

FUNCTION AND TRAINING OF THE CLINICAL PSYCHOLOGIST.*

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(I) INTRODUCTION.

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THE past ten years have seen a spectacular increase in the number of psychologists who have elected to take up the type of work usually referred to as "clinical." This increase has been most marked in the U.S.A., where now some 25 per cent. of the members of the American Psychological Association are employed in this field, and where Government regulations and training schemes set up under the V.A. (Veterans' Administration) make it almost certain that within a few years clinical psychology will constitute the main field of employment for psychologists (1). In Canada, too, there has been a similar growth, leading to all the problems of registration and certification which are currently being tackled in the United States (2). In this country, while psychologists have occasionally been employed in hospitals for the

* This article owes much to the opportunities which the writer has had during a six months' visiting professorship at the University of Pennsylvania of investigating the growth and development of clinical psychology in the United States. Thanks are due to the authorities of the university, particularly Professor R. A. Brotemarkle, for their kindness in permitting the writer to travel widely during term time. The writer thus had an opportunity of inspecting mental hospitals, V.A. clinics and university departments engaged in the training of clinical psychologists in places as widely different as San Francisco and St. Louis, Los Angeles and Durham, Chicago and Philadelphia, New York and Washington. Thanks are also due to the many individuals, whether connected with the V.A. programme or in some other way concerned with the training of clinical psychologists, who discussed their problems, plans, and views with the writer, and who answered patiently many queries and objections which must have betrayed a good deal of ignorance, as well as a certain amount of prejudice. However critical one may be of certain details in current practice, it is impossible not to be impressed by the sincerity of those who are trying to transform clinical psychology into a genuine profession, and with the considerable success which has attended their efforts so far. If the writer is still convinced that the pattern of training currently followed at the Institute of Psychiatry (Maudsley Hospital, has certain advantages over the American system, this belief is now predicated on a much better realization of the very real differences which exist between the two countries with respect to many variables which affect the aims and purposes of such a training course.

mentally ill, the development of "clinical psychology" in any formal sense may be said to have started in 1947 with the foundation of the Psychological Department at the Institute of Psychiatry (Maudsley Hospital), one of whose objects was to give a course of training in clinical psychology to graduate students of psychology (7).

In view of the novelty in this country of the discipline as a whole, it is scarcely surprising that no very clear conception regarding the functions it subserves exists among psychiatrists and psychologists, or that the type of training required is not widely recognized or understood. It is the purpose of this article to discuss these problems, and to give a brief picture of the functions and the training of the clinical psychologist. In doing so, our intention has not been to slur over differences of opinion which inevitably exist in so new a field, and our conclusions should be regarded as tentative and provisional, not as dogmatic assertions.

No formal definition could indicate with any accuracy the variety of different functions which clinical psychologists fulfil or should fulfil. They serve in hospitals and children's clinics; in prisons, courts, and on parole boards; in psychoanalytic institutes and non-directive "counselling" units; in Government agencies and in the armed forces; in Universities and in mental defective institutions. More informative, however, than their place of work will be a description of the duties which they perform, and for which they are trained. These duties, in turn, having grown organically from seeds planted long ago, can best be understood in terms of a brief historical review.

(2) GROWTH AND HISTORY OF CLINICAL PSYCHOLOGY.

In 1896 Lightner Witmer established the first psychological clinic at the University of Pennsylvania, an event frequently taken to have marked the point of origin of the whole movement. In 1917 the first professional organization for the study of clinical problems was founded (18). In 1931 a symposium on Clinical Psychology was published by the University of Pennsylvania, which showed how widely this term had become accepted, and to what extent agreement had been reached with respect to the field covered (20).

