CLINICAL PSYCHOLOGY, WHO IS TO DECIDE?

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This paper comments on the changing role of clinical psychology in N.Z. and focusses on the necessity for clinical psychologists to become individually involved in their professional futures.

This paper was written following the author's realisation, shared by colleagues, that at present time negotiations are ongoing that both directly and indirectly affect the role and functioning of clinical psychologists in areas of their work. In all these negotiations only a few senior members of the profession are involved and they are, in the main, neither consulting with nor advising junior psychologists about any of the plans or developments being discussed. These junior psychologists currently make up the bulk of the profession and will be ultimately those most affected by any changes that occur.

At the same time, however, these same junior psychologists collude to maintain this status quo. They make few effective moves to involve themselves in matters that ultimately concern them. They often mutter in discontent at informal gatherings but then they typically subside passively into a disgruntled inertia.

Because the profession in N.Z. is young and has grown to its present numbers quite recently, the channels for the desirable communication are not yet established. The establishment of these may require some initial effort on the part of those who care about this state of affairs.

This paper is an attempt to discuss factors relevant to this situation. It is hoped that it will prod some people into initiating remedial activity where necessary.

It is quite clear to all who have some experience in the field that clinical psychology is changing. But who is changing it? Are psychologists remoulding themselves or are they being pulled into some new shape by unseen forces? What are the directions of change? Are these directions acceptable?

Before clinical psychology goes very much further these and related questions must be asked. It is true that they have been asked before and discussed at great length, but now they must be asked on a much more specific level. Deficits must be made clear and the clinical psychologists themselves at all levels must assume responsibility for them.

In order to systematise this questioning, this discussion firstly makes reference to the background philosophy of clinical psychology, moves on to a discussion on the teaching of clinical psychology in N.Z. Universities and then moves on to a consideration of clinical psychology as it is commonly practised in Hospital Board or Health Service Areas and in individual psychiatric hospitals.

The Background Philosophy of Clinical Psychology

The background philosophy has been well discussed and described in the literature. Indeed, frequently discussion at this level is thorough and extremely useful (Hobbs, 1967; Hoch, 1967; Albee, 1970). But practising clinical psychologists typically regard discussions of philosophy as non-productive and irrelevent and so deny themselves this means of imposing order on their haphazard world and their role within it.

The Teaching of Clinical Psychology: What Do Clinical Psychologists Need to Know?

The very divergence of emphasis across the New Zealand universities' M.A. clinical psychology courses suggests that clinical psychology, as a discipline to be taught, is not a clear-cut persuasion. This leads on not only to a discussion of clinical psychology but also to an important questioning of the universities' function. Should the universities look to the consumers and determine what sort of graduate clinical psychologist is needed and then try to supply them, or should the universities rather be looking at clinical psychology, deciding where this is going, and then casting their graduates in this mould? Are the universities service suppliers or community leaders?

Quite obviously some middle-of-the-road approach is called for. The community does have needs within the existing structures of its health services that must be met, and the university with its close proximity to research facilities does have a responsibility to provide grounds and initiative for the definition of future perspectives and approaches within which community progress can occur.

Whoever provides the facilities for it, clinical psychologists must have the opportunity to acquire knowledge across a very wide field. Those working in association with medical programs need to know some basic physiology, pharmacology and medicine. Specialist areas, e.g. obstetrics, require a knowledge that is much broader than simply psychology in helping with the total care of the patient. Even within the field of psychology the breadth of necessary knowledge is tremendous. Learning and cognition alone now present enormous and complex arrays of information; and the area of cerebral functioning and related aphasias is largely unknown to most clinical psychologists, even though its importance to a complete understanding of some patients is obvious.

Away from applied clinical psychology per se, it is apparent to those working in large institutions that clinical psychologists in these situations would benefit from a closer knowledge and greater application of social psychology. With about two years undergraduate introduction to this field they are already more aware of social psychological factors than most of their colleagues. But nevertheless quite frequently a clinical psychologist with sound knowledge in his own area of interest is rendered practically useless because of his inability to understand and appreciate interpersonal behaviour at staff organisational levels. Added to this some administrative training would be useful so that clinical psychologists moving into various types of institutions could have some insight and therefore foresight into the various forms of bureaucratic systems within which they will be trying to function.

It is quite obvious that graduates in clinical psychology do enter their profession with basic skills in psychometrics, behaviour modification and counselling, but at present knowledge beyond this is largely acquired in an apprentice-type on-the-job, sink-or-swim fashion. To be sure this has its advantages, but quite apart from the responsibility to give patients optimum care regardless of whether their primary therapist is experienced or brand new, it seems unfair that young clinical psychologists must risk a reputation of professional naivete and administrative blundering whilst they learn the subtleties of their everyday work.

