly establish itself as a leading actor in the establishment of clinical psychologist qualifications.

In July of 1966 the preparatory committee for the formation of an institution to recognize the qualifications of clinical psychologists then released its final report, stipulating "completion of a master's program and one year of clinical experience (graduation from a university and three years of clinical experience as an interim measure)" (Bulletin 1966.8.25: 1) as the prerequisites needed in order to obtain qualification as a clinical psychologist. Also, on the basis of this final report, on November 25<sup>th</sup>, 1967, a general meeting for the establishment of a committee to authorize the qualifications of clinical psychologists was held, and it was decided that the committee to authorize the qualifications of clinical psychologists would begin operations in October of 1969 and the recognition of clinical psychologist qualifications would begin in December of the same year. Preparations for the issuing of clinical psychologist qualifications thus proceeded smoothly until just before the 5<sup>th</sup> annual conference of the Japanese Association of Clinical Psychology held in Nagoya in October of 1969, which I will discuss later, and by September of that year these preparations had reached the point of guidelines for application for recognition being given to each association.

### **3 Start of the association reform movement: The 1970s part 1**

#### **3.1 Reexamining the establishment of clinical psychologist qualifications**

While initiatives aiming at the establishment of clinical psychologist qualifications had proceeded smoothly throughout the 1960s, the annual conference held in Nagoya in October of 1969 brought

about an abrupt change in this state of affairs. On October 13<sup>th</sup>, the day before this conference began, a petition for the holding of a discussion meeting signed by “all members of the 5<sup>th</sup> annual conference discussion meeting preparatory committee” was submitted at the executive director meeting and proposed “changing the annual conference into a discussion meeting for all participants” in order to “make it a place for deep debate and mutual understanding between the members concerning issues related to the establishment of clinical psychologist qualifications” (Bulletin 1969.11.25: 1). This petition was instigated in particular by issues raised by clinical psychology professionals and inadequacies in the clinical psychologist qualification system that were coming to light as the date for recognition [of these qualifications] drew near.

First, while it was not the case that inequities/inadequacies had not in fact been spoken of before the Nagoya annual meeting, what had been focused on up to that point was the fact that the clinical psychologist qualifications issued by the committee to authorize the qualifications of clinical psychologists did not make any contribution to improving the treatment of medical psychology professionals. For example, then medical psychology professional Kyoko Iwasa sought “1. A university degree, 2. 2~3 years of clinical experience, and 3. a state exam” (Bulletin 1966.11.25: 4) as prerequisites for obtaining clinical psychologist qualifications more in line with the actual state of affairs in the medical psychology profession, and raised the issue that as a private-sector qualification with no legal basis this recognition lacked any power to determine common practice or enforce conformity. Also, when it came to the recognition of clinical psychologist qualifications, concrete standards for examination and the study system were not clear, and “in the end, under the pretense of ‘practical training’ trainees were simply being made to work” and “[this system] intentionally creates the kind of intern system that has been a source of conflict within medical departments” (Bulletin 1966.11.25: 4). The view that clinical psychologist qualifications were simply intended to bring about the establishment of new clinical psychology courses/clinical psychology departments in order to “expand the rights and benefits of the director class” (Japanese Association of Clinical Psychology Steering Committee, 1975, p. 6) was put forward, and on this point the criticism of these qualifications had something in common with the criticism of the medical office course system that had also been a trigger of student protests.

The second point raised was that the clinical psychologist qualifications issued by the committee to authorize the qualifications of clinical psychologists were not ones that contributed to the protection of the human rights of clients, or that in the issuing of these qualifications the client perspective itself was lacking. “Fundamentally, qualifications are a ‘sign’ that professionals satisfy the conditions – abilities and responsibility – necessary to the execution of their duties, and the entity that bestows qualifications should not be [one comprised of] professionals themselves but rather one that stands on the side of their ‘clients’. Things like a fixed position, securing of status,

and a monopoly on certain kinds of work that arise out of the bestowing of qualifications are to all extents only incidental consequences, and qualifications never exist for the sake of professionals themselves” (Bulletin 1969.9.25: 4). In other words, what was being advocated was a return to a starting point of “qualifications for the sake of clients” and a clarification of the roles and responsibilities clinical psychologists ought to be carrying out.