Such success as clinical psychology had had did not, however, lead universities to undertake professional training in the application of psychology to the problems of the individual. While single courses on mental testing, psychopathology, industrial psychology or social psychology were given to students who elected to work in this area, little was done to develop a type of training which could in any sense be regarded as "professional." This fact, together with the lack of agreement on the duties and responsibilities of a clinical psychologist, led to a situation of great difficulty and danger. A person who called himself a "clinical psychologist" might be someone of great eminence, highly qualified academically, and with 20 or 30 years of practical experience in the fields of diagnostic testing, research, and therapy, or he might be a student just graduated from the University, without any kind of relevant experience, capable only of grinding out Binet I.Qs. without even an adequate understanding of their relevance to the clinical problem presented (6). This was

the position in America until about 1940; with only minor ameliorating features, it is still the position in this country to-day.

Miller has painted an accurate picture of the situation: "Before the war the profession of clinical psychology had little organized self-consciousness, despite the existence of various associations established to further the interest of the field. One of the chief reasons for this was the fact that it was almost impossible to find anywhere a well-rounded and complete program of education for the practice of clinical psychology. Either training was in the basic experimental and academic tradition of American university psychology, in which research and teaching were permanent considerations and the application of the principles learned was only incidental; or training was obtained almost wholly in the hospital, sanitarium, guidance clinic, prison, or social agency under the supervision of psychiatrists and others not trained or skilled in psychology proper. All too commonly training was an individually determined hodge-podge of poorly integrated university sources, clinical internships, private study of special techniques, and unsupervised practice. There was no agreement throughout the country on how curricula should weave together all the divergent strands into a properly designed education for clinical psychologists" (16).

During the past few years a transformation has occurred which to many people has seemed miraculous. While many factors have contributed towards this transformation, a catalyst was needed; it was provided by social need arising out of the war. Examination of the draft revealed that over 30 per cent. of the young men conscripted suffered from disabling neuropsychiatric defects (19); examination in England of a working-class group showed a very similar percentage (10). More than three-fifths of all patients in Veterans' Hospitals in 1946 were neuropsychiatric cases, all other types of cases combined amounting only to two-fifths (16). "Necessity of war mobilized the resources of clinical psychology in a way comparable to the mobilization of the resources of physics and chemistry. . . . It became recognized that the diagnostic skill of psychologists and their superior understanding of the principles of normal behaviour and how these can be applied to problems of personal adjustment were invaluable adjuncts to the medical profession. The result was that psychologists in the Army, Navy, and other military organizations were given tasks of great responsibility and professional importance" (16).

This importance did not diminish after the end of the war. Through the Veterans' Administration the American nation assumes a measure of responsibility for looking after its war casualties; as pointed out above, the majority of these casualties at present are neuropsychiatric. "With the rising morbidity rate of mental disease, demand for psychiatrists and psychologists will increase. This demand will occur because of the necessity of implementing the social responsibility which has been assumed for treating the largest part of mental disease of veterans—a segment of the population which now represents about one-seventh of all America. The significant and inevitable consequence of this development is that a large portion of the whole profession of clinical psychology will come under Governmental control" (16).

Within the V.A. programme five sorts of installations are being (or have

been) set up : Mental Hygiene Clinics ; Neuropsychiatric Convalescent Centres in general medical and surgical hospitals ; Neuropsychiatric hospitals ; Paraplegia Centres in general hospitals ; and Aphasic Centres in general hospitals. These various units are described by Miller in some detail ; in all of them the clinical psychologist will have important diagnostic, therapeutic and research functions. " Diagnosis of personality characteristics will remain the primary task of the psychologist, for his training makes him better qualified than the psychiatrist in this field " (16). Even more important perhaps is the research function of the clinical psychologists, " trained as they are in test construction, experimental design, and scientific method, and the independent conducting of research, will make their most significant contribution to the program in the field of research " (16).