Obviously some integrated formulation of clinical psychologists' needs is required. Complaints must be listened to and difficulties noted, and some attempt must be made to rectify the situation where possible. Wise recognition of perennial novice grumblings is hardly progressive.

Recently-qualified psychologists should not recover from the culture shock of their employment and then subside into institutional security. The responsibility falls to them to systematise and publicise their needs so that teachers in future can look to all the resources they might mobilise (within and beyond the precincts of clinical psychology itself) to produce a psychologist better trained for the job.

Clinical Psychology in the Hospital Boards or Health Service Areas

It is in the consideration of clinical psychology at the Hospital Board or Health Area level that its patchiness and quasi-specialisation becomes most apparent.

Most such areas are served by a large complex of hospitals providing a high standard of general care and offering specialist facilities in many spheres. Clinical psychologists like to call themselves specialists but offer their services in the main only to acutely-ill psychiatric patients. Some modicum of attention is paid to long-stay psychiatric patients and by special arrangement clinical psychologists may agree to see other patients who look as if they will be interesting to work with.

Clinical psychologists generally claim that they have skills that could be deployed directly to assist patients through life crises, to enhance new learning and to aid adjustment to changed life styles. But they are seldom found in obstetric units, terminal care units, plastic surgery units, amputee rehabilitation units, cardiac aftercare units or any other non-psychiatric areas.

Many clinical psychologists are proud of their training in the scientific method and consequently lay great claim to their potential skills for research. But the amount of research achieved by clinical psychologists working for Hospital Boards is low and frequently the standard of this work is questionable. Research that does occur beyond the mandatory M.A. thesis commitments is commonly patchy and ill-co-ordinated.

Clinical psychologists also talk grandly of principles of healthy living. But they are not involved in any administration or planning of health services beyond those of psychiatry. At this time health officers all over the country are talking about bridging the gap between hospitals and the community. Clinical psychologists take a part in this discussion but are unable to shake off their psychiatric trappings. They look on broad community health programmes with praise and offer encouragement but are themselves caught in a psychiatric revolving door.

The community health developments themselves surely offer a new frontier to clinical psychology. Now clinical psychologists can step forward as community leaders and offer their services directly to the community unhampered by large institutions and complex referral systems.

Clinical Psychology in Psychiatric Hospitals

Within the boundaries of psychiatric hospital services, clinical psychologists can ignore their wider claims and absence from other health services. But even within this protected setting there are inconsistencies between claims that clinical psychologists make about themselves and the actual commitments they make to their hospital.

Clinical psychologists typically describe themselves in terms of their abilities for research, teaching, testing and therapy. But clinical psychologists' claims relating to research are in practice largely unsupported hypotheses.

As teachers of psychology clinical psychologists have achieved some limited recognition in their involvement in the training of students in various disciplines. But the methods and topics for teaching are often at variance with the very principles that clinical psychologists would usually hope to represent. They typically fail to apply the most basic principles of learning in their teaching programmes and then put their students down for failing to generalize their unreinforced, formal lecture material to the informal and variously structured ward setting.

For decades a major claim by clinical psychologists has been of their ability to test people and so produce special information about intelligence, organic states and personality traits. With this function now assuming reduced importance, clinical psychologists now demand much more specific requests for information than previously. They no longer want permission to follow their psychometric noses when assessing a patient. Rather, they now frequently reject requests for psychometric assistance because the reason for referral is too vague or because the referral is thought to be inappropriate. But little effort is made to maintain the educative flow between the clinical psychologists and the referring agents who apparently need to keep pace with the changing self perceptions of clinical psychologists in order to consult successfully with them.

Within the psychiatric hospital and ward settings the major development in clinical psychology has clearly been in the contribution made to ongoing patient treatment. Certainly, clinical psychologists have always been involved in treatment programmes but now their involvement is much greater than before. Ten or so years ago clinical psychologists treated a few individual patients who went from their ward to the mysterious Psychology Department where they drew on a special and undisclosed relationship with the psychologist. Usually treatment followed a counselling/psychotherapeutic model. Occasionally strange behavioural programmes were mounted. Now the situation is quite different, and the most far-reaching development has been in the shift of the treatment arena from the psychologist's office to the ward.

To be fully appreciated this move must be seen within its own developmental context. With the exception of the introduction of chlorpromazine and related drugs to psychiatric hospitals, probably the most far-reaching development has been the realisation of the role of group dynamics in psychiatric settings and the emergence of group treatment techniques for all levels of patients.

Built on this has come the move from the isolationary Doctor-who-knows-best standpoint to the now popular responsibility-diffusing team approach. Now decisions about patients are ideally preceded by staff discussions and consensus of opinion with opportunity for dissent and persuasion.