At the root of this kind of reexamination of the establishment of clinical psychologist qualifications was a latent awareness of these issues from the two perspectives of securing the status of clinical psychologists and protecting the human rights of their clients, and in this regard it shared a similar awareness to that found in the association reform movement within the Japanese Society of Psychiatry and Neurology discussed in section 1.1. Over the two days of the Nagoya annual meeting the majority of the schedule was thus spent on proceedings, and the submission of the “Petition regarding the establishment of clinical psychologist qualifications”, which demanded that the committee for the recognition of clinical psychologist qualifications cease its recognition activities, was adopted as a resolution.

### **3.2 The raising of issues by the discussion meeting group**

After the Nagoya annual meeting, the discussion meeting group, a group composed mainly of young members of organizations such as the hospital clinical psychology discussion committee and the conference of clinical psychologists, staged discussion meetings in each part of the country and developed criticisms of the directors/board of directors. For example, while making clear their lack of faith in the directors/board of directors who were not heeding the voices of the people on the ground, the hospital clinical psychology discussion committee, a group focusing mainly on medical psychology professionals, called on members to make their association one that forthrightly addressed the problems that arise in the places where this profession is practiced. For instance, Shoko Akamatsu, who at the time was working in the psychiatry department of Tokyo Adachi Hospital and had been involved in the activities of the “hospital clinical psychology discussion committee”, says the following about the terrible conditions she herself had encountered in mental hospitals:

I started out with a burning desire to be a “good clinical psychologist”. My first [place of employment,] hospital B in Prefecture A, was a terrible hospital, and patients were shut away in places not suitable for the treatment of human beings. There was a large room with only worn-out tatami mats and no furniture. There was a heater, and everyone shared the worn-out blanket draped around it. There were no mirrors in the bathrooms and the enclosures [stalls] were only waist-high. The patients wore threadbare clothes and were made to sleep with a

single cotton blanket in cold protection rooms. It was really no place for a human being to live. When an order came from a doctor I would call the patient's name and speak with them for a bit or give them a psychological test in the second floor reception room. But then they would go back there [to their rooms]. A doctor said to me, "You aren't earning your pay", so I did lots of Kraepelin psychological performance tests. Then he said, "This month you've earned [enough]".[4]

The members of the discussion meeting group criticized the majority of the directors for not being sufficiently aware of the terrible conditions at mental hospitals and for having very little understanding of the circumstances in which the medical psychology profession, which was only paramedical[5], had been placed. For example, violations of patients' human rights, such as isolating them in protection rooms or giving them excessive medication, were occurring on a daily basis within the closed-off space of mental hospitals. Even if a medical psychology professional tried to improve these conditions, in practice, "when he tries to do something about a patient's problem, the domain in which he can act is very limited, ...there are many cases in which he has to serve a doctor or nurse before he serves the patient" (Suzuki, 1971, p. 11). Akamatsu, too, relates her anguish at being aware of the poor conditions to which patients were being subjected but being powerless to do anything about them because medical psychology professionals did not have the right to treat patients. Here it was not recognized that "psychological techniques themselves are oppressive to patients"; what was considered problematic was the powerlessness of medical psychology professionals and the fact that "psychological techniques are not being adequately implemented"[6].

Further criticism of the directors and board of directors was then carried out by the discussion meeting group, and just before the 7<sup>th</sup> annual conference of the Japanese Association of Clinical Psychology held at Tokyo Kasei Gakuin in November of 1971 a meeting of the association reform committee preparatory committee was organized as a result of a call from the hospital clinical psychology discussion committee. The association reform committee preparatory committee presented the chair and board of directors with a "petition to hold an emergency board of executive directors, board of directors meeting", and proposed to "1. Make this annual meeting a general meeting, and there 2. Have every director declare their resignation, and 3. Establish a reform committee to rebuild the association" (Bulletin 1972.1.10: 1). Then on November 27<sup>th</sup>, 1971 at the Tokyo Kasei Gakuin annual conference, a resolution of non-confidence in all of the directors was adopted, and within the association an association reform committee was established to "examine the state of affairs at places where each person involved in the work of clinical psychology is employed and the problems they are facing directly, and consider how these issues

should be dealt with going forward” (Bulletin 1972.1.10: 5).

