ONE FLEW OUT OF THE CUCKOO'S NEST?*

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My brief is to discuss the present and future relationships between clinical psychologists and psychiatrists. I shall be speaking from the, no doubt restricted, viewpoint of a Consultant in Adult Psychiatry working in a general hospital unit in a Teaching Area. My comments will not, therefore, apply to child psychiatry or mental handicap, and may well be received less than enthusiastically within mental hospitals. The highly efficient organizers of this conference, in their letter of invitation said, 'We want a sensible, middle of the road view'. Did they realize, I wondered, that the middle of the road can be a rather dangerous position to occupy? I shall try very hard to avoid a head-on collision.

Those with long experience in psychiatry are aware of the remarkable transformation that clinical psychology has undergone in the past two decades. Twenty years ago the clinical psychologist was a shadowy figure who occasionally surfaced at a case conference to read out the result of an intellectual or personality assessment but otherwise had little contact with the medical or nursing staff. The mental hospital where I obtained part of my Senior Registrar training had no psychologist, whereas today the Royal College of Psychiatrists, rightly, will not approve a hospital for psychiatric training unless it has a psychological service. The extent of the change is well described in the Introduction to the Trethowan Report: 'In former times the clinical psychologist's role consisted largely of undertaking routine psychological measurements such as intelligence testing at the request of psychiatrists and other doctors and represented in effect an ancillary service to the medical profession. Recent years have seen a substantial expansion in the body of psychological knowledge accompanied by the development of new techniques which have major implications for treatment. One of the effects of these developments has been to make psychological assessment a much more sophisticated process with a wider range of implications both in determining various aspects of individual need and in evaluating the progress of patients and their response to different forms of therapy. At the same time psychologists have developed a number of new forms of treatment, some of which have been widely applied and represent an important addition to the range of therapeutic resources.'

This change has been accompanied by a three-fold increase in the number of clinical psychologists employed in the NHS. It was because of this expansion, both in numbers and functions, that it became necessary to set up the Trethowan Sub-Committee, for the present organization must adapt to the new relationship between clinical psychology and other professions so that the fullest use is made of new techniques and skills.

The adoption of a 'middle of the road' position implies the existence of more extreme views on either side. As in politics, and many other human activities, there are those who prefer to maintain the *status quo* or even turn back the clock to a mythical golden age when order and efficiency reigned. Unfortunately the clock cannot be turned back very far before clinical psychologists drop out of sight altogether. Those with this attitude can be regarded as on the right-hand side of our road. They are to be found mainly in the medical profession and can be recognized by their nostalgic recollections of mental hospitals in the days of the Medical Superindendent. I have a certain amount of sympathy for such views. There is no doubt that an autocratic system is tidier and more efficient and there were some excellent forward-looking Medical Superintendents. On the other hand there were many who were quite the opposite and had a stultifying effect on the institutions under their control, including staff and patients. Their spiritual heirs have, nevertheless, had a rough time. They have watched helplessly as the nurses and social workers have escaped from medical control. They can perhaps be forgiven for resisting the efforts of clinical psychologists to follow the same path. To their credit, they fight under the banner of 'patient welfare', and the battleground is an area marked 'clinical responsibility'. The GMC reflected this opinion in its evidence to the Trethowan Sub-Committee: 'Within the NHS the practice of psychology as a therapeutic procedure by persons other than registered medical practitioners is ultimately the responsibility of the referring GP or consultant . . . improper delegation of medical duties to unregistered

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persons may render a doctor liable to charges of professional misconduct.'

On the left-hand side of our road we find those who cannot wait for situations and relationships to change by evolution but are intent on bringing about a quick change by revolution. Here the *bête noire* is something called 'the medical model'. Thus Fay Fransella (1975) writes: 'It is difficult to overemphasize the dominance of the medical conceptual framework in the field of psychiatry with its central concept that of mental illness. But this is meaningless from the point of view of psychology as a science. There is nothing whatever in the training of a psychologist that leads him to think in these terms. Yet it is the key concept of those with whom he must closely work. It is a concept about which he must learn if there is not to be a total breakdown of communication. The use of a psychological model carries with it the implication that the psychiatrist is a medical man functioning as an untrained psychologist, while the medical model implies that the psychologist is a technical auxiliary who provides evidence which the doctor takes into account in arriving at a diagnosis. Some clinical psychologists consider they now have sufficient bodies of knowledge and techniques for helping those with psychological problems to be allowed their freedom to see what they can do. This means they are no longer content to be helpmeets of psychiatrists (helpmeets without a place in the power structure). They are now in competition with the medical profession.'

