

TRAINING IN CLINICAL PSYCHOLOGY: AN ENGLISH POINT OF VIEW

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DEVELOPMENTS during and immediately following the war have emphasized the great importance which the rather ill-defined field of "clinical psychology" has, both in the theoretical and in the practical sphere. Much discussion has centered on the definition of the subject matter, and on the best methods of training appropriate for practitioners; the report of the Committee on Training in Clinical Psychology of the American Psychological Association (1), the papers of the Josiah Macy Jr. Foundation Conference on Training in Clinical Psychology (5), and the minutes of the National Association for Mental Health Committee on the Training of Psycho-Therapists (7) are evidence of the wide interest taken in this matter by respectable bodies both in this country and overseas. The great importance of the subject, the hope that our experience in training clinical psychologists in the only British University Centre which undertakes such training might be of interest to American readers, and the belief that the direction along which both the APA and the Josiah Macy Jr. reports point lies counter to the best interests of psychology as a whole, and of clinical psychology in particular, have led us in this paper to discuss what, in our view, the nature and function of clinical psychology should be.

The main conclusion of the APA report, which is also supported by the majority of other recommendations, transactions, conferences, and memoranda which we have seen, lies in the stress "of the need for preparing the clinical psychologists with a combination of applied and theoretical knowledge in three major areas: *diagnosis, therapy and research*" (1). Equally briefly, it is our belief that training in therapy is not, and should not be, an essential part of the clinical psychologist's training; that clinical psychology demands competence in the fields of diagnosis and/or research, but that therapy is something essentially alien to clinical psychology, and that, if it be considered desirable on practical grounds that psychologists perform therapy, a separate discipline of *Psycho-therapist* should be built up, to take its place beside that of *Clinical Psychologist*.

Let us examine in detail the arguments put forward in favour of their belief by the writers of the APA report. Unfortunately, these arguments are given throughout in terms of unproven assumptions, lacking in any kind of factual support. We have been able to discover only two reasons for the belief "that no clinical psychologists can be considered adequately trained unless he has had sound training in psychotherapy" (1). One is in terms of social need: "The social need for the increase of available therapists is great. Clinical psychologists are being called upon to help this need . . ." (1). This argument has been widely criticized on the grounds that we must be careful not to let social need interfere with scientific requirements; that ultimately psychology cannot simply go where social need requires, unless it wishes to be led into a cul-de-sac. A science must follow its course according to more germane arguments than the possibly erroneous conceptions of "social need."

That other pressures than that of social need may be more important is indeed recognized by the writers of the report. They say: "If a social need for therapy exists, then the need for research is even greater" (1). "The fact that there is not equal pressure for the latter is mainly due to the excusable but still short-sighted outlook of the public. The universities, with their more far-sighted orientation, have a serious responsibility to develop research interests and abilities in the clinical psychologists they train. The interest should be in research on the laws of human behavior primarily and on technical devices and therapy secondarily" (1). Thus the first argument leads inevitably to the second, which is based on therapeutic experience as an indispensable qualification for research.

"Our strong conviction about the need for therapeutic experience grows out of the recognition that therapeutic contact with patients provides an experience which cannot be duplicated by any other type of relationship for the intensity and the detail with which it reveals motivational complexities. A person who is called upon to do diagnostic or general research work in the field of clinical psy-

chology is seriously handicapped without such a background; a person who is called upon to do research in therapy . . . cannot work at all without such a background" (1).

To a scientist, a statement of this kind must be anathema. It is traditionally conceded that the value of scientific research is judged in terms of its methodology, the importance, within the general framework of scientific knowledge, of the results achieved, and the possibilities that other scientists can duplicate the experiment with similar results. We wish to protest against the introduction of a new kind of evaluating device, namely, the background training of the scientist. To say that research in therapy (which presumably means research into the process and the effects of therapy) cannot be carried out at all by persons who are not themselves therapists appears to us to take the concept of research in this field right out of the realm of science into the mystical regions of intuition, idiographic "understanding", and unrepeatable personal experience.

The arguments in favour of including therapy in the clinical psychologist's training course do not, then, appear very convincing to us. We may now turn to the arguments against the inclusion of therapy.