### **3.3 A critical view of the oppressive nature of professionalism**

As we saw in 3.2, the discussion meeting group addressed as problematic the fact that clinical psychology as a discipline and the work it was doing were not in fact benefitting patients in the places where treatment was being provided. Indeed, even during this period there were already some members of the discussion meeting group who had taken the view that “the professionalism of clinical psychologists itself is oppressive”. For example, Jun Watanabe, under the indirect influence of the student protests, asserted that “[clinical psychologists] are professionals who are expected to undertake sorting in order to discover which children are worth educating as soon as possible, register them, and deprive them of their civil rights”, and, in this respect, “their professionalism is only secured by betraying their clients under the pretense of acting on their behalf” (Bulletin 1970.1.25: 4). However, this view that “the professionalism of clinical psychologists itself is oppressive”, as Shinji Suzuki puts it, “was thought of as merely an ideological criticism ignorant of the situation on the ground”[7], and was not necessarily accepted by the members of the association reform committee. Several critical opinions of the view that “the professionalism of clinical psychologists itself is oppressive” can be seen to have existed within this committee.

First, it was asserted that the “the professionalism of clinical psychologists itself is oppressive” view “overemphasizes only the negative aspects of clinical psychologists’ professionalism” (Bulletin 1972.6.1:10). For example, “when [clinical psychologists] are defined as simply tools of the system, the independent agency of clinical psychologists is ignored” (Bulletin 1972.6.1: 13). Also, “some part of what the system expected of clinical psychologists, however small, was ‘for the sake of the client’” (Bulletin 1972.6.1: 13). In other words, it was said that the interests of clinical psychologists and those of their patients were not always opposed to each other, and that clinical psychologists should independently establish a professionalism that would benefit their clients.

Second, it was argued that even if we cannot help acknowledging the view that “the professionalism of clinical psychologists itself is oppressive”, eliminating this professionalism is very difficult in practice. For example, “no matter how you put it, clients who are actually incapable of adapting to this system face the urgent reality of not being able to survive there [in this system]”, and we cannot ignore “clients’ pleas when they say, ‘false adaptation or anything else is fine, just make it so that I can survive’” (Bulletin 1972.6.1: 13). Deeply rooted claims that issues concerning the preservation of the status of clinical psychologists remained unresolved, and voices that said, “I think what the reform committee is saying is correct, but I have to survive in reality” also existed. In other words, the criticism of “not knowing enough about the places where treatment

is actually delivered” that had been leveled against the directors and board of directors by the discussion meeting group was turned against those who adopted the view that “the professionalism of clinical psychologists itself is oppressive”, and the professionalism of clinical psychologists was on the contrary spoken of positively from the standpoint of the interests of both clinical psychologists and their clients.

#### **4 Criticism of psychological tests: The 1970s part 2**

##### **4.1 Recognition of the oppressiveness of psychological tests**

As I will discuss later, the comprehensive reexamination of the work of clinical psychologists, and in particular the comprehensive reexamination of psychological tests, was carried out as an initiative of the association as a whole beginning in 1973. But as we saw in 3.3, it was not as though there had not already been members of the association reform committee who took the view that “the professionalism of clinical psychologists itself is oppressive” prior to this. For example, Jun Watanabe, who at the time was working in a psychological testing center at the national pediatric hospital and was involved in treating children with autism and counseling their parents, had addressed the oppressiveness of psychological tests before the inauguration of the association reform committee. Watanabe speaks about how he came to be aware of this oppressiveness as follows.

My job was to conduct tests in a small room and prepare the materials needed for a diagnosis. Taking the children outside was not part of my work but something I did on my own. When we went to Shinjuku Gyoen or another nearby park they could do as they liked. In the midst of this, while autism means being interested only in yourself, I really started to see a different aspect [to their personalities]. When parents talked to me, they told me that when they went to the school their child’s name had been covered with a white piece of paper or erased even though it had been written with the other children’s names when he or she had entered the school, and as I heard more and more of these stories I gradually realized what was happening in society and what I was being asked to do. Hearing parents’ stories was one [factor], and, as emblemized by intelligence testing, what was produced by hospitals as the work of psychology was, ultimately, classification. ...looking at it now, I think I was able to address clients as an issue because at Tokyo University’s graduate school I was able to say whatever I wanted. Other people did not have a connection to a university and were isolated in workplaces where they were badly treated.[8]

At the time, the national pediatric hospital provided daytime treatment (daycare) for children

with autism, and Watanabe, separately from the work he had been assigned, took them out of the hospital to play as a recreational activity. According to Watanabe, this was possible because “by chance the doctor supervising me did not restrict me to my own work”, and “the national pediatric hospital had just opened, and the atmosphere was one in which you could act quite freely”[9]. Elsewhere, Watanabe also states that when he started seeing children with autism twice a week for a total of around ten hours, rather than once a week for one hour, and “when I moreover started spending time with them during various activities such as eating, urinating/defecating, and going for walks, ...the image I had constructed in my mind of what children with autism were like was completely shattered” (Watanabe, 1971, p. 193). In short, by taking children with autism outside of the hospital and playing with them he came to believe that “children with autism are not special children”[10].

