

Clinical Psychology: Between Psychologist's Power and Client's Empowerment

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Psychology is a political and historical science in which a concrete human being (researcher, lecturer, author of a handbook, psychoterapist etc.) thinks about (or deals with) the other – in case of „pure“ science rather „universal“ – human being.

Applied psychology is much more **handicraft and trade** than science. The concrete human being (psychologist) thinks about (or deals with) the other concrete human being (client, patient) in the broader context of his/her life.

Clinical psychology belongs to the family of applied psychology branches and it is learned and taught as a handicraft – mainly by imitation of a model and by experience. The question is what we – teachers and mentors as models – are really teaching and what our students are really experiencing.

Now we can put and sometimes answer several basic questions about clinical psychology in our republic. Let's begin to look at what **clinical psychology is** and **what it is to be and can be**.

1. What clinical psychology is – how is it defined?

The Association of Clinical Psychologists in Czech Republic defines clinical psychology as (Růžička a kol., 1999) *“separate scientific branch; it deals with a mental life of a human being in a biopsychosocial context on the health – illness continuum”*.

We offer a little change: clinical psychology is *“a handicraft which uses and enriches human sciences knowledge and deals with the uniqueness of a human being and his/her mental life on the health - illness continuum defined in our culture; human being is treated as a biopsychosociospiritual unit and system in systems of surrounding world (family, community, society)”*.

Principal concepts are: **“science or handicraft”**, **“mental life (in systems of surrounding world)”**; **“biopsychosocial(spiritual) context”**; **“health – illness continuum”**.

Principal question is: *Aren't these definitions too narrow? Where is the space for staff support and for the involvement in e.g. improving or influencing the health care policy and system?*

I am glad that

- the subject is “**mental life**” and not “behavior”, because we are in the Czech-Jewish-German speculative middle of Europe, and not in the middle of the U.S.A.;

Nevertheless, I looked (by means of the Internet) at the middle of the U.S.A. and found there the Wesley Medical Center in Wichita, state Kansas. I did not find the word “psychologist” in their web sites and I was not surprised. They do not need them, because they have nurses, chaplains and social workers. On the first page there is a nurse Mary from Cardiology claiming: *We treat illness, and we care for the whole person.* And on page called **quality**, there is a clear mission:

Quality means intensive caring

At Wesley, we know that quality is not just about physical care, it is also about emotional and spiritual care. Quality care includes a nurse who hold a patient's hand, a child-life specialist who eases a child's fear, a chaplain who comforts a patient and family. Quality care includes providing a bed for a new father to stay overnight with his wife and baby, and helping a family find appropriate after-hospital services for an elderly parent. Quality care is Wesley's number one goal, and striving for quality is the mission of every staff member every day.

- there is a vision of a **continuum**; maybe we all are capable of having schizophrenia or paraphilia;

I am not so happy with

- *scientific*: we need a broad discussion about our notion of science and about our trust in it (and about ordinary people who treat themselves by so called non-conventional approaches despite our unwillingness to include non-conventional approaches into the university clinical psychology curriculum);
- *biopsychosocial*: it is rather “old-fashioned”, last decade counts also with spiritual dimension.

We can ask what the basic concepts mean for clinical psychology education and practice:

- “**science**” or “**handicraft**”

Pregradual curriculum of clinical psychology has two levels and two great examinations: first is after three years of studying theory, the second is in the end of the fifth year and students have some practice at this time.

The problem is: if psychology is a science, then it is necessary to have good theoretical basis and maybe spend first three years only by reading and processing original works of the most important authors (our students rely mainly on Internet sources).

If psychology is a handicraft (and a motivation for studying psychology is often based on desire to help people and to help oneself), then it is necessary to have good reflected practical basis.

- **“mental life on health – illness continuum”**

The concept of **mental life** itself deserves our attention. Does it mean that we are interested in patients' will and goals and not only in observing their behavior or in talking about their experiences and emotions?

Do we accept **continuum** e.g. of paraphilia and do we ask how the patient himself/herself understands his/her experiences and how s/he manages his/her (ab)normality on everyday basis? Or do we recite ICD categories without doubts and without knowing anything at least about axes?

