A REASSESSMENT OF THE ROLE OF THE CLINICAL PSYCHOLOGIST IN THE MENTAL DEFICIENCY HOSPITAL

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Introduction

It is just over a decade since Gunzburg (1956) in what was the original paper on this topic, somewhat diffidently remarked that "The psychologist as a member of the clinical team of a Mental Deficiency Hospital is a fairly recent innovation and his contribution to clinical work is still barely defined." Hetherington (1956) simultaneously reiterated this view in relation to the role of the clinical psychologist in the mental hospital. To many contemporary clinical psychologists in hospital practice this must seem overmodest. Eleven subsequent years of life in a burgeoning if somewhat diversified science is enough to disqualify the psychologist from being described as a recent innovation, but there is a case to be made for a re-assessment of his contribution to the field and for his role within the institution to be re-defined. Desai (1967) has very recently written of clinical psychologists that it is "essential to take a periodic look at ourselves and to conceptualise, as far as we can, the identity of our field. The development of the discipline and of the profession depends to a considerable extent on such periodic reappraisals and many areas of our activities depend on the concepts of Clinical Psychology that we hold."

Two further main justifications for choosing the present as the time to attempt this essay present themselves. First, there has been new legislation, in the form of the Mental Health Act (1959) and the Mental Health (Scotland) Act (1960), which have introduced new definitions, responsibilities, aims and types of patient to those concerned with mental subnormality services in and out of hospital; and secondly, the merest glance through any recent volume of the Annual Review of Psychology, and at new and thriving journals like "Programmed Learning," "Behaviour Research and Therapy" and "Neuropsychologia" will reveal striking developments in both general and applied psychology, which cannot but be reflected in contemporary clinical psychological practice in the subnormality hospital.

Gunzburg's original thesis was essentially that there was in the mental deficiency hospital relatively little scope for the psychologist "as a psychometrist and diagnostician" since most assessments of patients were done before the patients were admitted. He went on to point out that, especially in the case of the so-called non-pathological subnormal, there was little merit in his being treated by a doctor since "his (i.e. the patient's) certification changes his legal status but does not transform a primarily social into a purely medical problem." He outlined the nature of the social problem in terms of a lack or maldevelopment of adjustment skills which it was the psychologist's primary concern to remedy by specially developed techniques of education, training and rehabilitation. Gunzburg was careful at the time to differentiate between the "pathological" defective whose aetiology was one of medical interest and whose treatment was properly instituted in a medical-nursing atmosphere, and the simple feeble minded where, as he saw it, "the real problem in such a case is the complicated and easily disturbed relationship between a person with limited mental resources on the one side and the community with scant understanding and too many demands on the other." In this instance it was for the psychologist with his special training in assessing mental capacities and weaknesses together with his awareness of the interaction with them of personality factors and a variety of environmental and cultural pressures to exert his expertise "to initiate and supervise

a rehabilitation scheme which will satisfy the requirements of the subnormal within the existing custodial framework as long as the administrative handling of this problem fails to separate the two groups." Major responsibility for this function was to be vested in the psychologist rather than the doctor since the former is the one who by his training, at least theoretically, is the expert in this area of competence. Finally, Gunzburg reveals his bias towards "verstehende" rather than toward "erklärende psychologie" by proclaiming that "the scientific, purely research minded psychologist has at present scarcely a place in the hospital, where there is not even sufficient time to cope adequately with day to day problems." While it will be the aim of this paper to demonstrate a need for an expansion of the role which Gunzburg outlines it will nevertheless be abundantly clear to those who know the work and the hospital concerned that no one could have met better the particular aims which he has set himself than has Gunzburg. High grade patients and high grade psychologists alike owe him much.

A brief review of the evidence from other sources does demonstrate, however, how far the practice of clinical psychology in mental deficiency has developed in the U.K. compared to elsewhere, with the possible exceptions of Holland and Scandinavia. Only a year ago, in striking contrast to Gunzburg's (1956) then forward looking views on rehabilitation and training, Peiffer (1966) stated that in France no clear role had emerged for the clinical psychologist in hospitals and that his main task was the straightforward assessment of I.Q's. Not only that, but the writer goes on to express the view that most clinical psychologists coming into hospital work must work hard to adapt to medical views and activities whereas the main trend here would be toward mutual understanding and expansion of the distinct contribution which each discipline can make to the other. While it is well known that privately run institutions and schools for the retarded in the U.S.A. have produced personalities, techniques and research results pre-eminent in the field (Kirk, S. A. and Johnson, G. C. 1954, Kirk, S. A. 1958; Stevens, H. and Heber, 1964) at the same time Baumeister (1967) reported earlier this year that so far as public institutions for the mentally retarded in the U.S.A. were concerned the role of the psychologist there, was that primarily of the psychometrician and that both psychologists and superintendents were at ease in this role, both parties feeling that the psychologist was well qualified for this. Superintendents, however, were less than happy about the psychologists' general knowledge of retardation and there was a general tendency to play down the role of the psychologist as a researcher, that being considered as his least important function.

Many of these discrepancies in the adopted or attributed role of the clinical psychologist in mental deficiency, can of course be traced to major differences in either the training and professional background of psychologists or in the great variety, size and development of the relevant institutions elsewhere. In this country however, there is the advantage of an organised attempt by the Universities and by the British Psychological Society to achieve some uniformity of standards in regard to the former, together with the effect of a National Health Service which necessarily involves the setting of reasonably uniform standards of hospital care, amenity and staffing. Given that there are certain differences of emphasis between mental deficiency hospitals, it would not be in any way difficult for a clinical psychologist in one British M.D. hospital to move to and to continue effectively the work in another.