More controversial perhaps than either of these two is the therapeutic function of the clinical psychologist. Our own position on this point will be stated later ; here we may just note the official V.A. statement on this point : " The clinical psychologist will carry out individual or group therapy under direction of the responsible neuropsychiatrist. This means that the neuropsychiatrist will first review the case and decide whether it is the type of problem which may reasonably be handled by a clinical psychologist. If the case involves such fields as readjustment of habits ; personality problems within the normal range ; educational disabilities such as reading defects, speech impairments, or similar difficulties requiring re-education ; or relatively minor psychoneurotic conditions without important somatic components, the patient may be referred to a clinical psychologist for individual or group treatment. The Chief neuropsychiatrist will delegate such therapeutic duties only when he believes the individual clinical psychologist to be fully competent to carry them out. The clinical psychologist periodically at staff meetings or other times will report to the responsible neuropsychiatrist on the progress of the therapy and consult with him as to further measures to be taken."

In addition to outlining the functions of the clinical psychologist, the V.A. has gone further in laying down minimum standards for the various grades of clinical psychologists ; in starting a large-scale training scheme with the co-operation of most of the better universities ; and in taking a large measure of responsibility in the financing of the training of large numbers of clinical psychologists. In all these activities the influence of the V.A. has been almost wholly beneficial, and by working in close co-operation with the American Psychological Association as well as with the universities, the V.A. programme has been successful to a very considerable extent.

Before turning from this brief historical review to a discussion of the present-day position, we must say a few words about the British scene. Here conditions are very different, largely because of historical developments which have forced a rather divergent pattern of growth on applied psychology. With very few exceptions, clinical psychologists in this country have worked almost exclusively with children ; all training in the field of applied psychology (other than industrial) has been in what became known as " educational psychology," although the relation of such activities as play therapy or child guidance work to education is not always clear. The result has been a three-

fold one. In the first instance, applied training in this field has been given almost exclusively to psychologists who have had teaching experience of at least two years. The theory underlying this practice appears to be that the educational psychologist would thus be able to acquire "maturity," to learn about "normal" children, and to become more acceptable to teachers during his later career, when presumably he would have to come into frequent contact with them.

A consequence of this insistence on "educational" psychology has been that therapeutic activities have been growing up *sub rosa*, as it were, and without adequate training or supervision. Many educational psychologists working in child guidance clinics are actually engaged in full-time therapeutic work, although their title prevents the recognition of the absolute necessity of training in the therapeutic field if they are to practise in it.

In the third place, the close relation between psychology and education thus fostered has led, on the other hand, to a rather less close relation between psychology and psychiatry, and medicine generally. Particularly in the important adult field contacts between the two professions have been correct rather than cordial, and there can be little doubt that this lack of recognition of the inseparable destinies of the two disciplines has been detrimental to the advance of both. That a strong, respected and highly competent profession of psychiatry is essential to the growth and flourishing of clinical psychology appears obvious; it is perhaps no less true to say that the existence of a large group of well-trained, competent, and friendly clinical psychologists can be of the utmost value to psychiatry.

In order to facilitate such a rapprochement, a course of training in Clinical Psychology was started at the Institute of Psychiatry (Maudsley Hospital) two years ago. At the same time, negotiations which are being carried on with the appropriate Whitley Council by the A.Sc.W. should have resulted in agreement on salary scales, as well as an acceptable definition of "clinical psychologist," and the various grades into which this profession should be divided. Thus more slowly, and less spectacularly, than in America, here also a new profession, with defined status and training, is coming into being.

(3) STATUS AND TRAINING OF CLINICAL PSYCHOLOGISTS.

Function, status and training of any professional group are clearly closely interrelated. Discussion of the present position in the field of clinical psychology can perhaps most usefully begin with a consideration of three documents regarding the training of clinical psychologists. The first of these, "Recommended Graduate Training Program in Clinical Psychology," is an official report submitted by the Committee on Training in Clinical Psychology of the American Psychological Association (5); it will be referred to as the A.P.A. report. The second document is a report of the transactions of the first conference on Training in Clinical Psychology, sponsored by the Josiah Macy Jr. Foundation (13); it will be referred to as the Conference report. The third is a discussion of the proposals contained in these two reports, comparing them with present-day English practice (7); this will be referred to as the Maudsley report.