Also, in Watanabe’s case, the hospital at which he was employed was a pediatric hospital, and it was having to conduct many intelligence tests that made him aware at an earlier stage than most of his colleagues that the work of a clinical psychologist involved classifying children with disabilities. In this sense Watanabe can be said to have been in a position in which he could not help being very sensitive to the discriminatory nature of psychological tests. He was also indirectly influenced by the student protests, and at graduate school was in a place where he could “say whatever I wanted”. In March of 1971, Watanabe formed the “committee to consider education”, a mainstream schooling activism group, to advocate for children with disabilities entering mainstream schools, and from the perspective of denouncing the oppressiveness of intelligence testing called on parents of children with disabilities to reject school-age health examinations (Watanabe, 1973; Gakko no kai, 1977).

#### **4.2 Assertions of the good uses of psychological tests and the spread of schooling activism**

Around this time the comprehensive reexamination of psychological tests as an initiative of the association as a whole began in earnest, with a small committee to consider the problem of psychological tests being established in February, 1973, and the association’s journal, *The Japanese Journal of Clinical Psychology*, publishing a special “comprehensive reexamination of psychological tests” series beginning in September of the same year. As impetuses behind this comprehensive reexamination of psychological tests, we can point firstly to criticism of the movement that argued for the good uses of psychological tests and secondly to the influence of the spread of the schooling movement that aimed to have all children, whether they had a disability or not, attend mainstream schools.

To begin with, there was the movement of the liaison conference of psychology associations[11] to establish a Japanese union of psychological associations, and in 1969 this

liaison conference received a request from the Japan Psychology Association to consider the ordinances of a Japanese union of psychological associations and established an internal Japanese union of psychological associations establishment preparatory consideration committee. According to this consideration committee's Japanese union of psychological association ordinance proposal, a Japanese union of psychological associations would aim to "facilitate through cooperation the research and practical activities of associations related to psychology, work towards the advancement of psychology, and contribute to the welfare of society" (Bulletin 1972.9.1: 4), and to conduct initiatives such as "activities related to the cultivation of this country's psychologists and to social improvement and welfare" and "activities related to the regulation of the creation, implementation, sales, etc. of psychological tests" (Bulletin 1972.9.1: 4). In response, the Japanese Association of Clinical Psychology asserted that "reexamining the problems of the role psychology is playing in various social circumstances, and the system of psychology itself, [is] an urgent task" and strongly opposed "creating qualifications in order to increase the social status of clinical psychologists and provide them with a stable lifestyle, or for the purpose of regulating the people using tests" (Bulletin 1972.9.1: 4).

On the other hand, separately from the movement of the liaison conference of psychology associations, there was also a movement of the Japan Association of Applied Psychology to establish a national test committee, and, instigated by the adoption of "Recommendations regarding the creation, distribution and use of psychological tests"[12] at the International Congress of Applied Psychology held in July of 1971, a "preparatory committee for the establishment of a psychological test committee", centered in the Japan Association of Applied Psychology, became active. This official recommendation "was one that advocated the creation of "domestic test committees" comprised of representatives of related professional and academic organizations with aims such as 1) the "appropriate" use of psychological tests, 2) stopping the distribution of "inappropriate" tests, and 3) the development and defense of tests "that have social value" (Shinohara, 1979, p. 371). The Japanese Association of Clinical Psychology participated in a test issues discussion committee[13] that considered issues such as the inauguration of a domestic test committee, and, in response to the Japan Association of Applied Psychology's assertions of the good uses of psychological tests, strongly rejected the possibility of such "good uses". For example, those on the side of the Japanese Association of Clinical Psychology declared that "even if cases in which [these tests] benefit clients sometimes happen to arise" (Bulletin 1974.4.20: 10), such cases are exceptional; "'judgment' and 'tests' fit perfectly within the administration of the 'exclusion of children with disabilities', and the optimism of [believing that there are] 'good uses' of [these] tests has become untenable" (Bulletin 1973.8.6). Around this time there was a movement within the Japanese Union of Psychological Associations to regulate psychological tests in new ways, and in

response the Japanese Association of Clinical Psychology took the position of emphasizing the oppressiveness of these instruments.

