

# LOOSENING THE MARITAL BONDS OF CLINICAL PSYCHOLOGY: PSYCHOLOGISTS IN THE GENERAL HOSPITAL

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The object of this paper is to argue that clinical psychologists should work harder at becoming applied scientists who happen to be employed by the Department of Health as opposed to any other public-service agency, such as Justice or Education. An example of relatively virgin territory awaiting the attractions of such a breed of scientists is the General Hospital, and an attempt is made to describe various activities in which a General Hospital Psychologist might become involved. Finally, some personal suggestions are offered about tactics for developing applied psychology in the context.

The bonds between clinical psychology and psychiatry reflect the historical development of a non-medical profession, clinical psychology, under the patronage of an emergent medical specialty, psychiatry, which was searching for clinical validity. Psychology provided a body of knowledge, and clinical psychology the medical paraphernalia of a diagnostic service. The situation might be compared to a marriage of convenience between master and servant-girl. However, the time has arrived for clinical psychologists to indulge in "free-love" and extend their favours into other areas of the Health Service.

## *The Clinical Psychologist as an Applied Scientist*

In Britain during 1972, the Standing Mental Health Advisory Committee set up a sub-committee under a psychiatrist, Professor Trethowan, to consider the role of psychologists in the Health Services. Evidence submitted to the Trethowan Committee by the British Psychological Society strongly advocated expansion outside psychiatry:

. . . . the principles and techniques of assessment, modification and research have general applicability. That is, these principles and techniques are not of relevance only to those problems encountered in psychiatric settings. Psychiatric settings have provided the major context in which the skills of clinical psychologists have been developed and demonstrated. It is appreciated that the association between psychology and psychiatry has been to the benefit of both professions and will continue to be so in future. Nevertheless, the skills of clinical psychologists have useful applications beyond psychiatry and mental illness (British Psychological Society, 1973, p. 7).

Eysenck and Rachman (1973) describe the alliance between psychiatry and clinical psychology as a "folie a deux", and present similar arguments for extending services outside the psychiatric institution or clinic.

The term, "clinical psychology", was first used by Lightner Witmer in 1896 in relation to his work with school-children who had learning difficulties. Over the next 70 years clinical psychology became increasingly identified with adult psychiatry, and we now have two largely separate professions with many applied psychologists labelling themselves as Educational or Clinical Psychologists. In the United Kingdom, if not in New Zealand, this distinction is tainted with an element of interprofessional paranoia and restrictive practice which is often revealed in Britain when an appointment is made to a Children's Psychiatric Clinic. This kind of professionalism is unfortunate because it encourages the protagonists to emphasise differences in their functions and training and ignore their substantial similarities. Educational psychologists stress the importance of their additional training as teachers and Clinical Psychologists insist on the necessity of psychiatric hospital experience, whereas both groups should be reacting primarily to the needs of the social services which employ them.

The functions of clinical psychologists are also limited to the extent to which their work is subordinate to the psychiatrist's view of the world and perhaps even more so by the public's acceptance of a disease model for explaining away deviant behaviour. Added to these restrictions is the reactionary influence exercised by senior colleagues who have failed to acquaint themselves with recent trends in academic psychology. The net result is that clinical psychologists are not stimulated to think like applied psychologists whose role in the health service should be to exploit their undergraduate training to its fullest extent in an attempt to find solutions for problems in other settings as well as psychiatry. Large areas of social, physiological and general experimental psychology which are not necessarily associated with psychiatry could have beneficial applications in departments of, for instance, surgery, medicine and orthopaedics.

It is not being suggested that the psychiatric applications of psychology are deficient or that this work should be curtailed. However, the present focus is too narrow and, in the circumstances, it is not surprising that the public persistently confuse the two disciplines of psychology and psychiatry. We need to attract more psychologists with applied experimental interests. The existing opportunities in the health service appeal too strongly to thwarted medical students and quasi-psychiatrists, and offer little obvious scope for potential social engineers or experimental scientists who have no special interest in psychiatric issues.

One objection to proposals for extending the psychologist's contribution is that the Department of Health might be difficult to convince. However, the utility of such an extended role was recently accepted in principle by the British Health Department apparently as the result of evidence submitted to the Trethowan Committee. In a consultation document released in March 1974, the Department commented:

The contribution of psychology in the fields of mental illness and mental handicap is now well-established. It has been strongly argued, also, that Psychology has much to offer in a wide range of fields of health care and, assuming a sufficient expansion of the numbers of the profession, this is the view we share. (Department of Health and Social Security, 1974, Para. 3).