Eysenck (1975) goes a stage further. He writes: '. . . not only does psychiatry suffer from depersonalization and an identity crisis, it also suffers from split personality and possible schizophrenia as well. The outlook is grave, only surgery is likely to save the patient.' He goes on with his surgical solution: 'It is justifiable to split psychiatry into two independent parts, one concerned with organic disorders (into which category he places the functional psychoses) and their treatment, which is largely medical in nature, the other concerned with behavioural disorders and their treatment, which in turn is largely behavioural. The former discipline should be the prerogative of medically trained psychiatrists, while the latter should be the prerogative of non-medical clinical psychologists. Such a division promises to make optimum use of the scarce medical skills of psychiatrists by removing the burden of treatment of neurotic and other behavioural disorders from their shoulders—ill-fitted as they are to bear this particular burden by virtue of a training which does not embrace, to any serious extent, teaching of the principles of behaviour therapy which has been found to be most useful in treating these types of disorder. Objection on the grounds that only doctors are qualified to treat diseases are unjustified because behavioural disorders can only be considered 'diseases' by an undue extension of the meaning of that term for which no rational grounds exist. Behavioural disorders are more in line with an educational model requiring re-education than with a medical model requiring medical treatment.'

Not to worry! Eysenck is surely pulling our legs, as the next priceless paragraph indicates. 'By adopting these recommendations we may be able within a measurable time to wipe out disabling phobic fears, obsessive-compulsive behaviours and many other serious neurotic disorders, possibly by sending around the country mobile treatment trucks staffed by clinical psychologists.' I must admit that I have already earmarked my most difficult neurotic patients for the arrival of the first mobile treatment truck to reach Newcastle. If they can't cure them they might at least drive away with them.

Is it possible to reconcile these conflicting attitudes? We can perhaps begin by each discipline learning what the other actually does. Psychiatrists and clinical psychologists are often surprisingly ignorant about the beliefs, education and responsibilities of each other. Dispel the ignorance and the misconceptions might disappear too. Let us first compare the respective training systems.

A clinical psychologist will have spent three or four years getting a good honours degree in psychology of a University approved by the British Psychological Society (BPS). He or she then has the option of three years' in-service training leading to the BPS Diploma in Clinical Psychology, M.Phil, or M.Sc. Career grades in the NHS as Basic Grade, after two years Senior, followed by Principal and Top Grade depending on the responsibility of the posts. The Senior Grade is normally regarded as the level at which a psychologist should carry independent responsibility, i.e. two years after completing postgraduate training or four to five years after obtaining his or her initial degree.

A psychiatrist, by the time he or she achieves a Consultant appointment will have spent five or six years at medical school obtaining a medical degree, then a year as a house doctor in general medicine and surgery to get on to the Medical Register. He or she may spend one or two years in general medicine or neurology before commencing psychiatric training. This consists of at least three years general professional training in a hospital or group of hospitals approved by the Royal College of Psychiatrists and attendance at a Day Release Academic Course, which includes Behavioural Science. The budding

psychiatrist then takes the M.R.C.Psych. examination, which includes a section on psychology. If successful, he or she then competes for a Senior Registrar post and if appointed undertakes three to four years special professional training during which experience is extended and increasing responsibility allowed, but independent clinical responsibility is not accepted until Consultant status is achieved, again by competitive appointment, at the end of this period, i.e. about ten years after leaving Medical School or three to four years after obtaining the postgraduate qualification. A recent College document on Consultant responsibility states: 'There are few areas of human endeavour where such long apprenticeship is required, and where there are so many obstacles to achieving the position of (NHS Consultant).' This perhaps explains why Consultants are jealous of their authority and not keen to relinquish it to other professionals whose experience may not always be comparable.

Now what does each actually do?

The BPS lists the activities of clinical psychologists as follows:

(i) Development of systematic methods of scientific enquiry into different aspects of human behaviour.
(ii) These methods are applied to the study of normal as well as disordered psychological functioning.
(iii) Provision of a link with academic and research psychologists through which useful knowledge is transmitted.
(iv) Addition to the sum of knowledge and develop methods.
(v) Carry out assessments and administer treatment.

The BPS recognizes four categories of assessment:

(i) Psychometric techniques.
(ii) Physiological measures used as indices of psychological functioning or change.
(iii) Diagnostic assessment.
(iv) Monitoring techniques.

The BPS recognizes five categories of treatment:

(i) Behaviour therapy.
(ii) Organization and evaluation of rehabilitation and training for the mentally and/or physically handicapped.
(iii) Counselling and related activities.
(iv) Modelling/training methods.
(v) Group methods.

The BPS even estimates the use of a clinical psychologist's time as follows:

Assessment and diagnosis	10%
Treatment and rehabilitation	45%
Teaching	15%
Administration and training	10%
Research	20%—I should be so lucky!

Note the terminology—'Diagnosis' and 'Treatment'. The despised 'medical model' seems to have crept in!

What about psychiatrists? Do they in fact spend their time applying this much-abused medical model, as Fay Fransella implies? As Professor Cooper has recently pointed out, psychiatrists use a whole variety of 'models' to help their thinking and problem-solving, e.g. biochemical, pathological, behavioural and social. There is no one special 'medical model', except apparently in the minds of some non-medical colleagues and, of course, the producers of television programmes.

