THE CLINICAL PSYCHOLOGIST IN THE MENTAL HOSPITAL

BY

RALPH HETHERINGTON, Ph.D.

Senior Clinical Psychologist, Crichton Royal, Dumfries

The appearance of trained clinical psychologists in mental hospital practice is a comparatively recent phenomenon. It is therefore not surprising not only that many mental hospitals are still without psychologists but that those that do employ them are not all using them in the same way. Indeed, many medical men have but a sketchy notion of the training and capabilities of the clinical psychologist and are therefore not clear about what duties may properly be assigned to him. It is hoped that this article may make matters clearer by giving an account of how clinical psychologists are employed at the Crichton Royal, Dumfries, where the first psychologist was appointed twelve years ago.

Training of the Psychologist

Arrangements for the selection and training of clinical psychologists are set out in the Ministry of Health circular P.T.A. 39 and the appropriate covering memoranda.

No psychologist is now accepted for clinical training unless he has an honours degree in psychology. He is then required to gain a further three years' experience with mental patients, usually in a mental hospital, under the supervision of a senior psychologist, before he can be regarded as being fully trained. At the end of this time, if he is to be allowed to continue, he must gain a proficiency certificate from his employing authority. This period of hospital experience may be reduced if he has also received postgraduate training in clinical psychology in a university department. The psychologist, then, comes into the mental hospital with a background of academic knowledge of normal psychology, in contrast to the psychiatrist, who begins with a training in general medicine. Thus, whereas the psychiatrist is interested in eliciting symptoms which may lead him to diagnosis and so to treatment, the psychologist is concerned more with describing the patient in terms of personality traits of intelligence, temperament, and character. The psychiatrist's training has given him a knowledge of the abnormal, the deviant, and the pathological; whereas the psychologist's training has given him a knowledge of the normal range of human behaviour.

Work of the Psychologist

The work of the psychologist in the mental hospital may be classified under four heads: diagnosis, research, treatment, and teaching. It is unlikely that he will be able to give an equal amount of attention to each of these. All psychologists engage in a large amount of diagnostic interviewing and testing, which probably forms the major part of their work. The relative amount of time spent on research, treatment, and teaching depends on the psychologist himself and on the hospital in which he works. The man who is interested in research often does little or no treatment, and vice versa. As Sir Thomas Lewis (1930) pointed out, the research and clinical attitudes are not easily adopted by the same person concurrently. Whether or not the psychologist is called upon to teach depends on the presence in the hospital of medical officers training for their D.P.M. or of a school of nursing. Where psychology lectures are to be given the clinical psychologist is best fitted to give them.

Diagnosis.—The psychologist in his diagnostic work aims at providing information about a patient which will help the

psychiatrist to assess the nature of the illness. The tests he uses are based on scientific research and depend as little as possible on personal subjective impressions and as much as possible on objective measurement. The intellectual level of the patient, as well as signs of intellectual impairment or deterioration, is always an important factor, and the psychologist is equipped to make objective assessments of all these. Disorders of perception or thinking may give the first indications of a cerebral lesion or functional psychosis. These can be fairly easily demonstrated by test procedures. The various so-called "projective techniques," such as the Rorschach ink-blot test and Murray's thematic apperception test, give valuable information about a patient's personality. The former gives indications of how the patient operates: anxiously, depressively, obsessively, and so on; the latter yields information about his attitude and opinions with regard to his parents, death, violence, sex, and the like. Tests such as these not only help in diagnosis but are valuable research tools and often form a useful basis for psychotherapy.

Research.—So far as a psychologist has had training in scientific methods he is able to render valuable assistance in designing and in carrying out research projects; he can also give advice on scientific research in general. Since university courses in psychology usually include statistics, the psychologist is able to advise on statistical methods in medical research in the hospital. Recent psychological research at the Crichton Royal has included work on the effects of E.C.T. on memory and efficiency, the psychological changes in senile dementia, and the changes in attitude of alcoholics after treatment.