#### *Illustrations of Applied Psychology in General Hospitals*

The field of doctor-patient communication offers considerable scope for useful applications of cognitive psychology. Patients in all areas of medical practice frequently fail to carry out their doctor's recommendations, even when these relate to effective treatments of serious diseases (Ley, 1972; Bradshaw 1973). A partial explanation might be that patients are unable to remember or comprehend what they are told. Studies indicate that patients recall only 40-60 percent of their doctor's statements within minutes after the consultation (e.g. Ley, Bradshaw, Eaves, and Walker, 1973). Furthermore, recall for advice is worse than for other categories of statement (Ley and Spelman, 1967). Abundant evidence has been published which shows that many patients have a poor understanding of medical terms and human biology (e.g. Riley, 1966; Bamford, Frazer, Culy, Wright and Scally, 1969; Boyle, 1970). Simple, practicable changes to the way in which medical information is presented have been shown to increase patients' recall (e.g. Bradshaw, Ley, Kinsey and Bradshaw, 1975), and improved satisfaction with communication has been obtained with hospitalised patients if minimal efforts are made to help them understand information already presented (Ley, Bradshaw, Kinsey and Atherton, 1975).

The task of motivating patients to trade off short-term behavioural changes for long-term health benefits has involved the application of persuasive communication research (see review by Leventhal, 1973) and behaviour modification techniques (e.g. Azrin and Powell, 1968; Penick, Fillon, Fox and Stunkard, 1971). Since the patient's cooperation is always required at some stage in the administration of many medical treatments, socially acceptable methods of improving levels of cooperation are as important as the treatment itself. Some physicians have suggested that such methods should be evaluated according to the traditional paradigm of therapeutic trials (Rose and Udechuku, 1971).

From the patient's point of view, a major concern is that of coping with the pain and distress of some physical investigations and treatment procedures. This might be an issue in which psychologists could

rapidly become involved by introducing, for instance, the principles of prior-warning (Janis, 1969). The beneficial effects of providing subjects with realistic information about forthcoming discomfort has been demonstrated in the laboratory (e.g. Johnson, 1973) and in naturalistic settings with patients having endoscopic examinations (Johnson and Leventhal, 1973) and with surgical patients expected to suffer post-operative pain (e.g. Vernon and Bigelow, 1974).

The last 10 years has seen the rapid growth of biofeedback control and autonomic conditioning. Serious prospects of a new branch of medical treatment, described as "autonomic behaviour therapy" (Shapiro and Schwartz, 1972) are emerging. Claims based on studies of healthy subjects, on results obtained within but not outside the laboratory, and on a few uncontrolled clinical trials can be exaggerated and encourage unwarranted optimism. However, this work provides some promise of future developments in the behavioural treatment of essential hypertension (Shapiro, Schwartz, and Tversky, 1972), cardiac arrhythmias (Weiss and Engel, 1971), tension headaches (Budzynski, Stoyva, Adler and Mullaney, 1973), and possibly migraine (Sargent, Green and Walters, 1973). On a very much more speculative level, biofeedback may prove helpful in the treatment of Raynaud's disease (Schwartz, 1973), gastric ulcers (Gorman and Kamiga, 1972), and epilepsy (Sterman, 1973). It remains to be seen whether any of these techniques has any real therapeutic value. The regular clinical use of biofeedback is still only a twinkle in the eyes of the less expansive psychophysicologist, but the stage has been reached where a number of properly controlled long-term trials on cardiac patients, in particular, would be appropriate.

Unfortunately it is impossible to elaborate on but a few of the contributions which applied psychologists could make in a General Hospital. Others have referred to the advantages of signal detection theory in clinical tests of sensory and psychomotor function (Coombes, Dawes and Tversky, 1970), the use of cognitive models in the investigation of neurological memory disorder (Shallice and Warrington, 1970), and the applicability of behaviour principles in the rehabilitation of the physically disabled (Parsonson, 1973). One could quickly add to this list: the clinical exploitation of placebo effects, which are normally regarded as nuisance variables, to amplify or replace costly or undesirable action therapeutic agents; the applications of studies of leadership-style, communication networks, and group dynamics in helping to improve hospital administrative systems; attempts to create a more favourable hospital environment for staff and patients by the application of ergonomic principles and research into the behavioural effects of architectural design and the allocation of personal space.

#### *Tactics For Developing General Hospital Psychology*

The final section of this paper is concerned with strategies for the immediate promotion of clinical psychology in General Hospitals. The

same arguments will also apply to collaboration with general practitioners, particularly in group-practice clinics. My suggestions are based on several years of entrepreneur activity in the sub-department of Clinical Psychology at Liverpool University, which took a special interest in these developments, and can be summarised in the form of three simple ground-rules: (1) avoid presenting psychologists as psychiatric workers, (2) where possible, provide group rather than individually orientated services, and (3) give special emphasis to research.

The first edict follows directly from a shift of emphasis from clinical to applied psychology. Unfortunately, when psychologists are asked to consider their potential contributions outside psychiatry, they frequently produce proposals which amount to little more than an extension of psychiatric service functions. A good illustration of this can be found in a letter to the *New Zealand Medical Journal* (Taylor, 1974). Professor Taylor cites his own experience of the type of clinical and research activities which are typically undertaken by clinical psychologists working in a General Hospital. Taylor envisages the establishment of departments which have a different set of functions from those in psychiatric institutions but, judging from the examples he describes, it is clear that no noticeable difference has been achieved. His examples of clinical work include the diagnosis of prepsychotic states and of personality disorder in patients referred by psychiatrists, and neurological referrals of patients with memory defects and suspected hysteria. His examples of research ranged from studies of alcoholism and transsexualism to projects on agalmatophilia and tattoo-removal. All this strongly resembles the somewhat passé traditional work of psychologists in psychiatric hospitals. For the reasons discussed earlier, clinical psychologists should make a more deliberate effort to remember that their home-base is psychology, not psychiatry, and that their potentially more useful role lies in finding applications of modern social and experimental psychology which will help to provide practicable solutions to problems confronting widely diverse categories of patients and staff. A more limited goal would seem to deny the value of their undergraduate training in psychology.