Another impetus behind the Japanese Association of Clinical Psychology emphasizing the oppressiveness of psychological tests was the influence of the spread of an activist movement to have children with disabilities enter mainstream schools. The government issued “a decree (decree 339) to set the implementation date of the section of the school education law concerning the obligation to educate children with disabilities at schools for the physically and mentally impaired or to establish schools for the physically and mentally impaired” in November of 1973, and announced that schools for the physically and mentally impaired would become mandatory in 1979. In response, from around this time the spread of school activism focusing on the issue of which children would attend mainstream schools can be seen to have arisen, mainly in Tokyo and Osaka. In the second half of the 1970s not only the government but also most guaranteed development advocates, such as the Japanese association for the Study on Issues of Persons with Disabilities, promoted making schools for the physically and mentally impaired mandatory from the perspective of protecting the right to education of children with disabilities, while on the other hand most disabled people’s or school activism groups, such as the National People with Disabilities Liberation Movement Liaison Conference (Zenkoku shogaisha kaiho undo renraku kaigi), developed a movement in opposition to making schools for the physically and mentally impaired mandatory in every area of the country. In August of 1978, the year before schools for the physically and mentally impaired were to be made mandatory, the Japanese Association of Clinical Psychology also held a general meeting entitled “What is the mandatorization of 1979? - Learning from history and reality” and adopted a resolution in opposition to making schools for the physically and mentally impaired mandatory.

#### **4.3 The comprehensive reexamination of psychological tests**

On what grounds, then, did psychological tests become the target of criticism? I will present the criticism pursued within the association organized in terms of the following three points: 1) The arbitrariness of the scales/standards of evaluation on which psychological tests relied; 2) The effects of psychological tests on human beings; 3) The connection between psychological tests and classification.

First, there was the argument that the “scientific” / “objective” facts provided by psychological tests were one-sided. To begin with, the artificiality of the implementation of psychological tests was criticized. For example, “steps in the work of classification that is nothing more than human sacrifice are established, observational items are created, sometimes numbers are given, and these are passed off as scientific, objective, and positive [tests]; in other words, they

deceive us using the faith in science we have had since the 19<sup>th</sup> century” (Watanabe, 1972, p. 34). In other words, the fact that children’s disabilities are not givens but rather something discovered by the people who organize this classification was being pointed out. Next, there was the argument that the “scientific-ness” and “objectivity” provided by psychological tests are unclear when it comes to the question of for whom the client’s “abnormalities” are inconvenient. Association member Yukio Togawa, for example, states, “[things like] symptoms, abnormalities, defects, and maladaptation, and at the same time their opposites such as normality, excellence, and adaptation, are determined by some sort of “convenience” of the world, and we must investigate whose “convenience” this “convenience” is.

Second, there was the argument that psychological tests had negative effects on people. Association member Tsuneo Yamashita, for example, declared that “understanding in personal relationships is not something that arises in a one-sided manner, but something that only emerges in the midst of mutual interaction, and even then it takes time”, and “that kind of [psychological test] ‘information’ only fosters pointless prediction and prejudice” (Yamashita, 19979, p. 402). At the March, 1973 discussion meeting, Moeko Ōno, a person with a mental illness, said, “that feeling of pressure [of being given a psychological test] was unparalleled.” “When we are told [something] by an expert, even if we have an inclination not to believe it, people are put under a spell” (Ōno, 1974, p. 4). In other words, she indicated that even if she tried not to care about the fact that she was being rejected by psychological tests, or about these sorts of evaluations, in the end such efforts were futile.

Third, there was the argument that psychological tests were being used to classify children in terms of whether or not they had a disability. The critics of testing argued that when it came to determining where children with disabilities would spend their time, evaluation using psychological tests did not constitute valid grounds to justify how they were treated. To these critics, the primary task of education concerning children with disabilities was not encouraging the development of these children or the overcoming of their disabilities, but rather “getting the children around them to understand how they should behave when they grow up” (Japanese Association of Clinical Psychology, 1973, p. 2), and what this required was nothing other than living alongside children with disabilities. They asserted that all children, regardless of whether or not they have a disability, should attend mainstream schools.

