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Clinical Psychology vs. the People: A Community Psychology Perspective

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Clinical psychology in New Zealand, with its trend towards private practice and its adherence to outdated intervention models, is rapidly getting out of touch with the urgent mental health needs of the population. A total overhaul of the system is required, and it is argued that a community psychology orientation is the most appropriate for this purpose. Suggestions are made about how this orientation could be incorporated into existing clinical training programmes.

As Webb (1975) and Innes (1976) have pointed out, there is currently something wrong with clinical psychology in New Zealand. While this may be viewed simply as the continuation of a long standing malaise, a new dimension has been added by the sudden growth of private practice. While private practice is not necessarily a bad thing in itself, it becomes so if it takes people from public institutions which are in need of reform, and if it restricts the recipients of services to those who can pay. I believe that the time has come to mount a strong counter-argument to the blandishments of private enterprise in clinical psychology, and in this paper suggest that the new and important field of community psychology can provide an appropriate perspective.

Therapy vs. Social Change

In the past, psychologists have expended a great deal of pious range on the "medical model." However, it now appears that we are emulating this model to an ever increasing degree. The whole fee-for-service, big-professional-puny-patient, treatment-oriented approach previously ascribed to the medical profession is now being increasingly adopted by psychologists. Yet our clinical training fits us perfectly for an entirely different role, one which is so far being relatively ignored in New Zealand — that of the community psychologist. Here the concern is with organization; the use of systematic approaches to bring about widescale personal, social and institutional change, to make maximal use of whatever resources are currently available to improve people's lives. To quote from the University of Queensland's prospectus for their Master of Community Psychology programme (the only such programme in Australasia):

> Community Psychology is concerned with ... fostering the human potential of individuals through alterations in the major operative subsystems, particularly in the educational, political, judicial and social arenas ... The one to one relationship is insufficient to cater for the needs of a growing society affected by ever-increasing complexity of relations and situations.

If this seems to be beyond the scope of clinical psychology, the prospectus continues thus:

> Clinical Psychology is the basic building brick upon which Community Psychology is built. The skills and abilities of the clinical psychologist in assessment, evaluation, psychological intervention and research, are essential tools for the community psychologist in developing appropriate strategies for modifying system-wide behaviours.

I do not necessarily agree that community psychology needs clinical psychology to the extent described here. But I do believe that clinical psychology is urgently in need of input from community psychology.

The Community Psychology Perspective

In his well known 1970 Presidential address to the American Psychological Association, Albee bemoaned the sad state of clinical psychology, and raised basically the same issues as I do here. Albee actually predicted the demise of clinical psychology as a profession, and said that what was crippling it was the adherence of clinical psychologists to the trappings of medicine. Albee advocated what is essentially a com-

munity psychology approach and argued for a clinical training emancipated from hospital based psychiatric activities. To quote from Albee's address:

> In psychiatric settings the clinical psychologist in training learns to speak the language of psychiatry, learns to use and accept the *sickness* model, and often aspires to a career in the private practice of psychotherapy ... What I am suggesting to you is that we now try standing back at a great distance and with as much perspective as we can manage, to see what are the truly most pressing psychological problems that afflict our society, and whether clinical psychology or some new field of applied psychology like community psychology, might not select these more urgent human emotional problems as our focus after breaking free of psychiatric influence on our choice.

This comprehensive or global view encouraged by Albee is one of the most important characteristics of a community psychology approach. Instead of starting with a narrow range of ready made assumptions about types of clinical problems and the solutions to them, the community psychologist stands back and views the total universe he has chosen to handle. He attempts to assess needs from scratch, always from the point of view of ordinary people rather than that of institutions, although institutional needs are considered too. He then attempts to match resources and interventions to these needs. Inevitably, this leads to considerations of total communities and of complex interactions of environmental, biological, cultural, sociological, economic, political and other influences on behaviour. Thus, typically, there is a softening of the often tightly delineated professional and academic boundaries which exist in more conservative disciplines.