The Sociological Characteristics of the Hospital

All such hospitals, however, are necessarily "total institutions" in the sense that Goffman (1961) described them as being places of "residence and work where a large number of like situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered brand of life." It is

salutary to bear in mind that this is the setting in which the psychologist has to work. Granted that he has the advantage over the patient of being able to move out of the institutional mores and restraints more or less daily, he still is at risk of becoming indoctrinated, stultified by habitual preconceptions, and restricted in his scope and usefulness by the pressures within the 'total institution' to force him into a particular type of role. Ready compliance with these often subtle pressures may well be rationalized in terms of "getting along with other staff," "pursuing previous researches or special interests," or "maintaining a rigorously scientific outlook." The first stage, therefore, in the formulation of a definite role within the institution must be some attempt on the part of the individual psychologist to assess what in fact may be the pressures of the social environment on him to adopt this or that role and how far these pressures may be accepted or resisted, with minimal adverse effect on the useful application of his professional skills. To do this demands awareness of the sociological nature of an institution on the one hand and a grasp of what skills the psychologist has to offer on the other.

As for the first point, it has been claimed by both Goffman (1961) and Russell Barton (1961) that three features predominate in the 'total institution' far more than they do in the wider world. In the latter, "a basic social arrangement in modern society is that the individual tends to sleep, play and work in different places, with different co-participants under different authorities and without an over-all rational plan." Life in the hospital is the antithesis of this. Secondly, in the institution, each phase of the patient's daily activity tends to be carried out in the company of a large group of others, all of whom are treated more or less alike and are required to do the same thing together. Only in very few instances does this occur in normal life. Thirdly, all phases of the day's activities—or lack of them—are tightly scheduled and programmed beforehand by a system of explicit formal rulings originating from a body of officials. One may well feel that this type of organisation is necessary when a few are made responsible for many in so many respects, but these features do certainly characterize the institution, be it barracks, prison, ship or hospital.

The general role of the clinical psychologist therefore is bound to be one in which he is prepared to accept, by dint of the fact that he can move in and out of the institution at will, a Them/Us dichotomy between staff and patients which will impose limits both in the form and content of communication between himself and the patients. Goffman (1961) describes this situation at its bleakest thus: "In total institutions there is a basic split between a large managed group, conveniently called inmates, and a small supervisory staff. Inmates typically live in the institution and have restricted contact with the world outside the walls; staff often operate on an 8 hour day and are socially integrated into the outside world. Each grouping tends to conceive of the other in terms of narrow hostile stereotypes, staff often seeing inmates as bitter, secretive and untrustworthy, while inmates often see staff as condescending, high-handed and mean. Staff tends to feel superior and righteous; inmates tend, in some ways at least, to feel inferior, weak, blameworthy and guilty. Social mobility between the two strata is grossly restricted; social distance is typically great and often formally prescribed." Stanton and Schwartz (1954) provide many endorsements of this view.

Even where strenuous efforts are made to establish a "therapeutic community", the hospital remains a community within the community and the historical nature of professional/patient relationships together with the limitations imposed by the Mental Health Act, make it inevitable that the Mental Deficiency hospital will retain many of the essential characteristics of the "total institution." The practical implications for the clinical psychologist are that he must exercise his skills in social psychology, be they the manipulation of attitudes, the structuring of groups

or the measurement of valencies, more within each separate side of the dichotomy rather than across it. Not only that, but the techniques available to him will be different according to whether he operates among Us, with whom he is identified, or among Them with whom he is not. Participant observation is possible in the former case, not in the latter as soon as he is known to belong to the other camp. In the only recent study of the special culture obtaining among a ward of patients in a mental deficiency hospital using this method (Miles, 1965) its success was due largely to the fact that the observer was not one of the normal hospital staff, and even the author shows herself to be tending indirectly to express the ethos of "Staff" when she, wishing to carry out interviews "within the framework of participant observation", "stressed the voluntary nature" of the interviews and "offered the patient a cigarette or a cup of coffee".

In spite of these difficulties the role of the clinical psychologist is still one which will encompass the utilization of concepts in social psychology to effect teamwork toward accepted goals of both staff and patients. This may take the form of staff meetings to discuss topics which are either of general importance or causing specific anxiety, or meeting groups of patients in tightly or loosely structured situations for discussion, therapy or simple instruction. There is value, too, in sociometric analysis of both staff and patient changes in the wards. Anyone who has assessed the differing constellations of attitudes associated in patients with, for example, different night sisters or the night versus the day sister, will be aware of this. The removal of a patient from one ward to another may readily be seen to be a reward or punishment by him, but his impact on the group values and structure of the receiving ward is less often considered. It is here that a knowledge of the informal gradings which the patients attribute to each other, as Miles (1965) has demonstrated, is of the utmost value.

These social psychological functions of the clinical psychologist are particularly relevant to his work in the mental deficiency hospital largely because it is, and seems likely in view of present clinical and legislative trends, to be a long-stay hospital with a relatively low admission/discharge rate. For this reason, questions of morale among patients and, because of the low level of pay-off, among staff, become important. Consequently, the clinical psychologist may find his scrutiny of sociological conditions leading to practical suggestions about "leisure activities", the scope of parole opportunities, the content of and composition of groups in daily work, among other things. In the case of staff he may develop improved channels of communication up and down the hierarchy at both formal and informal levels, he may flavour the plain diet of nursing routine with the sauce of research involvement, or act as an uncommitted mediator in resolving inter-personal difficulties, not only between patients themselves and between staff themselves but also between patients and staff.