## **5 Criticism of psychological treatment: The 1970s part 3**

### **5.1 Recognition of the oppressiveness of psychological treatment**

The comprehensive reexamination of psychological treatment, in contrast to the comprehensive reexamination of psychological tests that had begun to be conducted in 1973, did not begin to be

carried out in earnest until the latter half of the 1970s. Since until that time it was thought that “psychological tests are tools for ‘separating out and throwing away’, but psychological treatments are tools for ‘saving’”, and that in the case of psychological treatment “there are actually people seeking treatment” (Japanese Association of Clinical Psychology Steering Committee, 1975, p. 28), there was almost no doubt about the usefulness of psychological treatment. For example, Shinji Suzuki, who at the time worked in the psychiatry ward of National Kohnodai Hospital and was involved in clinical psychology work targeting patients with a mental illness, describes the circumstances of his coming to recognize the oppressiveness of psychological treatment as follows:

After the formation of the association reform committee the association invited patient groups to attend its meetings, and it was hearing about the world in which these people were living, and their opposition to doctors and psychology professionals, that made me criticize myself over what I was doing. Ms. Ōno, in particular, spoke out about things the patients I was dealing with in my work must also have felt but were unable to say. They couldn’t talk about these feelings because they were afraid of being put in a protection room. The effect of this is huge. ....most [striking] is the depth of suffering. There are cases in which our involvement helps them, but more often it hurts them. There are many instances in which the things we say thinking they will be good for a patient end up doing great harm. We aren’t aware of this. We want to think that while tests may be bad, treatment is good. The world of these suffering patients has a severity that goes far beyond the understanding of common sense or psychology. This is not the same level as the suffering of people we often support. ...in such circumstances it isn’t the sort of thing professionals say, but just being beside them in silence [that is needed]. It is a primitive interaction between two living beings without words, and it doesn’t have to be a professional – anyone will do. No professional judgments or theories, just being beside someone wanting to help them while being unable to do so.[14]

The direct cause of Suzuki’s becoming aware of the oppressiveness of psychological treatment was denunciations made by patients, and in particular Ōno’s criticism of psychological treatment. During this period many groups of people with a mental illness were formed in various parts of the country, such as the Japan National Group of Mentally Disabled People, which was established in May of 1974. People with a mental illness such as Ōno, Osami Yoshida and Terutake Aoki also made many declarations in venues such as the Japanese Association of Clinical Psychology’s symposiums and journal, “*The Japanese Journal of Clinical Psychology*”, and developed their own criticisms of clinical psychologists. And for Suzuki, who at the time was working in a psychiatric hospital, the “denunciations of doctors and psychology professionals”

made by the patients with a mental illness he dealt with directly on a daily basis in his clinical work were presumably something that could not be ignored.

What particularly shocked Suzuki was the “depth of suffering” of people with a mental illness. According to Suzuki, since “the world of these suffering patients has a severity that goes far beyond the understanding of common sense or psychology”, there are many instances in which “the things we say thinking they will be good for a patient end up doing great harm”. And he says that what patients really need when they are suffering is not the “professional interaction” that can only be provided by a professional but the “primitive interaction” of simply being beside them.

## **5.2 The comprehensive reexamination of psychological treatment**

So on what grounds did psychological treatment become a target of criticism? In general, psychological treatment refers to “a method of supporting personal development in which, as a measure to deal with behavioral maladaptation, emotional maladaptation, or mental illness, psychological conflicts are resolved, anxiety is eliminated, and problematic behavior is reduced through interpersonal interactions between a treatment provider who has undergone special training as a treatment provider and a patient seeking treatment (client)” (Sotobayashi et al., 1981, p. 244). In other words, the purpose of psychological treatment, primarily, is to get rid of disturbances and inconveniences related to psychological issues. In contrast to this, within the association, criticism surrounding psychological treatment shifted the focus away from getting rid of inconveniences related to psychological problems and toward ordinary interpersonal relationships, relationships with clients, and the negative effects accompanying treatment.

First, there was the criticism that psychological treatment “increases social indifference...cuts off the ordinary relationships between people” and intensifies isolation and alienation. Techniques such as attentive listening and non-directive treatment used in psychological treatment can also be viewed as ordinary conversation and counseling, and the act of listening to someone else’s worries is not one that can only be performed by a professional. Nearly all of these worries “are things that could be resolved without needing to consult a professional as long as in the workplace or school, or in the neighborhood or family, there is a conversation partner or consultation partner who has experience or information about these sorts of problems, or a close friend with whom [the client] can exchange information” (Suzuki, 1985, p.301). In this respect the existence of professionals is something that robs people of their ability to help and care for each other, and nips connections to the people close to them in the bud.