Community psychology is still in its early stages, and it is probably more accurate to describe it as a "philosophy" or "perspective" than as a new examinable subject in the psychology curriculum. Until recently, community psychology has mainly been associated with community mental health, as reflected by Zax and Specter's (1974) *Introduction to community psychology,* the first textbook in the area. However, others see it as much more than a mental health issue, with the promise of offering a whole new perspective and value system for applied psychology. There are now a number of books available in the area, and amongst these, Julian Rappaport's *Community psychology* (1977) stand out as a major contribution.

Briefly, here is what a community psychology perspective means to us:

(1) A primary concern with people, not the profession.
(2) A view of man which is positive, not "clinical" or "pathological."
(3) An awareness of the ecology of the human situation, especially the interaction of the individual with his or her everyday living context.
(4) An integration of many disciplines and viewpoints, not just clinical psychology.
(5) A concern with prevention and the development of personal and social resources, not just treatment.
(6) The use of new research strategies, especially those associated with systems and evaluative approaches.
(7) A determination to make the world a better place for everyone, not just the privileged few who can pay.

The Registration Bill

Each of the above points could be elaborated at some length. Here, I wish just to make special mention of the first, since it is particularly relevant to the current concerns of clinical psychologists in New Zealand. It is probably true to say that about the only issue in living memory to have stirred New Zealand clinical psychologists out of their customary torpor is the Registration bill — or, more correctly, its absence. It is therefore interesting to speculate why this is so. At present, many "marginal" professions such as psychologists, social workers and chiropractors are clearly preoccupied with establishing their credibility and value in the eyes of the public. This leads one to suspect that the interest of clinical psychologists in the Bill is not so much to protect the public from the psychological ministrations of charlatans, which is the ostensible purpose of the Bill, as it is to enhance the status of the profession. The dangers of a pre-occupation with professionalization on the party of helping agents is a recurrent theme of many writers, with Ivan Illich a good example for the medical profession. In clinical psychology, it leads to

what Bender (1976) in his little book called *Community psychology* refers to as a "guild mentality," that is, an attitude which is concerned first and foremost with the betterment of one's own status, power, and income, rather than that of the people we are supposed to be helping.

Training

The direction taken by clinical psychology in the future will ultimately be determined by the nature of the training programmes available to students. Albee considers that academic university departments are simply not the place to teach clinical psychology, largely because of their adherence to a "psychiatric" model, and their resistance to change. And it is clear that in spite of the contribution of behaviour modification, the old testing/treatment model of clinical psychology is an anachronism in the light of the large and pressing needs of our disordered society. The position taken here is that I accept that clinical training will continue to take place in the university, but that the whole philosophy and direction of training programmes be reviewed from the ground up.

More specifically, I suggest that clinical training programmes consider the following:

(1) That new job opportunities for clinical psychologists be explored. Overseas, clinical psychologists are working in many settings outside the traditional mental health and justice institutions. For example, in Vancouver, there are several psychologists working for the city government in local community projects, and in Perth, psychologists are employed in key positions in the Department of Community Welfare. Locally, organizations such as sheltered workshops, church social services and societies for the disabled are employing clinical psychologists, and many more such positions are possible. Thus, training would have to take account of the need for a wider range of skills than at present.

(2) That new settings for training be used. Much of our so-called "applied" training takes place in the university, and often, the only on-the-job training is in traditional health and justice settings. If new jobs are to be sought, then new places for training will also be required, with much more time spent outside the classroom. Many settings such as those mentioned in (1) would welcome a university contact, and all it requires is an energetic course organizer to get out and seek these positions, and to do some supervisory work in the community. This in turn is likely to generate more awareness in the community of what psychologists do, and produce more job opportunities.

(3) That courses on organization and management be included. Increasingly, the role being advocated for clinical psychologists is that of consultant (e.g. Caplan, 1970), that is, as an advisor to other mental health agents so that professional skills can be distributed to wider segments of the population. Also, even in New Zealand, clinical psychologists are taking on managerial positions, such as the running of psychiatric wards. For these positions, the ability to be an affective organizer is crucial, especially as there is inevitably a difficult "system" to contend with. Thus, as is done in the Queensland course, some direct training in this area is essential.

