# THE CLINICAL PSYCHOLOGIST IN A GENERAL HOSPITAL

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Psychologists have had a limited role in general hospitals in Australia, but as more fully-trained clinical psychologists will be available in the future, a description of their potential talents may encourage hospitals to make the most effective use of their psychological personnel. Such a description sets standards that show up present shortcomings in our profession, while raising hope for it.

Psychologists' basic training begins with undergraduate studies in development, individual and group behaviour, and research methods. Postgraduate training in assessment, abnormal behaviour, behaviour change, and clinical research is now increasingly emphasised in Australia as it is overseas. Their experience of the dialectic implicit in the study of psychology is a further source of potential strength. There are tensions between psychology as a science and psychology as an art, between psychology pure and applied, between its foci on man as biological organism, as social product, and as unique self. Not least, there is the indivisible handicap and advantage that one is oneself part of the subject studied, and part of the methods used.

The clinical psychologist could be of value in five main areas within a hospital - in research, teaching, consultation, and treatment, as well as in psychological assessment.

For clinical research, the psychologist has rigorous training in scientific methods, the clinical techniques that may be needed to collect objective data, and the clinical knowledge to identify problems and the variables and difficulties involved. His professional attitude requires that continual evaluation be part of his own practice. He will be keenly aware of a problem which may be easily forgotten in a teaching hospital, where the students who take cases move along each year - the vital necessity for follow-up, for the sake of the patient, for evaluation of treatment, for scientific research per se, and for the psychologist himself, whose experience may be illusory without such criteria to assess his own work. He can share in the responsibility for follow-up borne by the permanent staff.

He has two qualifications for teaching in a hospital. His special fields of knowledge are increasingly relevant to medicine and nursing. His studies of the principles of learning and of communication should aid him to transmit his knowledge and to stimulate his students.

The psychologist can be a useful consultant on psychological aspects of medicine, surgery, hospital practice, personnel management and therapeutic ward management. In administration, he can develop and apply principles of social organization, group dynamics and role theory, so that the hospital organization is kept 'human', but not 'too human' and not snagging on personal conflicts disguised as principles. Applications of human engineering and work-flow techniques can obtain efficiency and flexibility without wasted effort or outlay.

As a social scientist, the psychologist is very aware of the place of the hospital in the community, with a wider role in social health than simply patching up what comes in. He can be an effective link with agencies, programs and patient rehabilitation outside the hospital.

The particular specialty of the clinical psychologist is usually seen to be assessment, the use of special techniques to assess personality, abilities or pathology. But his colleagues may not be very clear about what he is doing or how, and there may be unnecessary difficulties in communication. The doctor has a fair idea of what other hospital tests seek to measure, but even when the psychologist is using such 'objective' tests as reaction time or galvanic skin response, his findings are usually given in terms of constructs ranging from visuo-motor skills

or reactive inhibition, to intelligence, ego strengths or yet more ineffable terms. These constructs resemble 'the black box', as intermediary between the given aim and what the psychologist actually does. He makes an organized attempt to take samples of behaviour that will be most relevant to the questions set. These samples are assessed basically by comparison with previously observed patterns and correlations in the responses of other individuals in similar standardized situations.

The constructs serve as a form of shorthand to communicate findings. One means of attaching them to reality is to define them operationally, and it can be minimally presumptuous but useful to say, for example, 'the intelligence that this test measures correlates with . .' Nevertheless, the meanings such terms carry should be cogently related to theories of behavior which can be continually tested and developed.

The psychologist must consult his colleagues to ensure that his reports are written in the language they understand - whether it be the language of psycho analysis, learning theory, statistics, biosocial theories, basic English or gobbledygook. Colleagues also know that it is not only the psychologist's lack of skill that results in those cagey reports which say "it may be . . " or "possibly either this or that". All significant facts in a case cannot be known; consequently findings and predictions are based on probability, like those of an insurance assessor. Indeed, for some psychological predictions, the degree of probability can be estimated in actuarial terms.

Colleagues can accept that the psychologist's tests are tools of trade that still have limitations great and small, like many medical tests in the course of their development. What is to be made, however, of clinical psychologists who hardly use tests at all?

