# Section of Psychiatry

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## DISCUSSION ON THE ROLE OF THE PSYCHOLOGIST IN PSYCHIATRIC PRACTICE

**Dr. Henry Wilson:** The psychiatrist can afford the psychologist material for his researches, and should welcome the psychologist's clinical researches as well as his general ones. But he would be well advised to hesitate before asking the psychologist to do his work for him. He would be wise to exchange ideas with the psychologist every so often, but too intimate connexion may be wasteful.

In diagnosis: No psychological tests exonerate the psychiatrist from not using all his clinical acumen, and his powers of observation as to what the patient does, as well as what he says. The psychiatrist may well use the Matrices, or Kent's Oral Scale to discover how the patient sets about his task, as well as relying upon the psychologist to present him with some arithmetical result. The psychologist reveals much in his reports upon children which the psychiatrist is not trained to elucidate. But we must be critical when the academic psychologist presents clinical theories. With adults the most useful question is "Has this patient the capacity for this job, or not: or are his powers superior to his work?"

The criteria which are so usual and often so helpful "What standard did this person reach at school?" "Has he been regular at his work, or not?" must be augmented by a consideration of social dexterity. Some defectives are able to hold managerial jobs because of their capacity in a limited situation. This subject is in need of urgent clarification.

The weight of the protocols attached to any case may be in inverse proportion to their usefulness. The clinician's job is to keep his tools for diagnostic acumen sharpened and to ask of every request for outside help "Is this really necessary?"

Tests which either psychologists or psychiatrists could devise, and which would enable us to say "These symptoms are intensified because there is a search for gain" would be welcome, though even then we might find that our gains were illusory. They might lead us to seek a dualism between mind and matter which would still elude us. The same difficulty presents itself over the problem of "neurotic overlay". We long for clarity; every new step in knowledge seems to emphasize the intricacy of Body-Mind relationship.

The more complicated test procedures like the Rorschach test become dangerous if we see in them firm answers to our questions. They can be useful in getting the patients to talk about certain problems which will enable us to discuss urgent concerns more easily. On the other hand, the simple test procedures, which have been so well illustrated by Professor O. L. Zangwill's work, should be at the service not only of our neurological colleagues, but of ourselves. The openings of such test procedures to increasing numbers of organic cases which a psychologist is liable to see, should be considered; the necessity of understanding more about the characteristics of electrical convulsant therapy transient traumatic memory loss should be stressed. The same is probably true of the help the psychologist can give us over types of psychopathic personality, and mathematical procedures used by the psychologist might make assessment of prefrontal leucotomy results clearer, if we could straighten our basic thinking.

**Mr. O. L. Zangwill** (*Institute of Experimental Psychology, Oxford*): As I see it, the problem under discussion has two main roots. On the one hand, there has been a steady demand on the part of psychiatrists for more standard and objective methods of assessment, particularly in the intellectual sphere. This demand, which goes back at least to the time of Binet, shows no signs of receding and it is incumbent on psychologists to attempt to meet it. On the other hand, there has been some impatience on the part of psychologists with the somewhat narrow attitude to mental life fostered by the academic laboratory, coupled with a wish to seek more fertile and socially relevant fields of inquiry. In view of these two complementary demands, it is not surprising that many psychologists have responded eagerly to the opportunities which have become available to them in recent years for work in the clinical sphere. In what follows the term *clinical psychologist* applies to suitably qualified non-medical workers in the clinical sphere of psychiatry.

I think it is fair to state that, in this country at least, co-operative work between psychiatrists and clinical psychologists has made a good beginning. Although originally limited to Child Guidance and kindred services, it has developed widely in recent years and an appreciable number of psychologists are now actively employed in mental hospitals, neurosis centres and neuropsychiatric departments. Although their co-operative work with psychiatrists shows many signs of healthy growth, it would be idle to deny that problems and difficulties exist.

Some of these difficulties, most notably the reliance of certain psychologists upon somewhat abstruse mathematical procedures, have already been touched upon by Dr. Henry Wilson. Although mathematical methods are inseparable from certain aspects of experimental psychology, they should, I think, be properly regarded as tools in research rather than ends in themselves. When used with due consideration of the nature of the problem under inquiry they may, as Crown (1952) has pointed out, lead to real advances in the elucidation of problems of genuine clinical import. There are, however, many further difficulties which demand our consideration. A number of these, fortunately, I believe to be more apparent than real. They have their roots in certain misapprehensions on both sides which have not always been made explicit. The purpose of my communication is to state what I believe these misapprehensions to be, and to indicate how we might perhaps free ourselves from them.