It is here that the necessity presents itself for the clinical psychologist to make some attempt to work across the Them/Us dichotomy and to chip away at the very features that characterize his working environment as institutional. Those features which are wholly organisational, such as the separation of records offices from the wards, the maintenance of many-bedded wards and so on cannot easily be modified; but those features which are attitudinal, such as the taboos on the nursing of female patients by male nurses, or the within-hospital limitations of patients' movements and timetabling, can be actively dealt with, if slowly, by the psychologists finding and spreading ideas aimed at bringing under critical scrutiny by those involved, old but not necessarily well established prejudices. In his role as individual counsellor and group therapist too, the clinical psychologist will often be forced into the position of acting as intermediary since he will be seen by most subnormals as neither clearly aligned with the major authority figures, the doctors responsible in law, nor

with the nursing and other staffs who deal at a very close personal level with the patients. The unique quality of this relationship should not be lightly disregarded for it makes the psychologist's role one of the most therapeutically valuable in the institution.

If these then are to become legitimate aspects of the psychologist's role in a hospital one may well ask how far the contemporary post graduate trained psychologist is equipped to undertake them. Naturally there will be differences in the general "Weltanschaung" within which different psychologists conceptualize their role, most frequently epitomized for example in the straw man of the Clinical versus Scientific controversy. Differences too in the personality of the psychologist may modify the extent and nature of involvement with all the personnel concerned which the approach outlined above necessitates. Nevertheless all psychologists will have, from their under-graduate courses, a working knowledge of the principles and methods of social psychology and should from their post-graduate courses carry a legacy of practical awareness of what hospitals and other institutions are like, in terms of interpersonal and inter-group relationships, sufficient to permit of the effective marriage of the two in the course of developing seniority in the field. Sundberg and Tyler (1963) were adumbrating this wider role when they pointed out, that while the clinical psychologist is primarily concerned with the individual, he has also an interest in "on-going living groups, which is a natural outgrowth of interest in whatever affects persons—family, the hospital ward, the hospital or the community at large."

This function of the clinical psychologist as a kind of benevolent and informed mole, assiduously undermining the mountainous bastions of "the total institution" but leaving his own little heaps of manipulated subgroups and attitude change, is one which the junior psychologist may not see as easy. Either the authoritarianism of employers or Medical Superintendents (which happily applies less and less) may intervene to lay gin-traps in the form of accusations of "disregard of true function," "impractical theorizing," "interference with matters which are not a psychologist's concern" and so on; or the psychologist himself may be unduly concerned to spend most of his time establishing himself in fields where more objective measurement and more familiar tasks, if more limited ones, prevail to afford him greater security and a more positively identified role.

The Function of Testing

Turning now to the more commonly accepted skills which the clinical psychologist can apply in the mental deficiency hospital setting, one may take as a beginning a quotation from a document which has been approved by the Council of the British Psychological Society which states that "Clinical Psychologists use their knowledge of scientific methods, and a body of psychological knowledge of the normal and the abnormal, combined with clinical experience, in relation to problems of diagnosis, prognosis, guidance, treatment and rehabilitation of patients." The application of tests to the problem of diagnosis is a major concern of the clinical psychologist in mental deficiency since this is an area in which the particularly vague definitions of the Mental Health Act seem likely to perpetuate a pseudo-homogeneity which could be entirely misleading when the individual disposal of each patient is considered. It should neither be the policy of psychologists to eschew their skills at careful testing as Gunzburg (1956) might be thought to suggest, nor to lean too heavily upon them as Baumeister (1967) obviously thinks many American psychologists do. It was true, as Gunzburg says, that many assessments of mental level were made elsewhere before the patient was admitted, and especially so in the case of young patients, when there were fewer voluntary admissions before the present Mental Health Act. But how reliable were they and how long before were they made? At the moment, particularly in Scotland, where the Act does not make "subnormality

of intelligence" a necessary requirement of mental deficiency, many patients enter hospital who require the most detailed diagnostic testing not only of overall level of cognitive function but of specific assets and liabilities in both educational and behavioural spheres. Indeed even at the time Gunzburg refers to, there were in case-notes statements of mental level, some even in the form of an I.Q., which any competent clinical psychologist would have looked at askance. Happily this experience is becoming less frequent, but even recently this writer has read medical reports like "rapid testing gives this patient an I.Q. of 65% (*sic!*) and he was unable to give a clear account of himself. He is a mental defective," or "This defective girl has been arguing with her parents, persistently staying out with boyfriends and cannot tell me the date of St. Barnabas' Eve or repeat 13 digits backward!" The menace of the Kent Oral and other "brief tests" is still with us.

The confusion about the relevance of I.Q. to mental subnormality is acute even in England where the definition of subnormality under the Act is that it is "a state of arrested or incomplete development of the mind (not amounting to severe subnormality) which includes subnormality of intelligence and is of a nature or degree which requires or is susceptible to medical treatment or other special care or training of the patient." Castell and Mittler (1965) have shown that up to 25% of the *patients classified as subnormal in English M.D. Hospitals* admitted during the year 1961 had I.Q's. in the dull normal or average ranges and thus could hardly be regarded as having subnormality of intelligence. McKerracher and Scott (1966) in a sample of 31 admissions to a subnormality hospital found that only five out of the 31 patients fell below an I.Q. score of 70 (i.e. 2 standard deviations below the mean). They remarked that "the bulk of the patients in this sample are not intellectually defective by Wechsler's (1958) statistical definition yet 14 of the 31 are classified as subnormal." They go on to say that the results suggested that a W.A.I.S. I.Q. of 80 was a more realistic cut-off point "if the test scores were to bear a closer relationship to medical and legal diagnosis of subnormality." One may well feel constrained to ask why they should? Should it not be the case that more might be done to clarify the basis of medical and legal assessment? Certainly when one looks at the definition which must form the basis of this assessment in Scotland one feels bound to concur. The Scottish Act simply states that no person over 21 may be admitted compulsorily to hospital unless he suffers from "mental deficiency such that he is incapable of living an independent life or guarding himself against serious exploitation." This is a social and in no sense a medical criterion. At the level of a "reductio ad absurdum" it could be said that this writer is dependent on his wife and his employers and is exploited by both of them, but whether he is mentally defective is happily open to dispute!