These come, I think, in two types. The first is the rather ignorant, unskilled and lazy person who has not benefited by any proper training. Because he is sloppy in his test administration, does not really know how to go about finding what he needs to know or to understand the data he obtains, he naturally finds that his tests are not helpful or reliable. One of the creative tensions in psychology appears here in its negative aspect. It is easy for every man to feel he is his own psychologist, although he might be reluctant to believe he understood the workings of his television set or his stomach so well; psychology appears much simpler to those skating on the surface than to those exploring in depth. Face validity can be accepted too easily. It is a valuable experience for the trainee to review his earliest test protocols, and to find how much more information they carry since he has gained in knowledge and experience. A Rorschach, like an EEG tracing or a cell section, reveals more to the expert than to the student.

The second type of clinical psychologist who may hardly use tests at all is the highly experienced one whose aptitudes and interests have developed chiefly in therapy and who, facing the tension in psychology between the art and the science (in theory, arguably a false distinction, but of significance in practice), practises psychology primarily as an art. Medicine is still both an art and a science, but the question runs even deeper in psychology, which may be both an arts and a science subject at a university. There is still controversy as to whether, or how far, psychology can be a science. Eighty years ago, James remarked that this was no science, only the hope of a science - and often the emphasis is still on hope. The degree of hope, curiously enough, tends to depend on the personality of the psychologist, and the dichotomy between the 'tough-minded' and the 'tender-minded' has been described (see, for example, Winthrop 1956). At the extreme right on a psychologist's scale to measure position on the tough-tender continuum (Tomkins, 1966) is the hypothetico-deductive experimental psychologist, who believes with Thurstone that, if a thing exists, it exists in some amount, and

psychiatrist must often operate as if committed to a theory in order to be consistent, and must often try to get the utmost mileage out of minimal data. The psychologist can afford to be more sceptical and uncommitted, and can play the devil's advocate against assumptions and theories. While a virtuoso may delight in deducing a whole case from the patient's first words and first fantasy, the strength of the psychologist is that he can select a battery of tests which complement each other in tapping different behaviors and levels of consciousness, so that interpretations are confirmed through a consistent network. Hypotheses are put up and tested through assessment. If the evidence does not seem to 'jell', his first reaction is not to discard as unreliable or irrelevant that which is awkward for his first theory, but to seek further information and hypotheses which may elucidate and encompass the whole. He requires evidence of unreliability before rejecting, and confirmation before accepting.

This approach has its dangers too, as a mass of data may overload the psychologist with unmanageable detail, or he may simply pick out, as with tweezers, just what will fit his preferred hypotheses. Properly used, however, this method builds up a meaningful jigsaw in which alternative interpretations can be checked - even though there will be some gaps and leftover pieces, since no assessment is final.

A limitation that should be realized is that, as Anna Freud would predict, an assessment picks up more easily the personality processes which are not working adaptively than those which are, so that psychopathology may be overestimated. Here the background of training in normal psychology may be salutory, particularly if perspectives can be maintained to assess creative and useful clinical settings. And while psychological assessment can delineate tendencies to action very well, the psychiatrist and social worker must assess the reality factors which may determine whether or how these tendencies may be manifest in behaviour.

Plans for management of a patient should affect the way the assessment is handled. My own view that if the clinical psychologist is to follow up management, then he has the right to the full range of clinical interviewing techniques in which he has been trained. But if another professional will be carrying on management, style in assessment must be different, so that the patient knows that the relationship is different and the purpose is different. There should be should be an explicit arrangement, particularly inn working with children, to avoid duplication of materials and techniques and goals.

It may be all very well for an accident patient have his bandages removed and fracture examined by a series of doctors, but what is the effect on a psychiatric patient who is induced to talk about the same intensely personal things in the same way by a series of psychiatric personnel? My hypothesis is that it is bad. It violates the principle that all diagnostic interviews are an integral part of the therapeutic process, it encourages dependent, superficial soul-baring ways of behaviour in the patient, and it debases the coinage of the therapeutic relationship. At the very least, the patient will tend to pick certain techniques as being gimmicks that he is prepared for.