All three reports agree that professional training should be post-graduate, that it should occupy a period of several years, that it should lead to a high level of competence in diagnostic testing, and that ability in research design, and knowledge of the relevant statistical and methodological techniques, should be a prerequisite for the fully trained clinical psychologist. There is disagreement on the question of therapy, on separate courses for different grades of psychologist, and on the best method of integration of teaching hospital and university.

(a) *Undergraduate training.*—Professional training in clinical psychology should not begin until after the student has acquired a certain amount of grounding in general and experimental psychology, together with a limited knowledge at least of statistics, mental test methods, and abnormal psychology generally. This strictly theoretical background the student may be expected to acquire during his Honours course of studies for the B.A. or the B.Sc. degree in Psychology. While an Honours degree in psychology is thus considered an indispensable preliminary for further training in this country, it should be realized that in itself it does not suffice to give the student any competence in the applied field. Its orientation is rather theoretical, and lacks integration with clinical, industrial, or educational applications. This exclusively academic-theoretical approach does not make for practical usefulness of the student when released from the university; for acquiring any kind of practical training he has hitherto had to rely largely on non-University bodies and Institutions prepared to give tuition of very varying quality, or on his own ingenuity in picking up whatever knowledge he needed. While the Honours degree in psychology is thus a necessary prerequisite for further training, it does not in itself denote any degree of psychological competence in the applied field. This cannot be stressed too strongly, as many psychiatrists assume that possession of a degree in psychology qualifies the student as a psychologist, just as possession of a medical degree qualifies the student as a physician. Medical training is a professional training; psychological training is not professional, but purely academic. This is stated, not as a criticism, but merely as a fact; whether the present-day practice of undergraduate instruction is sound or not cannot be discussed here.

(b) *Duration of post-graduate training.*—The V.A. training programme envisages a four-year period of instruction and clinical practice, somewhat along the following lines. Each trainee is expected to spend 1,056 hours a year (22 hours per week times 48 weeks) at work in V.A. hospitals. The rest of his time will be devoted to training under the direction of the Department of Psychology at his University, carried on either at the V.A. station, at the University, or elsewhere. The universities are responsible for planning curricula, and for deciding how much training should be carried out at the University, and how much at the V.A. station. Trainees are paid at varying rates, depending on the amount of time given to the V.A., and on the stage of training reached.

During the first year the student administers simple psychometric tests, mainly of intelligence. He also interprets these findings in the light of details of the case-history, and makes factual reports on these results to supervising

psychologists and psychiatrists. During the second year he administers a wide range of techniques, including intelligence tests, personality inventories, attitude tests, vocational and other types of aptitude tests, projective techniques, group situations (psychodrama and others), and interprets the significance of the findings as they are related to the entire case-history. During the third year, in addition to the above, he makes recommendations as to the treatment or disposition of the case to supervising psychologists; interviews patients in the hospital or clinic, and other persons who have relationships to the patients, for purposes of diagnosis, counselling and guidance on matters of mental health and related subjects; he also does therapy under the direction of a psychiatrist. During the fourth year he adds to these duties that of carrying on psychological research and investigation on questions of mental health; instructs other interns in psychological principles, their application, and in simple psychological techniques. At the end of this year he would be expected to obtain his Ph.D. degree from his university on the basis of a thesis relating to his work.

Additional experience brings the trainee into progressively higher salary groups. After he has reached the highest stage, his remuneration depends on factors which cannot be put down simply in terms of agreed salary schedules; by analogy with the comparable civil service positions (21) the highest salary he may aspire to in normal non-commercial positions will be between £4,000 and £5,000. (In arriving at English equivalents for American salaries, we have divided by 3; having regard to differences in cost of living, in income tax, and other factors difficult to assess, American salaries would probably come out at an even higher figure.)