In the first place, I believe that misapprehensions of some gravity attach to the nature and function of *psychometric testing*. The psychiatrist, perhaps unduly impressed by the prestige of numbers, is apt to see in test scores valid, quantitative measurements having the same kind of finality as biochemical or serological test findings. In view of the uncertain rationale of psychometric methods, such confidence is, in my opinion, ill-placed and misleading. Whereas the actual test procedures are designed in accordance with scientific method, and are to that extent acceptable to all psychologists, profound differences of opinion exist as to the meanings which should most properly be attached to test findings. There is also divergence of view as to the most expedient methods of administering mental tests in the clinical setting (Shapiro, 1951). At the present time, therefore, psychometric testing is better described as a technology than as an applied scientific discipline (Zangwill, 1950). It has great value in psychiatry but may become a real danger if accepted in too uncritical a manner. If, however, the psychologist is content to regard his tests as pragmatic, tentative tools, and the psychiatrist to accept his findings with appropriate reserve, no serious misunderstandings on this score need arise.

Secondly, the *nomenclature* employed in psychological writings has given rise to a good deal of misunderstanding. This can be well illustrated by reference to the concept of *deterioration*. In his clinical estimates of deterioration, the psychiatrist lays stress on practical and social judgment, clarity and relevance of thought, and general efficiency of memory. The psychologist, on the other hand, tends to use this term in a more restricted sense, often attempting to define it operationally in terms of differential test performance (Wechsler, 1944). As a result, a psychiatrist may say that a given patient is not deteriorated and a psychologist aver that he is. Not uncommonly, both are right but mean different things. In my own experience, such discrepancies are particularly liable to arise in the assessment of post-traumatic intellectual loss. We have seen many patients who, on psychometric evidence, have clearly fallen below their previous levels of ability in certain fields of performance. This is undeniably deterioration. At the same time, the degree of impairment may be too slight or specialized to make itself apparent on clinical examination and prove to be of little or no significance in daily life. From the clinical point of view, therefore, there is no deterioration. It is plain that such differences of opinion, unless carefully scrutinized, do not tend towards mutual confidence and it is important that we should recognize their origin.

Semantic difficulties have also been responsible for certain criticisms which have been levelled against the work of the Maudsley group of psychological workers. Terms such as suggestibility, introversion and neuroticism have been defined by Eysenck (1947) in an extremely precise way in keeping with his extremely precise methods of investigation. But these very same terms have a much wider connotation in clinical psychiatry, opening grave possibilities for mutual misunderstanding. It must be recognized that many psychological terms at present do double duty and that a common vocabulary can only grow out of close common endeavour.

Thirdly, differences between the psychiatric and psychological viewpoints are extremely prevalent in the sphere of *research*. This, to my mind, places most unfortunate obstacles in the way of an integrated attack on basic problems in psychological medicine. In the past, much research work done by psychologists and psychiatrists within a given field of inquiry has been additive rather than integrative. A good example of such additive research is furnished by the massive Columbia-Greystones inquiry into the effects of selective partial ablations of the frontal lobes (Mettler, 1949). In this study, there was certainly a pooling of research techniques, but no attempt to devise fresh methods of investigation on the basis of a genuine inter-disciplinary attack. In my opinion, an integrative approach to research involves more than mere juxtaposition of techniques and skills. It demands genuine interaction between people of different training and background leading to original advance in descriptive or theoretical study.

In the sphere of neurology, prototypes of the integrative kind of research which I have in mind already exist. One may recall the long series of published studies by Gelb and Goldstein (1920) on the psychological after-effects of brain-injuries. In this country, the co-operation between Sir Henry Head and Sir Frederic Bartlett on the aphasia problem, while it led to no joint publication, profoundly affected the views of both men in their respective fields of inquiry. More recently, we have witnessed useful co-operation between neurologists and psychologists on a variety of special problems, e.g. the work of Smith and Akelaïtis (1942) on section of the corpus callosum and that of Bender and Teuber (1947, 1948) on disorganization in the visual sphere. These studies are collaborative in the best sense of the term and give hope of narrowing the gap between experimental and clinical methods in neuropsychiatric research.