Treatment.—Not having a medical training, the psychologist does not, of course, undertake any of the physical treatments. He can, however, undertake the psychotherapy of suitable cases under the general supervision of the psychiatrist, who remains in charge of the case. As this form of treatment is very time-consuming, this part of the psychologist's work can be of great assistance to the psychiatrist. Since the former is never concerned with problems of administration, he tends to be regarded by the patient in a somewhat different light from either the psychiatrist or the nurse. Consequently it sometimes happens that the patient finds it easier to confide in the psychologist in the first instance. Some aspects of the patient's rehabilitation, too, are often more easily handled by the psychologist.

Teaching.—In lectures to medical officers training for their D.P.M. the psychologist should be able to supply the academic framework for the psychological knowledge necessary for the diploma, and in lectures to student nurses he should be able to relate psychological theory to practical issues on the ward. It is particularly necessary to encourage nurses to observe and understand themselves as a basis for understanding their patients.

Role of the Psychologist in the Hospital

There has been a tendency at some hospitals to use psychologists as "scientific medical auxiliaries," much in the same way as radiographers, E.E.G. recordists, or biochemists. In this case the psychologist is based on his own separate department, which he leaves only when it is necessary to visit the ward to test the patient. In some cases the patient may even be brought to the psychologist in his department. This arrangement has obvious limitations. The presence of the psychologist in the ward to see a patient on request may be interpreted by the latter as indicating a serious turn of events in his treatment. As the psychologist is a stranger to the patient, rapport has to be established before he can usefully begin to test the patient, and this often involves the need for prolonged reassurance and encouragement. On the other hand, if the psychologist is based on the ward and is there every day and all day, he soon becomes recognized as part of the ward team of doctors and nurses. Patients indeed come to accept the psychologist as one of the group

of people he sees regularly, concerned as a team in his day-to-day treatment. The psychologist is not then a strange expert called in for a special purpose but is a well-known figure with whom most of the patients have a talk some time or other. When the psychologist works in this way the value of the material he gains from the patient is greatly enhanced. The patient knows him and has come to trust him, and it is recognized in the ward that patients go and see him. Therefore there is no strain; there is no initial discussion to be undertaken with a patient before valuable material can be elicited.

Another way in which the part the psychologist plays on the ward can be useful has already been mentioned: whereas the doctor and nurse are inevitably in positions of authority, the psychologist is not so. He is not required, nor is it necessary, for him ever to give orders to the patient or to anybody else. His advice may often be sought, but he never assumes authority. This often provides opportunities for the patient to work out his problems when he needs some non-authoritarian figure to consult.

When a psychologist is based on a ward in the way that has just been described, the sphere of his work is inevitably restricted, as he will be available for work only on the ward in which he is based. On the other hand, the value of his work is so much enhanced, and the fullness and richness of the psychological material he obtains is so much increased, that there can be no doubt of the value of this system of working. Unless his efforts are concentrated on a single ward the potentialities of the psychologist in the mental hospital setting may not be fully realized and he may get so little done that is really worth while that his usefulness may begin to be doubted. On the other hand, if his potentialities are exploited by putting him on the ward, his usefulness will become apparent.

At a time when mental illness and neurosis are becoming major concerns in national life, the increasing employment of clinical psychologists in this way may play a part in meeting some of the difficulties which at the moment beset work in mental hospitals.

REFERENCE

Lewis, Sir T. (1930). *British Medical Journal*, 1, 479.

NORMAL AND ABNORMAL BONE

SYMPOSIUM AT QUEEN'S COLLEGE, DUNDEE

[FROM A SPECIAL CORRESPONDENT]

The properties of bone, its growth and repair, and some of its clinical abnormalities were among the subjects discussed at a symposium and postgraduate lecture held at Queen's College, Dundee, on September 5. The Master of Queen's, Professor D. R. Dow, opened the meeting.