The classical sequence of the physician is inadequate for the psychiatrist. Hence diagnosis becomes 'diagnostic formulation', and this includes a description, an aetiological hypothesis and an assessment of problems. Treatment becomes 'management' and in this the purely medical aspect may be a small but often essential part. Prognosis is not thought of in terms of cure, but in terms of what level of independent functioning a particular patient can achieve. Perhaps Thomas Szasz could be persuaded to write about 'The Myth of the Medical Model', for this myth has been responsible for the heaping of much undeserved abuse upon psychiatrists.

Now for some of the more contentious issues.

Multidisciplinary teams

The College has just put out a rather forthright statement on this topic: 'The legal, professional, ethical, diagnostic and prescriptive responsibilities of the medical profession cannot be delegated to a multidisciplinary group when treating an individual patient. Each Consultant must formulate his own opinion whether assisted in this process by others or not. Multidisciplinary in this context, from the medical point of view, is a process of consultation, the final decision resting with the Consultant on matters where the Consultant has the final responsibility.'

This conjures up a picture of a Consultant who consistently pulls rank and overrules the other members of the team. The end result would probably be the departure of the Social Worker and Clinical Psychologist for posts where they felt their contributions better appreciated. It is salutary for the Consultant to have to discuss and justify his decisions. In practice the most heated arguments are more often with junior medical colleagues than with the non-medical team members. Many patients are managed on a truly multidisciplinary basis. A patient,

for instance, may be taking anxiolytic or antidepressant drugs and at the same time receiving systematic desensitization from the clinical psychologist while the social worker works with the spouse or family. Multidisciplinary team work has been defined as 'doing your job in co-operation with other people'. It is highly probable that psychiatrists who cannot get on with their colleagues will not get on too well with their patients either.

Clinical responsibility

The BPS maintains that it is the responsibility of a referring medical practitioner to assure himself that the clinical psychologist is qualified. Thereafter the psychologist is responsible for whatever acts he carries out in treatment. That is acceptable to me, in fact I understand that the medical defence societies disclaim legal liability for the actions of clinical psychologists in relation to patients referred by doctors. The BPS, however, goes further: 'Where a clinical psychologist and a medical practitioner are jointly engaged in the care of an individual they should establish by agreement their specific areas of responsibility.'

I may have misunderstood this BPS comment, but I believe that the responsibility for patients should not be divided and we should avoid the outdated mind-body dualism peddled by Eysenck. Within the NHS the weight of law, tradition and patients' expectation lays this responsibility on the doctor, whether Consultant or general practitioner. The Trethowan Report is quite firm on this point: Para 5.2.3. states: 'We fully recognise that, for any patient under treatment in the NHS there is a continuing medical responsibility which cannot be handed over to any other profession.' It is in the clinical psychologists' best interests to maintain this arrangement, for patients are often unpredictable in their behaviour, and crises such as suicidal attempts can erupt unexpectedly. Also many patients are on drug therapy and require monitoring for possible side-effects or changes of dosage.

Independent Psychology Departments and direct referrals

In 1973 a College statement registered disapproval of these on the grounds that they might encourage the by-passing of Departments of Psychiatry and the withdrawal of clinical psychological services from them. This ignores the fact that if the services withdrawn prevent patients being referred to the psychiatric department the net result might well be no change. A better argument is the need for medico-psychiatric evaluation of patients presenting with behavioural problems. The College lists a number of rather rare physical conditions such as cerebral tumour, thyroid disorder and hypoglycaemia which can present as behavioural disorders, but omits the commonest problem, namely the depressive illness presenting with obsessive-compulsive or phobic symptoms. As for direct referrals from non-medical sources, experience suggests that these would provide a mixed bag of quasi-mental problems requiring a good deal of preliminary diagnostic sorting.

I would like to see clinical psychologists continue their close association with psychiatrists, who still provide 95 per cent of their referrals. At the same time I support the independence of clinical psychology as a profession in the terms expressed in the Trethowan Report: '. . . the professional status of clinical psychologists in the NHS should be fully recognised—psychology should not be regarded as an adjunct of any other profession and psychologists should be recognised as constituting a responsible group having special skills to contribute to patient care in co-operation with the other professional groups concerned.' Clinical psychology has already acquired some of the hallmarks of an independent profession, such as a code of ethics, albeit unenforceable, and its own arcane language, e.g. 'apotrepic therapy' (the prevention of obsessional rituals by distraction and supervision). In due course might we see a Royal College of Clinical Psychologists?

There is just one small cloud on the horizon, in the shape of the increasing participation of nurses in behavioural therapy. How ironic if the role of the behavioural scientist in the NHS were taken over by the nurse, a process recently compared by Professor David Goldberg to lorry drivers being trained as airline pilots, watchmakers as eye surgeons and retired schoolteachers as Professors of Psychiatry. To be fair psychologists do not resent this intrusion into their domain; indeed there is more than enough human suffering to keep us all fully occupied.

If I have offended anyone I hope they are represented equally in both professions, for that will confirm my middle of the road position. It seems to me inevitable that clinical psychology will become increasingly independent, but I hope it will remain in the Commonwealth rather than declare UDI; or, to put it another way, will it stay with the other cuckoos or will it become the One Who Flew Out of The Cuckoo's Nest?

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