It is unfortunate that integral co-operation of this kind appears rarer in psychiatry than in neurology. This appears to be due, in part at least, to basic differences between medical and non-medical psychologists in their approach to psychological issues. The present-day psychologist draws his impetus from the experimental methods which began with Wundt, and places stress on the comparative, genetic and statistical approaches to his subject. As is well known, these methods have met with most success in regard to the intellectual aspects of personality; their applications to problems of emotion and character have so far remained slender. The psychiatrist, on the other hand, has found the non-experimental, descriptive and systematic types of psychology, associated particularly with the names of Bleuler, Freud, Janet, Adolf Meyer, Jung and Kretschmer, more nearly to his taste. These psychologies deal principally with the broader, dynamic aspects of behaviour and, although erected on an empirical foundation, can seldom be submitted to direct experimental scrutiny. It would seem evident that, if integrative research is to develop, a framework of psychological knowledge common to both psychiatrists and psychologists should be created as its essential condition. Professor Aubrey Lewis (1950) has written that: "... in the main, the future (of psychiatry) must be determined by progress in our knowledge of physiology and biochemistry, sociology, genetics and, most of all, psychology." In so far as the last-named discipline is concerned, I submit that such progress will not come about if we have *two* psychologies—psychiatrist's psychology and psychologist's psychology —having little in common apart from the name. Full co-operation in research must develop from common thinking and discussion and this, in its turn, demands a background of appropriate instruction in the Universities and Medical Schools. Such instruction must affect both psychiatrists and psychologists and should set the stage for mutual comprehension in methodology, clinical practice and research. Only in some such way as this can we hope to overcome the difficulties which at present keep us apart and come to understand one another's point of view.

## REFERENCES


BENDER, M. B., and TEUBER, H. L. (1947) *Arch. Neurol. Psychiat., Chicago*, **58**, 721; and (1948) **59**, 39.
CROWN, S. (1952) *Brit. J. med. Psychol.*, **25**, 17.
EYSENCK, H. J. (1947) Dimensions of Personality. London.
GELB, A., and GOLDSTEIN, K. (1920) Psychologische Analysen hirnpathologischer Fälle. Leipzig.
LEWIS, A. (1950) Chambers's Encyclopædia, **9**, 264.
METTLER, F. A. (Ed.) (1949) Selective Partial Ablation of the Frontal Cortex. New York.
SHAPIRO, M. B. (1951) *J. ment. Sci.*, **97**, 748.
SMITH, K. U., and AKELAÏTIS, A. J. (1942) *Arch. Neurol. Psychiat., Chicago*, **47**, 519.
WECHSLER, D. (1944) Measurement of Adult Intelligence. Baltimore.
ZANGWILL, O. L. (1950) An Introduction to Modern Psychology. London.


**Dr. H. J. Eysenck:** *The psychologist as technician.*—This implies first and foremost an acceptance on the part of the psychologist of the *conceptual system* of the psychiatrist (Eysenck, 1950*a*); it implies secondly an acceptance on the part of the psychologist of the *practical methods* used by the psychiatrist. Before the psychologist can do either, it will behoove him to consider the evidence.

If we consider first the conceptual systems used by psychiatrists, I think psychiatrists would be the first to agree that they are makeshift, *ad hoc*, and frequently inconsistent. To take but one example, it is clearly of the utmost importance to come to a decision regarding the problem of the relation between mental normality, psychosis, and neurosis. There are three plausible alternatives—these three states may be qualitatively different, as tuberculosis is different from hæmophilia; they may differ quantitatively in one dimension, as in the Freudian system, where psycho-sexual regression defines a unidimensional continuum from normal through neurotic to psychotic; or they may differ quantitatively in several dimensions, say one dimension of neuroticism, the other of what we may perhaps by analogy call psychotocism. These are three quite distinct theoretical models; they cannot all be correct, although they may of course all be false. Yet most textbooks of psychiatry adopt all three models simultaneously, using concepts implying qualitative differences in one connexion, concepts implying quantitative differences in another (Eysenck, 1952*b*).

What is true of this problem is true of many other fundamental problems in psychiatry. They are usually dealt with implicitly, rather than explicitly; they are shelved, rather than solved.

This brings us to the second point implied in the psychologist's acceptance of the technician's role—his acceptance of the practical methods of the psychiatrist. And here again, let us very briefly look at one particular problem, that of psychotherapy, from the point of view of the available evidence.