The point is, of course, that both independence and exploitation are relative terms and accuracy in meeting a criterion involving them demands normative data not only about the subject but about the environment in which he has moved and in which he might move. These data are not available. Even the Vineland Scale (Doll, 1947) is a *measure of social maturity and social opportunity, not of social competence* and was in any case standardized in the U.S.A. There is a tacit recognition of the importance of exogenous elements determining the diagnosis of mental deficiency in the fact that "treatment" of such patients is frequently no more than the bare removal of the patient to the more ordered or simplified environment of the hospital. Indeed it could be reasonably maintained for all subnormals excepting those with a known pathological aetiology, i.e. organic or genetic defect, there is little need for a doctor's surveillance at all and a medical training, even at post-graduate level, has little relevance to the type of decision making involved. Many doctors in the field, though responsible in law, are often conscious of the fact that they may be no better equipped, and sometimes less so, than any other highly edu-

cated and sensitive layman to make the kind of decisions the Act compels. Should a patient be discharged from hospital two years after a sexual offence on a little girl? He may never since have been adequately tried in a replicative situation, or even if he has while in hospital, how can one assess the general validity of any prediction of his behaviour on this basis? At least the clinical psychologist can set about using his scientific training to isolate and measure the relevant parameters, inadequately perhaps at first, with a view to basing such predictions on the firmer evidence of controlled behaviour samples, be they in the form of test data or experimental results.

For these reasons, and for the reason that "the group showing the greatest inconstancy of I.Q. seems likely to be the subcultural members of the subnormal" (Clarke, 1966) it is of the utmost importance that the psychologist should retain the role of diagnostic tester using not only recognised and adequate tests to define accurately the specific deficiencies and assets of each patient, if necessary repeatedly, but developing psychometric techniques which will go some way towards measuring and attributing weights to various types of sociocultural environment that the patient has emerged from and to which he might be returned. The result of intelligence testing is too often an I.Q. and too seldom a statement of how it was achieved and in what setting. This is why some psychologists might feel that diagnostic intelligence testing which asks the question "Is the patient mentally defective?" could be a waste of time better spent on active rehabilitation. Most authorities are agreed that where measured intelligence is very low, say I.Q. less than 50, then mental deficiency however it may be defined, is present. For predictive purposes other parameters are less important. On the other hand among the 6% of the general population above this level but still below say I.Q. 80 there will be numbered the residue of the mentally defective hospital population and surely there can be no *a priori* reason why they should not show the same heterogeneity in the determinants of their behaviour as their non-hospitalized fellows. Psychological techniques of assessing these therefore should include appropriate tests of emotionality, impulsivity, and modes of social and personal adjustment such as would be generally applicable to this dull group.

In an earlier paper this writer (Clark, 1958), was able to show that, in a large group (N=175) of industrial subjects not technically mentally defective but with a Progressive Matrices (1938) raw score of less than 19, of those who were successfully resettled in open industry, 82% were emotionally stable; whereas of those who quickly lost their jobs only 52% were stable. Put another way, among the cognitively dull there is a tetrachoric correlation of 0.52 ± 0.112 between emotional stability and satisfactory industrial resettlement. Out of 96 of these "subnormals" 71 were able to retain full industrial working capacity because overall I.Q's. were disregarded in favour of specific abilities seen in the light of the available working context.

The important factor loosely described as instability, whether endogenous or exogenous origin, is probably what one is committed to assessing, and modifying if possible, in the hospital setting. Approaches to its measurement have ranged from rating scales such as those of Claridge (1959) and Gunzburg (1960); through psychomotor tests like those of Porteus (1965) and Gibson (1964), through analysis of subtest patterns suggested among others by Wechsler (1958) and Jastak (1949); projective techniques such as those of Symonds (1948), Goodenough (1926) and Machover (1949), to psychophysiological measures such as suggested by Tong (1959), Berkson (1963) and Karrer and Clausen (1964, 1966). Most trained clinical psychologists are well equipped to use and differentiate between the relative values and applicability of such tools. Familiarity and frequent usage will soon make them aware of which require sharpening. None have the keenness of Occam's Razor perhaps, and some will be blunted by being unskilfully handled or by the material on which they are used, but the obligation on the psychologist to bring, by using them, some order into a chaotic field is clear. Careful application of the scientific method including expertise

with existing tests and a constant search for better ones could not be more clearly indicated anywhere than in the field of mental deficiency and must remain a fundamental aspect of the psychologist's role.

Training and Rehabilitation

There is less dispute about the psychologist's role in mental deficiency as an adviser and researcher on problems of training and rehabilitation, at least in the United Kingdom. Indeed it is probably true to say that the modern revolution in mental deficiency, apart from the important medical work on the genetics of defect and inborn errors of metabolism, has been instigated and maintained largely by clinical psychologists like the Clarkes (1958, 1966) Gunzburg (1960) O'Connor and Hermelin (1963) and Tizard (1964). A great deal of the day to day work of the clinical psychologist with defectives therefore is spent in maintaining a programme which is patient-centred rather than hospital-centred and at varying levels of productivity; of leisure and social training activities from the level of simple sensory training to extended parole in the open community; of appropriate and workable incentives both positive and negative; and of more directly educational measures aimed at the development and usage of simple vocabulary and rudimentary skills of literacy and numeracy to the prospect of work and life at home or in a job. At mental deficiency hospitals where this writer has worked the work has included semi-skilled tradesmen's work in building, plumbing, and electric maintenance, the operation of laundry machines, farm work, woodwork of all types, concrete moulding, toy making, sorting and finishing of plastic components and electrical apparatus, gardening and forestry, domestic work and tailoring. The learning rate of patients in work of this type is frequently mediated less by inherent cognitive limitations provided that the work is effectively broken down, reinforced and over-learned (Clarke, 1958) than by distractability, social pressure or emotional interaction between patients or between patient and supervisor. The psychologist must scrutinize therefore not only the content of the work but also the composition of the group, the tolerances of the supervisor and the nature of each individual patient.