(4) That new research approaches be included, especially those in the area of "action research," that is, research designed to develop and evaluate intervention programmes with clearly specified objectives. The now mammoth area of "programme evaluation" is highly relevant here, both for methods, such as Kiresuk and Sherman's (1968) goal attainment scaling, and for models, such as those of a systems orientation (e.g. Raeburn & Seymour, 1977). (An up-to-date resource for mental health program evaluation is the NIMH publication by Hargreaves, Attkinson and Sorenson, 1977.) These methods do not replace more traditional approaches; rather, they provide a different emphasis, one which is concerned with effective action rather than the pursuit of knowledge as such.

(5) That techniques of social intervention be taught. If change at the level of social systems is a worthy objective for clinical psychology, then techniques of "system modification" as well as of behaviour modification need to be learned. There is now a large literature in this field, and an in-

vigorating start can be made by reading Saul Alinsky's *Rules for radicals* (1972).

(6) That prevention as well as treatment be emphasized. The value of prevention hardly needs elaboration, but, as in medicine, clinical psychology usually only pays lip-service to the idea. Yet there are many psychological techniques suitable for prevention in the sense of strengthening the coping skills of "normal" or marginally impaired people. Examples are "stress inoculation training" (Meichenbaum & Turk, 1976), parent training, relaxation training, assertion training, and a variety of behavioural self control skills (e.g. Stuart, 1977). Again, it is the organizational side that requires emphasis here, that is, how does one disseminate these techniques in the general population on a widespread basis? However, good examples of such dissemination do exist, such as Bakker and Armstrong's (1976) Adult Development Program in Seattle, and Signell's (1975) use of nonprofessionals to teach parenting skills.

(7) That a new academic stance be adopted. Clinical psychology, in spite of behavioural and other innovations, has largely remained wedded to an academic approach that emphasizes the pathology of the individual. this point of view has been increasingly questioned by people such as Rappaport et al. (1975), with the result that not only is the contribution of the social, cultural and physical environment to mental health receiving more attention, but more importantly, the *interaction* of the organism with its environment is becoming a major focus. Such a psycho-social/psychoenvironmental approach is the quintessence of community psychology, and the adoption of a similar perspective could well serve to take clinical psychology out of its "psychiatric" rut.

(8) That, overall, a new vision of clinical psychology be promoted, one that expands the current limits of the area, and one that sparks the enthusiasm of students to go out to grapple with the real world, rather than retreat into private practice.

Obviously, these suggestions could only be incorporated into existing clinical programmes at some cost to their present curriculums. But since most university courses tend to contain much that is irrelevant, the setting of new priorities could well be a cleansing experience. It is reassuring to note that the new clinical programme at Otago has from the outset incorporated a number of community psychology features of the type described above.

What is being said here is hardly new. Ten years ago, Hersch had this to say of the American scene:

> In essence, the shift (in clinical psychology) is from an intensive preoccupation with individuals to a concern over large populaions ... Training programs incorporating this trend have appeared (Jones & Levine, 1963) and it has been predicted that in the future the mental health professional will become increasingly disengaged from direct clinical activity and will act instead as a consultant to community personnel, who will carry most often the burden of mental health intervention (Hersch, 1968).

No doubt, the usual "fifteen years behind" rule will apply for us here in New Zealand, just as it did for behaviour modification. Meanwhile, we can probably expect to plod on basically in the same old way, with the only notable feature on the local scene being a further retreat into the conservatism embodied in the current trend to private practice. Clinical psychology needs to move out into the arena of human affairs, to shed its professional self-seeking, and to apply its skills to the wellbeing of society as a whole. And ultimately, a healthy society is in the interest of us all. To quote Albee (1970) again,

> If the nation deteriorated, psychology will be amongst the first whose existence is threatened. Tyrants and totalitarians are not normally supportive of free scientific research, and particularly of free enquiry into human problems.

A better society or more private practice? The choice is ours.

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