Breaking Stress

Professor G. H. BELL and Mrs. JEAN OLIVER (department of physiology, Queen's College) reported on the strength of bone in various pathological conditions. In Professor Bell's earlier studies it had been shown, they said, that the breaking stress of individual bones could be calculated from simple bending tests. The breaking stress was a measure of the quality of the bone material. In rats, while changes in the calcium intake might affect the size and therefore the strength of the bones, they did not alter the quality; similarly, pituitary, thyroid, and parathyroid hormones and oestrogens had little or no effect on bone quality. In rickets, however, the breaking stress was diminished in parallel with the reduction in the ash content of the bone, but apparently neither the bone's inorganic nor its organic constituents were altered. Recent studies with Mrs. Oliver on experimental lathyrism in rats had shown that in this condition bone quality was reduced even when there was no corresponding

change in the quantity or quality of the inorganic component. At the end of this contribution Mr. I. S. SMILLIE asked why the breaking stress of a bone—for example, the neck of the femur—was reduced in old age. No answer to this conundrum could be found. One suggestion was that the explanation might lie in some variation in the connective tissue.

Dr. J. W. SMITH and Professor R. WALMSLEY (department of anatomy, St. Salvator's College) then discussed fatigue in bone. Dr. SMITH said that, while stress fracture from repeated strains during normal activity was a well-known clinical entity, previously it had never been proved experimentally that bone could be fractured in this way. He then proceeded to describe experiments in which stress fractures had been induced, illustrating in a film the apparatus used. He had found that the breaking stress was directly related to the elasticity of the bone being tested, and that the stress and static loads were the same for any given piece of bone. His experiments had been on dead bone, and so did not take into account any remodelling that might occur in the living subject.

Professor WALMSLEY took the matter a stage further by describing research he had carried out to correlate the elasticity of a bone with the collagen arrangement in its haversian systems. By means of stained sections he demonstrated that the collagen in a haversian system is disposed in alternate circular and longitudinal layers. He had taken a horse's radius, where the anterior cortex is under tension and the posterior cortex under compression, and calculated Young's modulus of elasticity for these two sections of the cortex. Section of the anterior surface of the bone, where the figure for the modulus was relatively high, showed the longitudinal fibres to be most marked, whereas section of the posterior cortex, which had a much lower modulus figure, showed the circular fibres to predominate. In the ensuing discussion Professor P. LACROIX asked if the sections had been examined under polarized light. Professor WALMSLEY said the findings were the same as those demonstrated by staining. The mineral content of bone was increased on the side under compression, he added.

Growth and Repair

These aspects of the subject were discussed both in the symposium itself, where Mr. J. A. GILLESPIE (department of surgery, Queen's College) reported on his studies on the effect of nervous influences on bone growth, and in the open postgraduate lecture given after the symposium by Professor P. LACROIX (department of anatomy, Louvain), this year's praelector in the faculty of medicine at St. Andrews. Mr. GILLESPIE's experiments had led him to believe, he said, that neither the peripheral nor the autonomic nerves exerted any trophic action on bone. Nor did changes in blood flow to the limb alter the rate of growth. In a paralysed limb the quantity, not the quality, of the bone was affected. The basic rate of bone growth was due, he said, to the inherent growth energy of the cells of the epiphysal plate and inner layer of the periosteum, and this basic rate was increased by the stimulus of muscle action. In his view the degree of muscle paralysis in a limb was directly related to the subsequent shortening. If maximum use was made of a paralysed limb, the shortening would be reduced to a minimum. However, Mr. G. MITCHELL (Edinburgh), speaking on the basis of preliminary clinical observations, did not think the degree of paralysis in poliomyelitis could be related to the limb shortening. But he thought the paralysis of muscles whose origins were close to a rapidly growing epiphysis was an important factor in leading to serious shortening of a limb, and Miss M. FORRESTER-BROWN (Edinburgh) agreed with him, citing paralysis of the gastrocnemius as an example.

Professor LACROIX began by reviewing his experiments on the induction of bone growth. In normal epiphysal cartilage, he said, a layer of subperiosteal cartilage was laid down,