Implicit in the practice of psychotherapy, whether Freudian, Jungian, or eclectic, is the belief that treatment will lead to an amelioration in the neurotic disorder which has prompted the patient to seek help. I have made a review of available reports in the literature dealing with the effects of such therapy (Eysenck, 1952*a*). Excluding psychotic and various doubtful cases, it appears that approximately two-thirds of the patients so treated were considered to be either cured or considerably improved by their physicians. However, while the improvement follows the therapy, it may not be caused by it. We must have what psychologists usually call a control group, i.e. a group as far as possible identical with the experimental group, but which is not submitted to the experimental treatment under investigation. There are fortunately two excellent studies—by Landis (1938) and by Denker (1946)—in which large numbers of severely neurotic patients were treated, not by any form of orthodox therapy, but either by custodial care or by ordinary G.P. treatment. The percentage of recoveries and considerable improvements was again two-thirds of the total sample. As the criteria of improvement were just as stringent in these two control studies as they were in the experimental studies, it is difficult to interpret these figures as lending any support to the claim that psychotherapy has a favourable effect on psychoneurotic disorders. They do not disprove the possibility of psychotherapeutic effectiveness, but they do quite definitely throw the burden of proof on to those who assert it.

It will be apparent why many psychologists are unwilling to accept the conceptual systems or the working methods of the psychiatrist as delimiting their activity. They feel, as indeed do many psychiatrists, that there is much that is unsatisfactory in both, and that the only reason which would justify their acceptance of both concepts and methods would be the immediate demands of therapy. That this assumption is correct is shown by American experience; there psychologists are in many cases called upon to act as therapists, and almost in every case this has made them accept *nolens volens* the concepts and working methods of the psychiatrist. Even in that part of their work which is not directly concerned with treatment, they have attempted to model themselves on the psychiatrist, and have used tests and techniques borrowed from psychiatric history, such as the Rorschach or the Thematic Apperception Test. And even in their research, this subordinate relationship has become apparent; they have usually taken for granted the precepts of some psychiatric system and nosology, and have adjusted their problems within the limits of such a system (Eysenck, 1950*b*).

This position must inevitably lead to conflict and friction between psychiatrist and psychologist. As therapy is the most prestige-giving part of the set-up in which the psychologist works, he will more and more concentrate on this aspect of his work, thus invading more and more the territory of the psychiatrist. Strong defence reactions will be set up—and have in fact already been set up in the United States. Under these conditions psychology cannot make an independent contribution to psychiatry, having accepted psychiatric concepts and methods in all material aspects; nor can it completely merge with psychiatry, lacking the essential medical background of the latter discipline. A more frustrating position for the clinical psychologist is difficult to imagine.

What of the alternative? As I see it, the psychologist should try to complement, rather than imitate, the psychiatrist. His basic training is in science, not in therapy, and he can make his greatest contribution by constantly stressing this aspect of all the problems which he may encounter. Science implies objectivity, abstract thinking, verification, experiment, and even mathematics and statistics. The attitude and training implied in these terms do not usually go with the will and the ability to be an efficient therapist. The obvious course would appear to be a differentiation of function similar to that which has taken place between the physician and the physiologist. It is this conception of the psychologist as an independent scientist, having his own professional standards, methods, and qualifications, which I would like to put forward, as opposed to the one which relegates him to the status of a technician grinding out Binets or Rorschachs in terms of a system the concepts or methods of which are not for him to question.

Both disciplines have enormously to gain by the closest co-operation. The close contact the psychiatrist has with his patients, and his powers of observation sharpened in long years of constant practice, are invaluable sources of theories and hypotheses for the psychologist; the obstinate scepticism of the psychologist, and his stress on experiment and verification, are invaluable safeguards against the easy acceptance of falsehoods and the "premature crystallization of spurious orthodoxies".

In thus accepting the scientific role, it seems to me inevitable that the psychologist must renounce the therapeutic ambition. Instead of aiming to carry out therapy himself, he should rather interest himself in such problems as the measurement of the effects of therapy, the comparison of different methods of therapy, the prediction of therapeutic success on the basis of psychological tests, or the question of the relative importance of method of treatment and person carrying out the treatment. All these questions, I would submit, are of the greatest importance to psychiatry; all of them, I believe, are capable of a solution along lines already tried and found promising. All of them, in addition, are of great theoretical importance in terms of general psychology; they can throw considerable light on the efficacies of rival theories in the field of learning, as well as in that of personality organization.