Compared with this four-year programme, the training scheme of the Institute of Psychiatry shows certain differences which will be explained when we have discussed the main points on which we differ from the American practice in respect of desirability of teaching therapy; perhaps the most potent factor, however, making the two programmes impossible to equate in any thorough-going fashion, relates to the fact that trainees in America are paid in large measure by the V.A., while students in this country usually have to bear their own costs. This fact thwarts any attempt to install a programme here which could rival the American in comprehensiveness; only if the State undertook in some form to be responsible for training and maintenance (perhaps through some form of internship scheme) could we hope to train clinical psychologists in comparative numbers to a similar standard of excellence. We do not differ, however, in our insistence that several years of professional training are essential before the clinical psychologist can be considered fully trained.

(c) *Diagnostic testing*.—To many readers the use of tests in the clinical situation is perhaps the most obvious task of the clinical psychologist; frequently the term "test" is understood in the severely restricted sense of "intelligence test," and the psychologist regarded as a psycho-technician whose sole duty is the grinding out of I.Qs. While such a misconception must appear grotesque to anyone familiar with the wide range of cognitive and temperament tests which the properly trained psychologist is able to administer and interpret, it nevertheless has some roots in the former practice of training educational psychologists in the use of the Binet to the exclusion of almost

any other test ; this has set up a firm vested interest of " Binet testers," of specialists in a rather outmoded, unrevealing, and only seemingly " accurate " scale of measurement which has been outdated by modern developments for at least two decades. Perhaps the worst consequence of this traditional hegemony has been the widespread belief that the I.Q. is the Alpha and Omega of psychology. Nothing could be further from the truth. While a suitably derived I.Q. is still the most diagnostic single figure by means of which a patient's cognitive ability can be characterized, there is much opposition to the idea that any one single figure should ever have to bear such a burden. It is usually far more important clinically to know that a patient has a high verbal ability, low visuo-spatial ability, very low manipulative ability, but comparatively good rote-memory and excellent associative fluency, than to be told that his I.Q. is around the 100 mark. The concept of the mental profile, rather than the mental index number, is to the fore in modern clinical testing.

In arriving at a mental profile, of course, the clinical psychologist must have a thorough background training in the experimental and statistical methods which have enabled us to isolate and measure the various constituent abilities which make up the general field of cognition. He must be familiar with the different testing devices which are at his disposal ; he must know their respective strengths and weaknesses, as well as their relevance and applicability to certain types of patient, of background, and of clinical problem. And he must be able to interpret the results in terms of the whole clinical picture, possibly by integrating seemingly divergent results from different series of tests. The actual giving of a test is usually the least skilled part of the whole procedure, and can often be handed over to a technician ; it is in the selection of suitable tests, and in their interpretation, that the skilled clinical psychologist shows his metal.

This is equally true, and perhaps even more obvious, when we turn to non-cognitive tests, either of the so-called projective, the objective, or the questionnaire-inventory type. There are enthusiasts who could elevate one of these categories, or even one test within one of these categories, such as the Rorschach, into the be-all and end-all of psychological testing, thus repeating in another field the error of the Binet-testers. There are others who would deny the slightest value to tests in one of these categories—questionnaires, for instance. The well-trained clinical psychologist should be familiar with the strong as well as with the weak points of tests of all kinds, and equally competent to recommend, give, and interpret the Thematic Apperception Test, the Level of Aspiration Test, and the Minnesota Multiphasic Personality Inventory. The multiplicity of tests with which the clinical psychologist should be familiar is perhaps best indicated in the writer's review of advances in this field during the past five years, which ran into a selected bibliography of over six hundred titles (8).

Also included under this general heading of diagnostics are certain types of investigations which are not always considered in this connection. For instance, the objective determination of the course and success of treatment would be included here, as would also be vocational guidance and other questions

arising in the disposal of the patient, in so far as the answer to these questions was aided by the use of diagnostic tests of validity, personality, attitudes, interests, knowledge, and so forth.