In the first place, it is our belief that in the field of mental illness, no less than in other fields of human endeavour, specialization of function is an inevitable condition for advance. The team of psychiatrist-psychologist-social worker constitutes such a combined attack on a problem, based on specialization of functions. In this team, the psychiatrist is responsible for carrying out therapy, the psychologist for diagnostic help and research design, and the social worker for investigation of social conditions in so far as they affect the case. Nothing but confusion and lowered efficiency all round would follow from an attempt to muddle up these different functions to any significant extent. There are far too few persons competent in their own sphere—be that psychiatry, psychology, or social work—to allow any but the most exceptional to combine several functions. But training courses are run for the average practitioner, not for the rare and isolated genius. It follows that training in clinical psychology should concentrate on those areas in which the psychologist can make his most significant contribution to the psychiatric team.

In the second place, it seems to us that there are

quite unanswerable reasons why therapy must be the prerogative of the physician. In this connection, we may quote Dr. D. G. Wright of the U. S. Naval Hospital, Great Lakes, Illinois, who points out that "the psychiatrist's part in defining the kind of pathological processes at work must be decisive. A great many pathological processes have significance only to the physician, and are in the first place illnesses which, although manifested by emotional and mental symptoms, are caused directly by injuries, diseases, and other organic processes in the brain" (8). Dr. Wright develops this point in greater detail in the article quoted.

In the third place, we believe that there are many dangers in the acceptance of the therapeutic role which can best be realized by quoting the following sentence from the APA report: "Psychologists, in our opinion, must come around to the acceptance of some kind of intensive self-evaluation as an essential part of the training of the clinical psychologist. We are not prepared to recommend any special form of such procedures, although some of us believe that whenever possible this should take the form of psychoanalysis . . ." (1). The reader may more easily see the danger in this recommendation (which itself is an almost inevitable consequence of the premise that clinical psychologists should do therapy) if he glances at the following statement, made by one of the best-known psychoanalysts in this country, whose experience in the field is probably unrivalled: "The transferences and counter-transferences developing during training analysis tend to give rise in the candidate to an emotional conviction of the soundness of the training analyst's theories" (3). In other words, it is proposed that the young and relatively defenceless student be imbued with the "premature crystallizations of spurious orthodoxy" which constitute Freudianism through the "transferences and counter-transferences" developing during his training. Here, indeed, we have a fine soil on which to plant the seeds of objective, methodologically sound, impartial, and scientifically acceptable research! It is because of this implication—no therapy without analysis—more than for almost any other reason that we wish to protest against the inclusion of therapy in the training syllabus of the clinical psychologist.

Our fourth reason for believing that therapy should not form part of the training of the clinical psychologist is closely related to our first belief that a thorough training in research and diagnostic test-

ing is, in itself, a full-time occupation and that the addition of a third type of training would merely result in a lower level of skill and knowledge in all three levels. In our experience, it takes two academic years to train students in diagnostic testing. It takes at least another two years to teach them the fundamental principles of research and statistical method. If part of this time were given over to learning how to fill the therapeutic role, it is difficult to avoid the conclusion that the training in diagnostic testing and in research would be much less complete than it should be. We need only point to the current research reports on psychiatric problems and those affecting clinical psychology to show that the level of research competence is distressingly low; anything mitigating against an improvement in this unsatisfactory state of affairs should at least be considered very carefully.

In the fifth place, it has been our experience that students who are interested in the therapeutic side are nearly always repelled by the scientific flavour of research training, while conversely, the students who are best suited and most successful on the research side betray little interest in active therapy. We feel that the APA Committee dismisses rather too airily this widespread belief that "the scientific and therapeutic attitudes mix poorly in the same person." If our experience be borne out by experimental work, which it should be easy to arrange, we suggest that here is a powerful reason for restricting training in clinical psychology to diagnosis and research.

In the sixth place, we believe that stress on the therapeutic function of the clinical psychologist encourages unscientific thinking in the field of selection. "The ability to carry out effectively the combination of functions called for depends upon the clinical psychologist's being the right kind of person" (1). It is interesting to note the qualities which the "right kind of person" must possess, according to the writers of the APA report. He must apparently possess, *inter alia*, superior intellectual ability and judgment, originality, resourcefulness, and versatility, curiosity, insight, sense of humor, tolerance, "un arrogance", industry, acceptance of responsibility, tact, cooperativeness, integrity, self-control, stability, and a variety of qualities whose operational definition would be even more difficult, such as "ability to adopt a 'therapeutic' attitude." It would be interesting to know the reliability and validity with which any of these "qualities" or

"faculties" can be measured or assessed, and to what extent they would characterize the clinical psychologist as opposed to, say, the lawyer, the doctor, the teacher, or any other professional person. As a job analysis, this list is perhaps typical of the "retreat from science" implicit in the adoption of the "therapeutic attitude."