The social learning of patients is facilitated in hospital by opportunities for mixed dancing, attendance at the social club, inter-ward visiting, cinema and church attendance, visits to nearby towns and cities and visits from relatives and friends. It begins, however, in the ward at the most intimate level of patient/nurse interaction and the introduction of mixed nursing on all wards at the writer's present hospital has done much to extend the range of social responses in patients of all grades. Individual counselling and group therapy also play some part as social training media as well as offering opportunities for the resolution of emotional conflicts and anxieties. Since the problems of the mental defective tend to be specific and concrete both needs are frequently met by a didactic rather than a wholly permissive approach. By the regular longitudinal observation of the patient's behaviour which this affords the psychologist can observe what part learning is playing in the control and regulation of emotional processes. Defectives, for example, frequently make unsuitable friendships not because they make poor judgements but because they make no judgement. By supplying criteria for such judgements the psychologists and nursing staff can frequently facilitate more effective social behaviour. Clark (1960) was able to demonstrate this using both rating scales and sociometric techniques, the latter to record successive inter-personal value judgements and the former to make available to patients the judgements of them by staff. By discovering the basis of supervisor's ratings of behaviour, in the form of concrete episodes, they came to apply the same standards to judgements about each other. Other approaches to similar problems are possible, and it seems very likely that "research into emotional disturbance as a special problem of learning and re-learning will assist future therapeutic endeavour with the subnormal." (Clarke, 1966).

The general field of sanctions applicable in the institutional setting is also one where the psychologist should legitimately operate. Experimental results from as widely separated fields as maze learning in rats, the learning of arithmetical processes in primary schoolchildren combine with the work of Gordon, O'Connor and Tizard (1954), O'Connor and Claridge (1955) and Walton and Begg (1958) to demonstrate, not only the relative value of positive reinforcement over negative, but also that defectives respond to incentive conditions in exactly the same way as do normals. Further O'Connor and Claridge's (1955) results suggested that so far as incentives are concerned a mere striving after a goal in itself did not significantly increase performance level unless it was accompanied by "social approval of work and encouragement." Loos and Tizard (1955) have also stressed the importance of the factor of self esteem in determining and maintaining an improvement in performance. Naturally, reported work on the effects of negative reinforcement is found in the area of behaviour therapy where unwanted behaviour patterns have to be eradicated, and this will be referred to in a later context, but the work of these researchers mentioned above makes it apparent that the effectiveness of rehabilitative procedures is best pursued by the utilization of the methods of experimental psychology and the clinical application of its most relevant findings.

This is equally true of the work of the psychologist as applied to specifically educational topics in the hospital. The place of these and some of the difficulties involved are dealt with in detail by Clarke and Clarke (1966) who remark that "research into the various problems of teaching is almost completely absent and whilst many of those who work in this particular field realize the undeveloped potentialities of their pupils, they have neither the knowledge nor the skills to encourage and stimulate their growth." One of the same writers (Clarke, 1966) has also drawn attention to the fact that in English Junior Training Centres educational activities are hampered by learning thresholds that seem to be too high, learning steps that are too great and the mistaken notion that handicapped patients unlike the normal child should not have learning pressures imposed on them. In hospital, the psychologist is often handicapped by having to devise teaching programmes which will be executed in the case of adult patients by staff not trained as teachers and in the case of children by staff with a limited training. This means that the principles according to which they are operating require repeated statement and elucidation by the psychologist if the direction and impetus of the programme is not to be lost.

The boundary between education and training is a tenuous one, especially in the context of mental deficiency, and similar methods are often applicable in both fields. For example, an extension of Gunzburg's S.E.F.A. cards for social sight vocabulary has been devised by the writer whereby two types of teaching machine, the "Canterbury" teaching machine which is a lever actuated card presenting device, and the Bell Howell "Language Master" which is a modified tape recorder are used to motivate selective verbal and motor responses to the material to be learned. On the "Canterbury" relevant words have to be selected from others progressively more like them in shape and sound—not in meaning, following Luria and Vinogradova (1959)—by lever pressing rewarded by the automatic presentation of the next item, and later, prerecorded questions on the other machine elicit the relevant words as verbal responses while the printed word is simultaneously presented visually.

The development of programmed instruction of this sort is clearly a task which is peculiarly psychological since it draws not only on the psychology of perception and on psychophysics but also on the theory of learning—something, which, with the notable exception of Thyne (1963) is all too seldom applied to teaching. At Banff, there are in the course of development a series of programmes for imbecile and feeble minded grade patients ranging from the discrimination of similarities and differences in simple forms to vocabulary building exercises. Some of the problems

of discrimination threshold and span of apprehension associated with these developments will be reported in later publications. A useful review of the contemporary position of programmed instruction with the mentally retarded, however, can be found in a paper by Simon Haskell (1966). Indeed, the monograph in which this paper appears provides the clearest possible evidence of the relevance and usefulness of applied psychology in the mental deficiency hospital setting (Gunzburg, 1966).