While psychologists have individual differences in approach which should be known to colleagues, by and large assessment interviews can be presented as task-oriented sessions which the patient can find interesting and enjoyable, and which assist patient and doctor by elucidating strengths that can be developed, as well as weaknesses to be helped.

It is often found that a patient will volunteer significant material to the psychologist who does not seem to probe, which he may try to withhold from an interviewer perceived as seeking it. Some pent-up patients appear to find projective testing an emotional experience, when they are able to express symbolically what they cannot verbalize directly. It may seem essential that

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the assessment be followed up immediately without the common delays. In other cases, no further intervention seems needed after such a symbolic ventilation of conflicts and anxieties; the individual has the ego strengths to heal himself now that the abscess has been drained, and it may be important for his independence and his self-respect that he be allowed to do it himself. The dynamics of a psychological assessment are still insufficiently explored, and the implicit assumption has been that it can be conducted in limbo, and not affect and be part of the whole case process.

Full examination of this question would include discussion as to when the roles of assessor and therapist should be taken by two members of a team, and when they should be combined in one person. Here there may well be misunderstandings about the clinical psychologist as therapist. It is possible for medical men to imagine him as the Arab's camel, let into the tent to do psychodiagnostics and, from this entry, insupportably expanding his territorial claims. The psychologist, however, sees his concern for therapy derived, not from his training in psychometrics, but from his wider grounding in psychological studies, particularly human development, learning, personality and the wide field of social psychology. The range of techniques that have been developed largely within psychology includes behaviour therapies, counselling methods, milieu therapies, attitude change and social change. Those now also developed within psychiatry may often be best administered by both working together. One extreme argument that could be put forward might be that
intensive, postgraduate training in psychotherapy could build better on the basic training and orientation of the psychologist, rather than on the psychiatrist’s grounding in physics, chemistry and physical pathology, and that the doctor might act more appropriately as the ancillary to monitor differential diagnosis, intercurrent disease and psychosomatic problems. The other extreme was stated by the American Psychiatric Association: “The application of psychological methods to the treatment of illness is a medical function . . . Psychotherapy is a form of medical treatment . . . especially those methods involving an understanding of the emotional state of the patient and aiding him to understand himself.” (APA 1954).

However, the paradigm of 'illness' from the medical model may prove too constricting if there is to be progress in knowledge of how mental suffering may be reduced and human potential more fully realized. With the growing realization of the importance of cultural, developmental, social and physical environmental factors, as well as of organic and relatively closed intrapsychic processes, we may aim for a clinical team within a hospital which includes intensively trained psychologists as well as psychiatrists, with mutual benefit in learning, consultation and research, and rational deployment in casework.

No clinical psychologist will be expert in all the areas described nor in depicting some Leonardo da Vinci do I wish to promote in practice a Jack-of-all trades. However, no psychologist is a mere 'Binet basher'; he can add valuable techniques, insights and ideas in wider areas and, in doing so, with greater participation in the hospital and in the community, he will be wiser and more effective in his chosen specialties.

REFERENCES

Anastasi, A. (1968). Psychological Testing. 3rd Edition. Macmillan. New York.

Eysenck, H. J. (1952). The Scientific Study of Personality. Routledge and Kegin Paul, London.

Eysenck H. J. (Ed.) (1961). Handbook of Abnormal Psychology; An Experimental Approach. Basic Books, New York.

Mischel, W. (1968). Personality and Assessment. Wiley, New York.
Mittler, P. (Ed.) (1970). The Psychological Assessment of Mental and Physical Handicaps. Methuen, London.
Tomkins, S. S. (1966). Affect and the psychology of knowledge. In : Tomkins S. S. and Izard, C. E. (Eds.) Affect, Cognition and Personality. Tavistock, London.
Resolution on relations of medicine and psychology approved by the Board of Trustees of the American Medical Association, the Council of the American Psychiatric Association, and the Executive Council of the American Psychoanalytic Association (1954). APA Central Office, Washington.
Vernon, P. E. (1964). The Structure of Human Abilities.

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