But these are broad lines of advance, and the psychiatrist may rightly ask whether the psychologist cannot aid him in the day-by-day execution of his duties. Here again, I would tend to disparage the routine administration of tests, which has become such a feature of American practice, and insist that even in this situation the scientist should proceed according to the dictates of scientific method, by regarding the particular case referred to him as a problem, by formulating hypotheses to account for the odd or inexplicable features of this problem, by systematically making deductions from these hypotheses, and by submitting these to rigid experimental tests. The foremost exponent of this method of approach in this country has been Shapiro (1951).

In both the fundamental as well as in the applied part of his work, I hold it to be particularly essential for the psychologist to relate his work to the well-established principles of general psychology. It is from these that his special competence derives; it is to these that he must look for guidance and explanatory hypotheses. His thinking about any specific psychiatric problem will be clarified when this problem can be brought under experimental control, and into contact with concepts and theories with which he is familiar. The term "anxiety" tends to be vague and free-floating; once it can be shown, as has been done by Taylor (1951) and Spence *et al.* (1951), that there is a close relationship between "anxiety" and the speed with which conditioned reflexes are formed, we immediately approach the possibility of operational definition, experimental control, and explanatory subsumption under a better-understood and more widely applicable concept. Indeed, such an approach may in due course lead to suggestions for novel therapeutic procedures; thus by making deductions from the principles of conditioning and learning theory, Mowrer (1950) has been able to show that 100% effective and lasting cures can be achieved for such difficult problems as that presented by enuresis—a striking demonstration, amply confirmed by later work, which contrasts with the much more usual, and much less successful, procedures of the psychotherapist.

## BIBLIOGRAPHY


DENKER, R. (1946) *N. Y. St. J. Med.*, **46**, 2164.

EYSENCK, H. J. (1950*a*) *J. ment. Sci.*, **96**, 710.

—— (1950*b*) The Relation Between Medicine and Psychology in England (in Current Trends in the Relation of Psychology and Medicine. Editor: W. Dennis). Pittsburgh.

—— (1952*a*) *J. consult. Psychol.* (in press).

—— (1952*b*) The Scientific Study of Personality. London.

LANDIS, C. (1938) Statistical Evaluation of Psychotherapeutic Methods (in Concepts and Problems of Psychotherapy. Editor: S. E. Hinsie). London.

MOWRER, O. H. (1950) Learning Theory and Personality Dynamics. New York.

SHAPIRO, M. B. (1951) *J. ment. Sci.*, **97**, 748.

SPENCE, K. W., and TAYLOR, J. (1951) *J. exp. Psychol.*, **42**, 183.

TAYLOR, J. A. (1951) *J. exp. Psychol.*, **41**, 81.


**Professor Alexander Kennedy:** It is generally agreed that the legitimate demand for the services of psychologists is likely to increase and that their function of applying scientific method to problems of behaviour and of human relations is applicable in a variety of fields of which psychological medicine is only one. In dealing with abnormal function of both mind and brain there is need for a reconciliation of the informed kindliness and clinical art of the physician with the objective efficiency of the scientist and it is my intention to discuss the future of this relationship in the clinical field. If psychiatry is not to become altogether mechanized and dehumanized it may be that the best means of achieving this combination of attitudes will be a division of labour such as has occurred, for instance, between clinical medicine and biochemistry. The psychiatrist, instead of converting himself into an amateur psychologist, must take the psychologist into his team and respect him for his qualities as a scientific worker. Within such a team in my experience the psychiatrist is daily reminded of the need for accurate assessment and his tendency to judge the normal from his experience of the abnormal is restrained, while the psychologist is in turn reminded of the importance of soma as well as psyche. In clinical work the psychologist will constantly be meeting examples of abnormal behaviour where his ingrained tendency to limit the number of variables will give poor results. Medical training produces a toleration of problems in which multiple factors are involved and a facility in the semi-intuitive and empirical methods which are essential in view of the complexity of the human organism and the limitations of our present knowledge. The difference in approach may be seen in its most exaggerated form in those psychiatrists who believe that statistics are the work of the devil and in the psychologist who appears to resent the fact that the human family is not made up of uniovular twins.