Second, there was the criticism that interactions with clients in a clinical setting were always through a closed-off form of connection divorced from the sort of relationships found in ordinary life. A “sympathetic understanding [of the client] based on absolutely positive emotions” is

possible because the meeting time and place are decided beforehand and there is no need to have any kind of ordinary contact with the client, and by no means because the treatment provider is a superior sort of human being. Also, in a clinical setting the treatment provider deals only with the mental fluctuations and conflicts that arise temporarily, and does not look at the client's life as a whole. Furthermore, not only were the people making this criticism conscious of the "shabbiness of the 'supportive relationship'", but "when I was told things like "'true human relationships' should be seen in counseling relationships" it made my hair stand on end" (Watanabe, 1979, p. 35). These critics went beyond the whitewashed interactions of clinical settings, took part in various forms of activism such as the disabled people's liberation movement, spent time with their clients outside of the clinic, and sought relationships of "suffering together, thinking together" not as professionals but as simply human beings.

The third criticism was that in the treatment of people with a mental illness, while treatment providers work to eliminate the person with mental illness's symptoms, they operate in a way that is oppressive to him or her. In other words, through treatment the figure of the person experiencing and living with mental illness as it is right now is rejected. For example, Osami Yoshida, who was a leader in the liberation movement of people with a mental illness and who had a major influence on debates within the association, says the following concerning the violence that came with getting rid of the symptoms of mental illness:

It is undeniable that "delusions" are unproductive. They cause problems for other people, and for the person in question they can cause suffering and destroy their way of life. The problem is how to get away from "delusions"[.] ... until now treatment has been the moving [of clients] from being confined to "delusions" (insanity) to being confined to the ordinary. Treatment providers also represent residents of the ordinary world, and the ordinary world has never been questioned. True treatment must, along with these things [the elimination of illness and the prevention of the destruction of ways of life], be something that aims at a free consciousness confined by neither sanity nor insanity (Yoshida, 1977b, p. 24).

Elsewhere Yoshida also says that "mental illness is just one way of living, not in its essence something that should be seen as a deviation from 'normality'", and rejects "treatment providers one-sidedly pushing the set of values they believe to be correct" (Yoshida, 1977a, p. 39). In other words, according to Yoshida, "healing" in its true sense is independently moving through insanity as a subject, that is, defiantly standing up to insanity. In this regard, what is required of treatment providers is to interact with people with a mental illness with a "free consciousness that is confined by neither sanity nor insanity", and, in the words of Suzuki cited in section 5.1, addressing people

with a mental illness not on the basis of our common sense or psychological understanding, but rather through the “primitive interaction” of simply being beside them.

## **6 Conclusion**

In this paper I have pursued the historical development of the Japanese Association of Clinical Psychology’s association reform movement and clarified how within this movement clinical psychologists recognized the oppressiveness of their own professionalism and conducted a comprehensive reexamination of the work of clinical psychology.

Throughout the 1960s, the Japanese Association of Clinical Psychology vigorously undertook initiatives to establish qualifications for clinical psychologists such as conducting supervision training to certify the first supervisors officially recognized by the association. Triggered by events at the annual conference held in Nagoya in October of 1969, however, there began to be a reconsideration of the establishment of clinical psychologist qualifications. The discussion meeting group, comprised mainly of young association members, developed criticisms of the directors/board of directors, a vote of non-confidence in all of the directors was passed at the annual conference held in Tokyo Kasei Gakuin in November of 1971, and an association reform committee was formed within the association. This committee criticized the directors for not adequately understanding the poor conditions at mental hospitals and for not understanding that the professionalism of clinical psychologists was ineffectual in practice. In other words, what was considered the problem here was psychological techniques that should have been useful not being used properly, and critical opinions of the view that the professionalism of clinical psychologists itself was oppressive existed even among many members of the association reform committee.