In principle, we believe that the division of labour which we have advocated above in suggesting that research and diagnostic testing should be separated from therapy ought to be carried even further. We find ourselves in full agreement with Dr. A. Gregg, who writes: "I doubt whether the proficiency in research at present called for by the degree of PhD is the best training for as large numbers of psycho-technologists as will meet the rapidly mounting demand for such services. I simply doubt whether research ability of an order appropriate for the PhD degree exists on so large a scale. If it does not and you insist on all students having the research training appropriate for teachers and investigators, many students participating in well-oriented and well-controlled research work at the PhD level might profit from it in some measure, but the demand is for very large numbers of persons with general practical experience and reasonable competence. Not much more than ten per cent of medical students are capable at any time of excellent research work. Yet medical research flourishes" (4).

Accordingly, we believe that clinical psychologists should be trained, as it were, in two stages. Stage one would give them an adequate theoretical and practical knowledge of psychometric techniques and "psycho-technology" generally; it would enable them to fill the very large number of jobs opening up for persons capable of fulfilling routine, every-day needs of the community. This training, in our view, could be carried out in one rather crowded year (eleven months plus one month's holiday, as is practiced at the Maudsley at present), or alternatively, in two ordinary academic years. This training would come after adequate undergraduate instruction resulting in a Bachelors Degree in psychology. Competence acquired in this way should be recognized, not by a degree, but by a University Diploma or a Certificate, granted after a searching examination involving practical as well as theoretical work. A person trained in this way could conveniently be called a clinical psychologist, junior grade.

Stage two would be additional to stage one, for a small number of students capable of benefiting

from it, and would consist in research training resulting in a PhD. Students having undergone this second stage of training could conveniently be considered as clinical psychologists, senior grade. Research work in this connection should be carried out in relation to problems relevant to clinical psychology, but preferably of a fundamental rather than of an applied nature.

In this connection, we place considerable importance on "program design." We agree with Marquis (6) that "program design" is of the utmost importance in the future development of psychological research in general, and of clinical research in particular. Program design, in his view, "is the attempt to plan a comprehensive, integrated series of studies in relation to a particular set of concepts focused on a central problem. It is the attempt to broaden and lengthen the scope of a research sufficiently so that we can tell whether it is really getting anywhere. It is scientific method in its full and complete form." We would suggest, therefore, that the research training of the future clinical psychologist should preferably be carried out as part of a general research program relevant to his specialty. In our limited experience, such a procedure has the double value of making the student feel that he is really assisting in the construction of something worth while, rather than merely fulfilling an arbitrary University requirement, while at the same time ensuring that fundamentally important research is done, rather than *ad hoc* work of little scientific value. Ultimately, if Marquis is right in his view that "program design" will assume greater and greater importance in the advancement of our scientific knowledge of human nature (and we have very little doubt that essentially this submission is correct), then it will be of very great importance that the next generation of research workers should be trained by actually participating in a research program of the kind mentioned. This argument is particularly strong in relation to clinical psychology, where almost any worth-while research implies co-operation between specialists of many different backgrounds. We have tried to set a pattern of "program design" in the series of researches reported in "Dimensions of Personality" (2), and knowledge gained in the process has been used in setting up the next stage of design growing out of our first series of findings.

We venture to make one further suggestion directed to an improvement of present-day training courses in clinical psychology. We believe that,

by and large, it would be advantageous for the student to be trained in clinical psychology in a University Department specially devoted to the purpose and directly located in a Teaching Hospital. Present practice tends to centre the student's academic teaching on a University Department and send him out as it were to a Hospital for practical work. In our experience, students are more likely to get a unified training in all aspects of clinical psychology when their training is given by a University Department itself centred on and located in a Teaching Hospital for Mental Disorders.

While, like most training courses in clinical psychology, our own is still in a very fluid and experimental state, we believe that essentially, the pattern followed and discussed briefly in this paper is one which has certain advantages over the type of course advocated by the APA Committee on Training in Clinical Psychology. We believe that the main points of difference, namely, the divorce of therapy from clinical psychology, the splitting up of training and diagnostic testing and of research into two relatively separate courses, and the combination of University School and Hospital under one roof are worthy of serious consideration. Our main intention has been, not to lay down rules to be followed, but to suggest for further discussion points of view which at present do not seem well represented in psychological thinking. Only through experimentation with different types of training can we hope to gain enough insight into the factors involved to make wise decisions regarding the training of clinical psychologists.

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