Behaviour Therapy

Work of this type merges easily with what is more often described as behaviour therapy, and like the latter is an important new extension of the clinical psychologist's role. For example, it is possible to use food at meal times, chocolate, "Smarties" and verbal responses as well as physical contact and smiling as reinforcers for behaviour shaping in the ward as well as at the teaching machine. Nursing staff can quickly be taught to act as agents in this but often require the help of the psychologist in behaviour assessment and analysis. The greatest problems in the application of operant methods in the wards are of course associated with the control of random or unwitting reinforcement. Gelfand, Gelfand and Dobson (1967) report an interesting study which was undertaken to determine whether mental hospital staff provide effective reinforcement contingencies for psychotic patients by rewarding desirable and by ignoring and thus extinguishing psychotic behaviour patterns. The hypothesis that the typical hospital social environment consistently reinforces both appropriate and inappropriate behaviour was confirmed and the patients themselves were the best behavioural engineers, followed by nurses and nursing assistants in that order. A positive correlation was found between the severity of the patient's psychotic behaviour and the inappropriateness with which he is reinforced. A similar study by Buehler, Patterson and Furniss (1966) using as subjects juvenile delinquents in a correctional institution illustrated that the treatment environment did not provide optimal conditions to produce therapeutic behaviour change since 70-80% of the subjects delinquent behaviour drew praise and approval from the other delinquents while staff members responded to the delinquent behaviour inconsistently. They were not like the psychologist of whom the rat in the Skinner box said to his pal "I've got this guy taped! Every time I press this lever he dishes out a food pellet!"

Extinction and counter conditioning is often necessary in patients in long stay wards where something like the randomly reinforced "superstitious" behaviour of Skinner's pigeons can be seen to occur; head banging, tics and apparently spontaneous noisy outbursts in low grade patients being of this order. The original reinforcement contingencies may have been at a fantasy rather than overt behavioural level. One is reminded of the tale of the patient who was parading round the ward snapping his fingers vigorously most of the day. The clinical psychologist was curious and asked him why he kept this up so long. The patient replied that it was to keep the tigers away. Psychologist: "But there are no tigers for hundreds of miles!" Patient: "Well that just shows how effective it is!"

Apocryphal anecdotes apart, there is sufficient evidence to assert the value of controlled operant procedures in the mental deficiency hospital. Tyler and Brown (1967) have used swift brief isolation as a negative reinforcer for misbehaviour in the ward, removal of privileges being a more traditional but similar technique demanding stricter control than is usually practised; and the use of positive reinforcement to achieve functional speech in echolalic and autistic children (Risely and Wolf, 1967); to achieve toilet control (Giles and Wolf, 1966); and to eliminate attention seeking in defectives (Wiesen and Watson, 1967) have all been recently reported. Naturally, the clinical psychologist will frequently advise also on the application of longer established techniques such as the treatment of enuresis using Mowrer apparatus and there is scope too for the application of avoidance and negative con-

ditioning to the treatment of exhibitionism, homosexuality and other sexual disorders (Clark, 1963, 1965).

One final point about the involvement of the psychologist in operant conditioning procedures is that he should be vigilant about the effects of and extent to which patients condition staff. Higher grade patients frequently decide deliberately to "butter up" or to "nip off" certain staff members in a way which may upset the social balance of the ward to the detriment of the treatment programme of these patients. The relative detachment of the clinical psychologist enables him to counter these effects by drawing attention to them.

Research

It has been a primary intention of this paper not only to illustrate the expansion of the psychologist's role in mental deficiency but to do so in a way which will illustrate the intimate relevance of both a research orientated point of view and an experimental approach in practice. Quite apart from the burning issues already alluded to in the field of testing both cognitive processes and social competence; in the development of training techniques and the application of social psychology; and in the expansion of programmed instruction and behaviour therapy, there is an untapped wealth of material being made available by growing sophistication in psychophysiological instrumentation. The possibility of recording aspects of autonomic functioning and arousal through the measurement of G.S.R., heart rate, respiration and systolic blood pressure while the external stimulus situation is manipulated systematically may make the assessment of personality traits such as impulsivity more practicable than it is using questionnaire or rating scale technique. If personality testing in the mental deficiency field is to progress significantly, it seems more likely to do so in this area than in any other since most mental defectives are so verbally limited that the usual projective and paper and pencil tests are not applicable.

The application of psychophysiological techniques is, however, far from straightforward especially when they are applied in the mental deficiency field. Historically, investigations of autonomic function have followed two main lines: the first attempts to relate A.N.S. activity to affective states as physiological correlates of these states; the second attempts to use A.N.S. activity as a means of describing and understanding individual differences. Naturally, the two are closely related, the second developing from the first. Fundamental problems of response specificity, the relation of resting levels to reactivity and cortical to autonomic arousal remain to be solved, but some researchers like Karrer and Clausen (1964, 1966), Berkson (1963) and Tong (1959), to mention only a few, are pointing the way.

Other interesting and important applications of psychophysiological methods recently reported include the study of the effects of extraneous auditory stimulation on learning performance. Brown's (1966) results raised the interesting possibility that measures of performance are differentially affected by extraneous stimulation and that brain damaged subjects are not always necessarily more distractible than others. In the quite different area of diagnostic techniques, there is the work of Blinkov and Arutyunova (1966) who have shown that hemispheric brain lesions may be indicated by differential reaction times to auditory stimuli of the right and left hands, a relative retardation of about 5-10 milliseconds of response time being found when the hand contralateral to the lesion is used.