(d) *Research*.—There is unanimity among almost all those competent to judge that it is in the sphere of research that the psychologist has his most important contribution to make. He has had a formal training in the techniques of research; he is acquainted with the statistical methods necessary for establishing significance; without such training little can be achieved in the complex and difficult field of human personality. It is his skill in research methodology, more than any other ability or proficiency, which makes the psychologist a useful member of the psychiatric team.

What precisely does the term "research" denote in this context? It has two different meanings, differing in importance and appealing to rather different types of psychologists. In the first place, we have what may be called technical or *ad hoc* research. By this is meant work on the reliability of tests and their intercorrelations, on agreement of tests with ratings, diagnoses, and so forth, and on the standardization or restandardization of new and old tests. Work of this kind is done within the framework of existing theory and practice, and while it requires a high degree of technical competence, it contributes relatively little to the systematic science of psychology. It is extremely unfortunate, though perhaps inevitable, that most of the research done under the aegis of the V.A. is of this routine, technical, uninspired kind. The mistake of believing that what is essentially actuarial work can do much to build up a systematic science is one to which psychiatrists have often drawn attention, and we cannot but agree with their point of view, without, however, denying the practical usefulness of much of this type of research.

Much more important from the strictly scientific point of view is fundamental research, which aims to uncover the structure of personality, its dynamics, and the general laws of behaviour and learning. It is here that close integration of psychiatric experience and theory, and psychological testing and research design, can prove most useful, because it is precisely here that the ultimate key to the puzzles which cause our joint difficulties lies hidden. A patient unveiling of the main dimensions of personality, the experimental study of the joint influence of heredity and environment, and the investigation of the results of different types of therapy on different types of patients—solutions to these and other fundamental problems have been adumbrated in researches published from many centres during the past ten years, and some of this work bids fair to revitalize and revolutionize a psychiatry partly straight-jacketed in Kräpelinian classifications, and partly enjoying manic spells of Freudian theorizing.

All types of research investigation demand, first and foremost, competence in statistical treatment of data, and in research methodology. The clinical psychologist should be familiar with factor analysis, analysis of variance and co-variance, and with other techniques which he is likely to encounter in his reading, and which he may have to apply in his research, whether technical or fundamental. Competence of this kind does not, of course, guarantee the scientific importance of the results; statistics is not an adequate substitute

for insight. It is, however, its indispensable helpmate, and no ingenuity in thinking out hypotheses and deducing consequences will outweigh fundamental weaknesses in methodology and treatment of data. It is the rare combination of worth-while hypothesis and technically competent investigation which must be aimed at, and under present conditions of training it is the clinical psychologist who is most likely to contribute the latter to the psychiatric team just as the psychiatrist so frequently contributes the former, though occasionally the roles may be reversed or inseparably conjoined.

(e) *Therapy*.—This topic is somewhat explosive, as strong views are held on all sides. Many psychiatrists consider that any form of non-medical therapy should be frowned on and discouraged, while others hold that it is impossible even to test a patient without in some important way contributing to his therapy. Clearly, many of the difficulties in this field are merely semantic, and centre around the definition of "therapy." If we understand by the term a prolonged, systematic attempt by means of psychological treatment to produce a fundamental reorientation of the patient's outlook and behaviour, then the writer is opposed to the proposal endorsed by the V.A. training programme, as well as by the A.P.A. and the Conference reports. It is his belief, which finds expression in the training programme at the Maudsley, that such therapy should not form part of the training of the clinical psychologist. The six main reasons for this belief are quoted below from the Maudsley report :

"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 and 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. 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, 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. It is the physician's knowledge of the course of the several neurological diseases, and his knowledge of the special investigative procedures . . . which make him competent to determine the localization of and treatment for such a disease. Second, there are several diseases of the organism

as a whole, or of other organs, the symptoms of which may reflect themselves largely in thinking, feeling and behaviour. Hypothyroidism and hyperinsulinism are in this category, and the existence and definition of these is palpably only the physician's job. Third, it is surprisingly common for a serious and progressive organic disease to co-exist with a neurosis of any sort, in which case neurotic-appearing manifestations may mask the other disease until, perhaps, irreversible changes have taken place. . . . It is fair to say that a majority of psychoneurotic patients suffer from somatic reflections of their illnesses of one kind or another and by means of one mechanism or another" (22). Dr. Wright develops this point in greater detail in his article, but what has already been quoted seems to us decisive in determining the respective roles of psychiatrist and psychologist.