The second strategy, a change in emphasis from individual to group procedures which has already been advocated by Hawks (1971) and Eysenck and Rachman (1973), is determined on more pragmatic grounds. Many applications of psychology in General Hospitals will normally involve groups of patients and staff rather than individuals, but there is an additional consideration which favours a group approach. It is improbable that Hospital Boards will be immediately impressed by the need for multiple establishments of psychology posts in General Hospitals. Psychologists can therefore expect to remain thin on the ground for some time in these settings. To avoid becoming inundated with individual referrals and, at the same time, to optimise the impact

of psychology throughout the hospital a more sensible approach would entail concentrating on the evaluation and analysis of group problems and on the introduction of group intervention procedures. For example, Parsonson (1973) has drawn attention to the potential adaptation of behaviour modification techniques in the rehabilitation of physically disabled patients. Programmes can be devised to reduce the acquisition of supplicative and dependent behaviours, diminish social withdrawal, and assist the process of learning new motor skills. In developing such programmes, first consideration should be given the introduction of group rather than individual behavioural analysis and training techniques, or, better still, the possibility of introducing regimens which non-psychologists can easily learn to use with those in need of rehabilitation.

One frequently hears clinical psychologists laying claim to being uniquely qualified to plan, execute, analyse and evaluate their own research projects, and to act as research consultants to other, less well qualified professionals. In spite of the almost perfunctory way in which these assertions are repeatedly made, they nevertheless contain some important element of truth although, perhaps if we are realistic, the methodological sophistication of many clinical psychologists falls rather short of the impression which either they or their colleagues are responsible for creating. Furthermore, there are reasons for suspecting that only a small proportion of applicants for clinical training are interested in the research aspects of the job (Claridge and Brooks, 1973). Nevertheless it is almost certainly the case that research normally provides the most effective means of gaining access to new pastures within the Health Service. Very few hospital administrators and non-psychiatric medical staff have anything like an accurate conception of modern psychology, let alone the potential value of clinical psychologists, and there is no reason why they should be expected to make any great effort to correct their misconceptions. By presenting himself as a researcher, the psychologist is less likely to be confused with paramedical technical staff such as ECG operators or physiotherapists, and to convince non-psychologist hospital staff of the utility of applied psychology it often helps to provide first-hand scientifically reputable evidence.

The provision of first-hand evidence may mean replicating published studies. Such a policy is usually desirable anyway, since psychological principles, particularly when employed in naturalistic settings, frequently fail to generalise from one subject population or environment to another, and replication offers the only means of testing external validity. Although scientifically defensible, replications in some quarters are considered wasteful of time and research. It can be an advantage to work in situations where they are encouraged.

Any research topic chosen by a General Hospital psychologist should be clearly relevant to problems which are perceived as big issues by staff or by patients and, preferably, by both. It hardly seems worth-

while making this point, but the obscure idiosyncratic interests pursued by some are ample justification for stating the obvious. For instance, there may be some uncertainty about the perceived importance of investigations into agalmatophilia and tattoo removal.

Finally, it is possible to generate useful data without aspiring to a Nobel prize. Not all psychological research requires the execution of grand, theoretical masterpieces, and the carving of great chunks from mysteries of brain and behaviour. Nor does it always demand enormous subject populations or chains of experiments entailing decades of data-collection. Many practically important issues will involve research of a highly operational kind of which small-scale investigation will be sufficient. Typical issues might be whether or not out-patients attending the radiography department understand the instruction leaflets which are sent to them before their appointment (Ley, Goldman, Bradshaw, Kinsey and Walker, 1972), how far patients attending a respiratory clinic comply with the medical advice to stop smoking (e.g. Burns, 1969), or the reasons why the staff turnover rate amongst nurses is so high (Revans, 1964).

None of these research questions is likely to lead to investigations which are worthy of publication in the *Journal of Experimental Psychology*, nor is it important that they do so. Many of these kinds of projects will produce information which is applicable only to the local situation in which the data were collected. Nevertheless, assuming their internal validity is intact, they can lead to a more rational brand of decision making and, therefore, have beneficial pay-offs for administrators, medical staff and patients.

For those who wish to make "scientific" rather than operational headway or have doctorates to complete, it would, of course, be wrong to think that applied research is necessarily confining. As one distinguished psychologist, who has made scientific success out of applied problems, has said: "The contrast of applied and theoretical research appears to the writer to be a false one: the most valid theory is one which works, and the most useful way of dealing with an applied problem is to spend ten minutes working out the answer from a sound theory, rather than ten years performing fresh specific experiments". (Broadbent, 1971, p. 4).

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