Space does not permit further elaboration of the possibilities of psychophysiological research in this field but no clinical psychologist who is aware of these researches can afford not to equip his department to use them. Biological amplifiers and transducers, reaction time apparatus, tape recorders and white noise generators

are as necessary as Kohs Blocks, Porteous Mazes and picture vocabulary cards, and the clinical psychologist who is limited in his tools can expect neither to make his full clinical contribution, nor to derive his full share of personal and professional satisfaction. The more he sees of mental deficiency in hospital the more he will feel aware of what he does not know. The fact that global rather than part answers are probably not possible should not deter him from a readiness to research. The clinical psychologist has the advantage over the pure laboratory researcher in that he sees the whole setting in which the problem presents itself. It is right that he should use research findings giving them their value in relation to the general disposal of the patients but seeing if he can the broader human issues. Nevitt Sanford (1965) has suggested that it has been difficult for psychologists to study "genuine human problems since quantification, precision of measurement, elegance of experimental design and general laws are so much more difficult to achieve once one goes beyond simple part processes." Sanford asks for the kind of theory "that makes free use of concepts whose ties to what is observable are highly indirect. The highest levels of observability and precision of measurement are attained in the laboratory experiment but the psychologist who restricts himself to this mode of investigation denies himself the opportunity to study the whole personality."

Teaching

Not directly part of his role *vis a vis* patients but clearly inevitable in the hospital setting is the psychologist's role as a teacher. Since it appears necessary to outline the clinical psychologist's role in mental deficiency hospitals to other psychologists here, it is not really surprising that the nature of psychology and its clinical applications requires to be taught to doctors and nurses either as part of a training syllabus or simply in the interest of mutual understanding and role recognition. In the first instance, such teaching is probably best carried out in the form of formal lectures whereas the best medium for the second is probably case conferences, demonstrations and seminars. Best of all, however, is for the staff to observe the clinical psychologist as he goes about his work, so far as this is possible, and in talking with him learn how he sees his work and what he does to apply psychology in his testing, report writing, therapy, training research and so on.

In larger hospitals at least there is scope for the psychologist using such teaching skills and clinical acumen as he has accumulated in an extension of university courses. This readiness to assist in the practical training of post-graduate and in some cases under-graduate psychologists seems more likely to be tapped with the continuing high demand for applied and especially for clinical psychologists. The development of a training programme for even a few such trainees is not something which can be left to *ad hoc* arrangements or to chance, if justice is to be done both to the trainee and to the prior academic and theoretical content of his course. Where such commitments are undertaken, the clinical psychologist must attempt to adjust his working timetable to meet the developing needs of the student and must try to do him the courtesy of keeping at least one academic jump ahead of him.

Conclusion and Summary

In this review of the contemporary role of the clinical psychologist in a modern mental deficiency hospital much that has been said might apply equally to his role in a general psychiatric hospital. There are necessarily, however, certain differences in emphasis. In the former, there is a high percentage of long-stay patients and a much higher percentage of physically, cognitively, and socially handicapped patients than in the latter. This has meant that the characteristics of the mental deficiency hospital as a particular type of institution must be heeded and manipulated by a clinical psychologist in a more positive way than might be the case in other hospitals.

Secondly, the application of test techniques and the interpretation of results requires the greatest care because of the inter-relatedness of social and cognitive factors made even more confusing by the current legislation. There is an absence of useful test tools for both the assessment of social competence and other personality factors in the dull which has led to a global approach to rehabilitation and socialization.

Thirdly, most psychologists in the field have concentrated, rightly, on this area so far but with the task becoming harder as the higher grade patients are progressively launched into the community, there is a growing need for intensive and extensive research into more detailed and specific aspects of cognitive and affective functioning of the defective. Some lines now being pursued have been described.

Counselling and group therapy retain their places among the psychologist's clinical skills; but in a largely non-verbal community, behaviour therapy, especially operant conditioning, must now play a large part. However, psychophysiological techniques are developing rapidly and though presenting many problems of interpretation, have much to offer at the level of description and prediction. It is maintained that research in all these areas must necessarily play a large part in the clinical psychologist's role in mental deficiency if his understanding is to keep pace with his aims.

Finally, there is a teaching role which may fill a more variable part of the clinical psychologist's working life but which will demand techniques appropriate to its intentions and which should be deliberately planned. Let it be hoped that in fulfilling this role the clinical psychologist will seem to his students, his colleagues and to his patients not *'fatuus naturalis'*—a born fool—but, at worst, only *'non compos mentis, sicut quidam sunt per lucida intervalla'*—apparently of unsound mind, yet having certain lucid intervals

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POSTSCRIPT

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Re-reading my article after more than eleven years' interval, in the light of Mr. Clark's remarks, leads obviously to reconsidering whether the role of the psychologist in mental subnormality has changed appreciably. I think it is important to see the situation in perspective. Though Mr. Clark's own contributions and the publications which have emanated from the mental deficiency field by half-a-dozen well-known names, indicate that much work is being done in a few places, the situation is fundamentally not different from the one outlined in my 1956 paper. It is true, hospitals have become far more aware of the existence of psychologists and are quite happy to add them to the Establishment for the sake of prestige, but they hardly know what to do with them if they should arrive. It is still true to say that the psychologist's contribution is seen as that of the technician supplying I.Q. figures which make a report look more respectable, and to leave him otherwise severely alone with his research work, to which he has to escape to get over his professional under-employment and loneliness.

Many hospitals are still acting in a custodial tradition, though some attempt has been made to camouflage the situation by the introduction of some sort of industrial work schemes, the value of which may be very exaggerated. In some hospitals, it is true, years of persistent work have succeeded in the psychologist initiating and organising some of these therapeutic activities. Such developments are possible and desirable, but they are still not as widely spread and accepted matter of course—professional obligations—as one would have hoped for after years of well publicised work. The attention paid to the successes of a mere handful of places, has made people forget that the majority of mental deficiency institutions is still as Victorian-minded as in the past.