The clinical psychologist takes his place in this setting and takes to it his particular training, skills and interests. Now the clinical psychologist runs and assists with group treatment programmes in the ward and his individual treatment programmes occur as part of an overall treatment scheme conceptualised and agreed on by the ward team. Dynamic and behavioural programmes are initiated and maintained with the full knowledge of all staff and usually with their vital assistance.

On the face of it, it would appear that clinical psychology has indeed reached great heights in these settings and it is no wonder that clinical psychologists are loathe to throw off the psychiatric cloak.

But what is the total picture? Most psychiatric hospitals have acute, long-stay, mentally handicapped and geriatric patients, with additional units for alcoholics, adolescents and seriously disturbed patients. Typically, clinical psychologists tend to be involved in some units but ignore others.

In those hospitals where clinical psychologists are active in the acute and specialist units nominal involvement only occurs with long-stay and mentally handicapped patients. In these hospitals, whilst claiming allegiance to the Behavioural swing in clinical psychology, clinical psychologists largely ignore those awards with patients who might benefit most from Behavioural techniques. Nursing staff who try, sometimes inadequately, to implement Behavioural types of programmes are criticised. Whilst concurrently discussing principles of healthy living in planning the community health programmes, clinical psychologists pay little practical heed to the continuing institutionalisation of long-term patients and offer little to other staff who may be striving to achieve more than custodial care. Clinical psychologists comment arrogantly on the need for the application of basic psychological principles in the development and co-ordination of nursing, occupational therapy, physiotherapy and other programmes, but then they remain with basic relevent knowledge quite separate from this area of need.

In those hospitals where clinical psychologists are working with the long-term patients they commonly ignore the acute areas. They work with Behavioural programmes and proclaim the superiority of behavioural techniques over pharmacological, physical and psychotherapeutic treatments. They discount these techniques as unenlightened psychiatric hobbies. Whilst assuming such a rigid stand, these clinical psychologists do little to learn of the skills of their colleagues from other disciplines and do even less to facilitate the dispersion of Behavioural skills in return.

In either case the result is the same. The hospitals as a whole are incompletely and inefficiently serviced by their clinical psychologists. The hospitals are generally willing to accommodate appropriate extensions of clinical psychologists' services into areas not yet serviced by them, but by their aloof attitudes and rigid intolerance of treatment models different from their own the psychologists themselves prevent this expansion from occurring.

Some mature intra- and inter-disciplinary open-mindedness and co-operation is clearly called for. Perhaps then there could be some co-ordination between the needs of the hospitals and the claims made by clinical psychology; perhaps then particular clinical psychologists with particular biases and skills could include in their ranks clinical psychologists with other biases and skills who could work with them to present a more complete clinical psychology to the hospitals geared to meeting the hospitals total needs.

Clearly, at all levels, clinical psychology has the potential for considerable change. However this is not something that will magically just happen just because the potentials are so apparent. Someone, or some group, must be called upon to make decisions that will initiate the steps of change and clarify the directions.

At this time a most crucial question stands begging: who will make these decisions?

If patterns of the past hold true, it can be predicted that someone-more or less unidentified and barely questioned, will evolve a path that all will traipse sheeplike along. Then, for a while, all will feel some sense of pride in the changeability and flexibility of clinical psychology. And then will come the all too easy hindsight and retrospective criticism of their leadership. Such criticism will exemplify well the failure of clinical psychologists to be alert to the very real role they might and should play in the determination of their own futures.

More than at any other time, with changes so very imminent in the hospitals and health services within which they work, clinical psychologists now have the opportunity, if they also have the courage, both individually and en masse to ask all the questions they wish and so involve themselves in the changes that will move them towards more fully realising their potentialities. They have a right to insist on answers. They also have the right again to involve themselves in any consequent discussions, decisions, developments and activities.

If clinical psychologists fail to do these things then it seems unreasonable that they should object to being planned for, or ignored, by various planning personnel. It seems all to easy, and unfortunately all too familiar, for clinical psychologists to sit tacitly not minding not being consulted about what higher plans might be evolving for them, add to them, after the wheels of progress are providing their own irretrievable momentum, stir, shake their heads in bewilderment, and set up a too late cry for democracy.

Most clinical psychologists are already aware of the issues presented here. Informal discussions about them, as at the last Hospital Psychologists' Seminar in Christchurch, often become quite heated. However usually the heat of the argument serves to dissipate any tensions and so no further action ensues.

Clinical psychology in New Zealand is young. If it is to grow beyond its present infancy in which its members are just led blindly and obediently along, it is up to clinical psychologists to look to their professional patriarchs and involve themselves in the basic and healthy questioning that will produce a healthy adolescent and a healthy and responsible, self-determining adult.

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