Also, beginning around 1973 a comprehensive reexamination of psychological tests was undertaken as an initiative of the association as a whole. Criticism of the movement for good uses of psychological tests in the Japanese Union of Psychological Associations and the influence of the spread of the school movement can be cited as triggers of the Japanese Association of Clinical Psychology’s emphasizing the oppressiveness of psychological tests. Regarding the latter, these criticisms focused in particular on psychological tests being used to classify children with disabilities, and asserted that all children, regardless of whether or not they have a disability, should go to mainstream schools. In response to this, the comprehensive reexamination of psychological treatment, triggered by denunciations made by people with a mental illness, was carried out in earnest beginning in the second half of the 1970s. Those involved in this reexamination addressed as problematic the fact that psychological treatment did not look at the client’s way of life as a whole, and, taking part in initiatives such as the disabled people’s liberation movement, sought a relationship of “suffering together, thinking together”. In this respect, their practice involved not

only initiatives that aimed to make them better professionals by critically reconsidering their own professionalism from the perspective of their clients, but also, in reaching the point of comprehensively rejecting the professionalism of clinical psychologists, an attempt to move beyond interacting with clients as professionals.

The fact that over the course of the 1970s they reached the point of comprehensively rejecting the professionalism of clinical psychologists, however, does not mean the critical view of the assertion that “the professionalism of clinical psychologists itself is oppressive” held by members of the association reform committee at the time of its inauguration had been invalidated as an argument. It is not discussed in this paper, but entering the 1980s the professionalism of clinical psychologists came to once again be spoken of positively among a certain portion of the membership, triggered by a notable reduction in members accompanying the establishment of the Association of Japanese Clinical Psychology, another organization specializing in clinical psychology, in 1982. Regarding how the professionalism of clinical psychologists came to be spoken of in a positive light from the 1980s onwards amongst a certain portion of the association’s membership and the contrast between this perspective and the perspective introduced by the association reform movement of the 1970s that comprehensively rejected this professionalism please see Hori (2013).

## Notes

[1] In this paper the term “clinical psychologist” refers to someone who makes use of the knowledge and techniques of clinical psychology and engages in work in this field.

[2] As is seen in Shūsuke Tamai’s estimates that in 1966 there were more than 300 psychological determination staff at child consultation centers, more than 200 technical officials at juvenile classification homes/prisons, and over 100 medical psychology professionals (including part-timers) throughout the country, medical psychologists constituted a minority among clinical psychologists as a whole (Tamai, 1967, p. 384).

[3] In this paper I have abbreviated citations of the Bulletin of the Japanese Association of Clinical Psychology, *Kurinikaru saikorojisuto* [*Clinical Psychologist*], as follows: (Bulletin year.month.date: page).

[4] October 3<sup>rd</sup>, 2008. Interview data from Shoko Akamatsu. Ms. Akamatsu was born in 1933 and began working at Tokyo Adachi Mental Hospital in 1967.

[5] In recent years usage of the term “co-medical” has been preferred, but in this paper I have used the term “paramedical” both from the perspective of historical description and because this term was used to emphasize a sense of “supplementing something” or “being subordinate to something”.

[6] October 28<sup>th</sup>, 2008. Interview data from Shinji Suzuki. Mr. Suzuki was born in 1938 and

worked in the psychiatry ward of the National Kohnodai Hospital from 1968 to 1973. Since 1973 he has worked at the Setagaya Rehabilitation Center, a treatment facility for people with a mental illness returning to society.

[7] Ibid.

[8] July 12<sup>th</sup>, 2008. Interview data from Jun Watanabe. Mr. Watanabe was born in 1935.

[9] Ibid.

[10] Ibid.

[11] The Japanese Union of Psychological Associations was an organization formed for the sake of “[addressing] problems in all areas of psychology” and “horizontal communication between fields” (Japanese Union of Psychological Associations, 1966, p. 60), and was comprised of the following eight associations: the Japanese Association of Educational Psychology, the Japanese Psychological Association, the Japan Association of Applied Psychology, the Japanese Society for Animal Psychology, the Japanese Society of Social Psychology, the Japanese Association of Criminal Psychology, the Japanese Association of Clinical Psychology, and the Japanese Group Dynamics Association. Its first meeting was held on January 14<sup>th</sup>, 1967.

[12] For the entire text of (the Japanese translation of) “Recommendations concerning the creation, distribution and use of psychological tests”, see the Japanese Association of Applied Psychology (1972).

[13] The “test issue discussion committee” was inaugurated in June of 1973 under the leadership of the Japanese Association of Applied Psychology, and its participating organizations included the Japanese Psychological Association, the Japan Association of Applied Psychology, Japanese Association of Educational Psychology, the Japanese Society of Social Psychology, the Japanese Association of Clinical Psychology, the Japanese Association of Criminal Psychology, and the Japanese Group Dynamics Association.

[14] October 28<sup>th</sup>, 2008. Interview data from Shinji Suzuki.

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