As psychiatrists we are naturally deeply interested in the growth of psychology as a profession and have been able to watch the successive stages of pioneer work, of excessive claims and uncritical demand, of the inrush of eccentrics into a new field and of the final emergence of work of great permanent value. We are also seeing the rapid progress which is being made by a professional body dedicated to the formulation of common aims and standards which has shown a strong sense of responsibility to

our own profession and to the public. In recognizing the work which our guests, the British Psychological Society, are doing, our attention is naturally focused on two aspects of their work which are very relevant to our future relations. The first of these is the setting of *standards of basic training* which will, we hope, prepare them for collaboration with psychiatrists and neurologists. The second aspect is the *code of ethical conduct* which psychologists will see fit to impose upon themselves as a profession and in relation to their contacts with the psychologically sick. With the Society we must also be anxious that the public can be helped to get a true appreciation of the function of psychologists and of their background.

So far as training is concerned, we cannot expect to achieve the ideal co-operation with psychologists unless we are willing to help in their training. Quite apart from formal teaching, we have much to offer in the way of clinical facilities and of allowing access to the neurophysiological laboratories and other ancillary scientific services. At the University of Durham, although the Department of Psychological Medicine is not yet five years old, it has been joined by an independent department of Psychology, and my colleague Professor Frederick Smith and I have accepted from the first the principle that psychologists and medical postgraduates should have certain parts of their training in common. We believe that they should have ample opportunities put in their way, through discussions and participation in research, of becoming acquainted with each other's point of view. The psychologist should learn from medical workers about neuroses and psychoses and his training must include actual contact with patients and opportunities for studying social factors in psychological disorder. He should be taught the functional anatomy of the nervous system, preferably by brain dissection and neurological demonstration. The psychiatrist in training on the other hand should learn in the nursery schools—and schools rather than in the hospitals—the psychological development of the normal child, and should learn with the psychologist about industrial conditions, selection and managership. He should be the guest in the experimental psychology laboratory.

The discussions which develop between the two groups are in my opinion most fruitful. Much of the purpose of the preliminary course in basic sciences and methods for the Durham D.P.M. is to practise the medical graduate in the vocabulary of the philosopher, the geneticist and the psychologist and such basic training helps to meet the urgent need, emphasized by Professor Zangwill, for a common language. Even with this amount of interchange the psychologist will not, of course, subsequently undertake the diagnosis of neuropsychiatric disorder. He will necessarily be an ancillary worker in the clinical field just as the psychiatrist is an ancillary worker in Selection procedure and a great part of Industrial psychology.

In psychiatric practice the psychologist is apt in some quarters to be regarded simply as a tester. Psychologists whose work is to carry out prescribed tests may well be needed in some quantity but it is to be hoped that selection for the profession of psychologist will produce a considerable proportion of graduates who will be able to accept much greater responsibility in medical work. The main fields at present in which the psychologist can help are in the assessment of constitutional differences, in special education, in re-education after damage to the nervous system, in the control of cases undergoing speech therapy and in the assessment of the effects of treatment. Very little has been said so far about his place in psychotherapy. In some quarters it seems to be felt that a qualification to practise medicine gives evidence of special ability in dealing with emotional problems. When it is considered how little time, relatively, is devoted to instruction in this subject in the undergraduate medical course the weakness of this attitude becomes apparent. The reason that the management of psychoneurosis is usually in the hands of medical men lies solely in the attitude of trust on the part of the public towards doctors. If, by maturing as a profession and recognizing a strict ethical code, clinical psychologists could achieve, as has the dental profession, a similar position, there seems to me no reason why they should not undertake psychotherapy, once diagnosis has been established. There are certain formal psychotherapeutic procedures, especially with groups, which under psychiatric control might better be undertaken by psychologists, especially in view of the shortage of psychotherapists. Psychologists who, on the other hand, become over-confident of their therapeutic powers, and lose the humility which is essential to sound clinical work, will not be helping their profession as a whole.

In the present phase of scientific research the contact of different approaches frequently produces new combinations of ideas and the co-operation between these two disciplines has already yielded good results. Professor Zangwill has already mentioned a field of research in which there is a great deal more to be done, namely the reduction to terms of measurement of the clinical examination of the nervous system at different levels of integration. Continued work in this field and the incorporation of the results in the training of psychologists will, I think, go far to increase the existing common ground. As Dr. Wilson has pointed out, psychiatrists have only recently gained acceptance in the medical world and psychologists are now following a comparable path. The final relationship which will emerge must be partly the result of planning and partly due to natural evolution of their profession and of its acceptance by the public. That progress can be made more rapid by insisting, as we now do in psychiatry, on proper selection and training of candidates. It is agreed that greater uniformity is necessary in the training of psychologists and the place of the psychologist in psychiatric practice and research will be the more secure if this training includes more contact with clinical psychiatry than it does at present.