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 A.P.A. 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 procedure, although some of us believe that whenever possible this should take the form of psychoanalysis . . . " (5).

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" (11). 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 testing 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 A.P.A. Committee dismiss 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" (5). It is interesting to note the qualities which "the right kind of person" must possess, according to the writers of the A.P.A. report. He must apparently possess, *inter alia*, superior intellectual ability and judgment, originality, resourcefulness and versatility, curiosity, insight, sense of humour, tolerance, "un arrogance," industry, acceptance of responsibility, tact, co-operativeness, 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" (7).

It will be noted that this general opposition to the inclusion of "therapy" in the list of duties of the clinical psychologist only holds as far as is implied in our definition of therapy. There are certain borderline areas which are clearly the psychologist's prerogative, although in some ways they might also be classified as "therapy." Included here are the treatment of educational disabilities, such as reading defects, speech impairments, and other difficulties of a segmental kind requiring re-education. If activities of this type are to be called "therapy," then it seems clear that psychologists should be trained to do therapy ; if the term "therapy" is to be restricted in the manner suggested in this paper, then it seems reasonable to suggest that therapy should remain the prerogative of the physician.

(f) *Different grades of clinical psychologist.*—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 Ph.D. is the best training for as large numbers of psychotechnologists as will meet the rapidly mounting demand for such services. I simply doubt whether research ability of an order appropriate for the Ph.D. 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-orientated and well-controlled research work at the Ph.D. 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" (12).

Accordingly, we believe that clinical psychologists should be trained, as it were, in two stages. Stage 1 would give them an adequate theoretical and practical knowledge of psychometric techniques and "psychotechnology" 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 practised at the Maudsley at present), or, alternatively, in two ordinary academic years. This training would come after adequate undergraduate instruction resulting in a Bachelor's 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 would conveniently be called a clinical psychologist, junior grade.

Stage 2 would be additional to stage 1, for a small number of students capable of benefiting from it, and would consist in research training resulting in a Ph.D. 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 stress on "programme design." We agree with Marquis (15) that "programme design" is of the utmost importance in the future development of psychological research in general, and of clinical research in particular. Programme 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 programme 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 "programme 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 programme 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 "programme design" in the series of researches reported in *Dimensions of Personality* (9), 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.

(g) *Integration of academic and clinical work.*—We believe that the American practice of centring the student's academic teaching on a University Department and of sending him out to a hospital for practical work is not the most efficient and useful way of training him. In our experience, students are more likely to get a unified training in all aspects of clinical psychology when this is given by a University Department itself centred on and located in a Teaching Hospital for Mental Disorders. The advantages for the student of being trained in clinical psychology in a University Department specially devoted to the task of research and training in clinical psychology, as well as to the carrying out of the routine duties of the hospital on which it is centred, are obvious from the point of view of centralization of functions, of specialization, and of participation in "programme design."

(4) PSYCHIATRY AND CLINICAL PSYCHOLOGY.

It will be clear from what has been said that the writer believes that the emergence of a large, well-qualified group of clinical psychologists will be of considerable usefulness to the psychiatrist. Conversely, the more able, well-trained and competent psychiatrists of the future are, the more will the clinical psychologist be able to benefit from association with them. The old and always untenable view which regarded psychiatrists and psychologists in some sense as rivals, and which posited a certain amount of antipathy and dislike between them, is surely ready to be thrown on the scrap heap. The general public fails utterly to distinguish between the two disciplines, and it may truly be said that they sink or swim together. An increase in status and prestige for one will almost inevitably mean an increase in status and prestige for the other; the more effectively psychiatrists and psychologists learn to work together, the greater that prestige, and the higher that status, are likely to be.