Yet, and this I want to make quite clear, the fault is not entirely, or even largely, that of the Establishment with a predominantly medical and nursing bias. It cannot be expected that people who have been organising these places for many years, should fall over backwards and hand over part of their responsibilities to a newly arrived profession, which has done very little else so far than "measuring" and "testing". Mr. Clark has pointed out in his article that my attitude is biased towards the "verstehende" rather than the "erklarende" psychology. I am unrepentant in that respect, and still maintain that the hospital has as its primary obligation "treatment

and cure", if possible, of the patient who needs it *now,* rather than devoting man power to the *exploration* of the condition. 'Exploration' may, perhaps help some generations of mental defectives in the years to come, but our first and foremost duty as members of a hospital team, is to assist with the problems which present themselves *now*, and not to deal with problems of our own choice. It could well be argued that research of an academic kind should be left to the University-based psychologist, who should be made aware of the practical problems of the hospital.

This rehabilitative contribution which the psychologist could make, has not been generally recognized by the medical and nursing profession. Neither has it been recognized by the psychologists who apply for appointments as clinical psychologists.

A little comment made by one applicant for a probationer's post in this department, is rather significant in this connection. He wrote that he could not accept the position, because "I would be involved with people in the sense of helping them". This attitude of the psychologist who fancies himself to be a detached scientist who is above the need of rendering help and assistance to the individual, probably underlies the reluctance displayed by psychologists towards actual rehabilitation and therapeutic effort. Yet, there is no need to give up the scientific research-mindedness of measuring and assessing, since this outlook is obviously required to learn about the efficiency of the method employed. It is true that the needs of the individual human beings and the practical needs of rehabilitation work may very often interfere with the tidy design of a research experiment, but it should not tax the ingenuity of the trained psychologist too much to select aspects of psychological work which are both useful for the patient, and for the systematic development of our knowledge (as for example the studies by the Clarkes on training of imbeciles).

Having spent quite a few years in this field, and having seen many clinical psychologists at work, I have always been struck with the unwillingness and reluctance of this profession to understand the patients and get on with them, to talk with them and to guide them, despite the fact that psychologists are supposed to be students of human nature. Unless the patient can be observed in the test room, assessed and measured on more or less well-known scales of intelligence, personality, etc., unless his reflexes can be studied and his memory, auditory and visual perception be investigated, the person as a whole and as a problem in his inter-action with the community, is not considered, is not even seen.

Perhaps this attitude is a correct one, and the investigator of human nature has to keep away from human nature in the interest of objective assessment. Yet, a hospital community which is therapeutic, rehabilitative, and provides services for the individual, cannot readily take to people who want only to study and give advice, but will not participate. If the psychologist does not wish to offer more, then it cannot be expected that those who have to deal with the problems, will rush forward and give him more work and more responsibility than he himself wishes to accept.

Yet, there is so much which psychologists could contribute in a field which has now got over the inertia of many years' standing. Psychologists have developed exciting, and potentially very promising theories, such as Rotter's social learning theory, and Hebb's neuro-physiological approach, which could provide a sound theoretical basis for therapeutic efforts and revitalise a field which is often barren of new ideas.

The 'clinical' label has probably also contributed to a misdirection of effort because the psychologist works in the hospital, medical and nursing field, which is perhaps not the best administrative placement for the mentally subnormal. There are comparatively few subnormals in need of skilled medical services of one kind or the

(*Continued on Page* 70)

A REASSESSMENT OF THE ROLE OF THE CLINICAL PSYCHOLOGIST IN THE MENTAL DEFICIENCY HOSPITAL

POSTSCRIPT

(*Continued from Page* 18)

other, and the majority are people who have simply not enough of what it needs to survive in the open community. They are training and rehabilitation cases, and to place them into hospitals under medical care and regard them as clinical propositions, is often quite misleading.

In the near future the Junior Training Centres in the community will probably no longer be a Public Health concern, but be handed to the Department of Education and Science. Teachers will be trained by Colleges of Education, and the problems of the severely subnormal child will become a matter of educational concern, as it should be. And it may not be long before the sheltered workshop will also be taken over by the Ministry of Social Security, and the Medical Officer of Health will no longer be concerned with problems which are not primarily medical. Are *all* the children and adults in the institutions so different that they require hospital care under Consultant Psychiatrists? Granted, that in many cases additional handicaps in the children require the boarding school aspect of the hospital and detailed clinical investigation, this still does not do away with the fact that the children and adolescents remain an educational responsibility in its broadest sense.

It is the educational psychologist who will be involved with them in the Training Centres and who will deal with educational problems of a different nature. It could be argued that the psychologist in the hospital for the subnormal should look at his work more from the educational point of view which has a bias towards action, than be overwhelmed by the clinical implications of his surroundings.

If the psychologist in the mental subnormality hospital realises how much he, in fact, has in common with the educational psychologist, he may well find that his contribution, his suggestions and his organisational influence directed towards a very definite and clearly therapeutic role, will provide more recognition and gather more support than his rather aloof, scientific attitude have gained him at present.

There has been, it is true, progress. I think the days are past when one Medical Superintendent enquired from the other one: "Is it safe to have a Psychologist"? The social status of the psychologist in the hospital hierarchy has changed from those times when a doctor explained to a medical colleague who had applied for a job, that the hospital was quite good, but unfortunately he would have to eat at the same table as the psychologists. Generally, the psychologist has been widely accepted as a professional colleague, but his contribution has been very limited because he himself has not clearly decided how to make a visible and relevant contribution to the hospital work. It will need a good deal more heart searching on the side of psychologists who come into this work, to convince the other disciplines which have a long tradition of helping behind them, that the psychologist *wants to participate* in work which needs to be done, rather than select work which he enjoys.