However, it is essential in such a relationship to see not only the strong points of each other, but also to recognize the weak. Cattell has pointed out, in commenting on the disparity between what is and what should be, that clinical psychology is "a field of unequalled intellectual challenge; yet it has actually recruited, in addition to its truly competent personnel, a multitude of camp followers of an amateurish status, unaware of the main issues, and large enough in numbers to drown the voices of those who are. It may be asked, at least in these days of shortage of plumbers, if clinical psychometry has not robbed the community of some who might have learned competently to assemble a faucet or understand a domestic water system. Certainly one may doubt whether in the history of applied science there has ever been an era in which so many have known so little about so much" (4). Psychiatrists can help

us in separating the sheep from the goats by insisting on the highest possible qualifications, and the best possible training, in clinical psychologists employed with or under them.

On the other hand there has been a rather different danger. As Burt has pointed out, "the general public, which is far more familiar with 'doctors' than with 'physiologists,' and with 'medical psychologists' than with 'normal psychologists,' is apt to confuse physiology and pathology, psychology and psychiatry, the investigation of a normal personality and the treatment of an abnormal personality that has resulted from actual illness, and generally to confound the practical applications of science with the theoretical research work on which those applications must rest. As a result there has been a widespread tendency to assume that the doctor must himself be a kind of scientist, and that because he is 'medically qualified' he must be not only officially exempt from any taint of charlatanism, but also a scientific expert on every kind of human ill. Magistrates and government departments often seem to share this feeling about the scientific prestige attaching to the medical practitioner as such" (3).

As Burt points out further, "this general attitude has spread far beyond the field of child guidance. By using popular metaphors about educational maladjustment as a 'form of mental illness' and industrial maladjustment as a 'symptom of social ill health,' quite a number of 'medical psychologists' have claimed, not merely that they are the proper experts in the field of educational and industrial psychology, but also that they are the right people to investigate the fitness of applicants for the universities, of entrants to the Civil Service, and of candidates for commissioned rank in the Army and other services" (3).

Burt's solution to the problem raised is that "instead of trying to sweep all human and social problems into its net, the profession of medicine should, now as in the past, seek more and more to hand over its outlying fields to specialists appropriately trained. But, of course, increasing specialization will call for increasing co-ordination, increased differentiation for increased integration. The paramount need is for specialist teams" (3).

(5) SUMMARY AND CONCLUSIONS.

This paper has described the present position of clinical psychology—firmly established and flourishing in the United States, just emerging and in need of careful nurturance in this country. A number of problems relating to the function and the training of clinical psychologists have been discussed, and the following main conclusions arrived at:

(1) It appears desirable from many points of view, not least among which must be counted the future progress and present efficacy of psychiatry, that a strong and competent profession of clinical psychologists be called into existence, to co-operate with psychiatrists and social workers in teams devoted to the investigation and therapy of different types of mental disorder in adults and children.

(2) A lengthy and well-balanced post-graduate training appears essential in order to guarantee such professional competence as is required to make clinical

psychologists as acceptable in their own field as medical practitioners are in theirs; such post-graduate professional training should concentrate on diagnostic testing and research design, but should not include therapy in the sense of "a prolonged systematic attempt by means of psychological treatment to produce a fundamental reorientation of the patient's outlook and behaviour."

(3) Because of their complementary functions and because of the inability of the general public to differentiate between them, psychiatrists and psychologists have everything to gain, and nothing to lose, by the closest possible integration of knowledge, experience and working methods; the closer this integration, the more likely is the ultimate emergence of that unified body of knowledge which alone will be worthy of being called a science of psychology, and of that agreed body of principles of pathology, prognosis and treatment which alone will be worthy of being called the applied science of psychiatry.

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