Are we sensitive to non-diagnostic characteristics of an ill person?

Sensitivity to non-diagnostic characteristics is one pillar of **evidence-based** approach in the field of clinical psychology.

Norcross (2002) describes the effort of the APA task force to appoint principals of evidence-based psychotherapy. They advise to take into account a **person of the therapist, therapeutic relationship and non-diagnostic characteristic of the patient**. As the most important they consider to appoint the efficient methods of tailoring therapy to the patient with respect to his/her (non-diagnostic) characteristics.

Once I referred my acquaintance to my colleague – clinical psychologist; other colleagues of mine work in private sector and are too expensive. The acquaintance worried about her brother who seemed to be depressive, having suicidal thoughts. After first session, the clinical psychologist phoned me back with a sign of horror in her voice: “Do you know that she had a psychotic attack? – Yes, I do, I answered. But she did want to talk with you about her worries, no about her late psychotic attack.”

- **“mental life in biopsychosocial (or biopsychosociospiritual) context in systems of surrounding world”**

Are we looking for strengths and resources of the patient?

Participants of our crisis intervention training look at a woman in panic in the video. Their task is to appoint her strengths. There is a long list of her strengths and of resources of her environment if we pay attention to them. Once I gave this task to clinical psychologist. They complained: “If we put attention to her strengths and resources how we will be able to explain that her treatment is covered by health insurance?”

Most of our clinical psychologists do not see and do not know their patients in their systems of everyday life – at workplace, at home, with families and friends, spending their time etc.

We can ask if the **“clinical”** concept is something that belongs only to the health care system or if it is a useful mode of thinking which can contribute to other psychological branches in other surroundings.

Again, we can ask: *Aren't our definitions of clinical psychology too narrow?*

2. What is clinical psychology composed of – what are its parts, its subdisciplines?

Let us see how definitions correspond to a composition of subdisciplines of clinical psychology. Clinical psychology is traditionally divided into child and adult clinical psychology and both are composed of:

1. understanding a patient = psychodiagnostics
2. type of illness: psychiatric, neuropsychological, somatic, or psychosomatic (= theoretical basis is psychopathology alias abnormal psychology, neuropsychology, psychosomatics or health psychology)
3. treating a patient = crisis intervention, counselling, psychotherapy

Our students usually believe that clinical psychology is based on abnormal psychology and psychotherapy done in inpatient or outpatient facilities.

Field and community work, family therapy, social policy and health-care policy, health communication and campaigns, primary and tertiary prevention programs and programs for elderly, standards of quality, care planning, outcomes measuring or caregivers support and education – these are themes often unfamiliar to our students and sometimes also to our teachers.

If I neglect these broader themes, still there is another division of clinical psychology interests (but it is partly copied from and partly inspired by the Wesley Medical Center chaplains offer):

- a. patient support + family support
- b. staff support
- c. services for local community
- d. medicine-psychology conference (*“these one hour luncheon conferences are for health professionals, chaplains ... and others from the community to discuss a variety of topics of mutual concern”*) – isn't it a very good idea?!
- e. clinical psychology education

Well, we can reduce the picture and say that good managed traditional parts of clinical psychology (diagnosis – knowledge of illness – treatment) can create good clinical psychologist. But: how are students prepared? What is the content of clinical psychology curriculum in this respect? And how are students of clinical psychology and new clinical psychologists supported during their practice and during first weeks, months and years of their occupation?

3. How are students prepared in university classes and during school practice?

I am very sceptical here, that's why I have only few „diagnostic“ questions:

- ✓ What is the difference between pregradual Bc. and Mgr. and postgradual PhDr. level?
- ✓ Do we think about ICD axes if we think about a patient? And do we think about family, work and community systems of social support if we think about a patient?

- ✓ Do we teach students to see a case history as a narrative or do we force them to cut the person to „personal“, „school and occupation“, „family“ etc. life histories and never connect them again? Do we know that a narrative is always social, created among and through people? Do we know that we – clinical psychologists – are „people“?
- ✓ Do we teach our students how to deal with spiritual life history of a patient?
- ✓ Do we lead our students to and through qualitative methodology as to the unique contribution of clinical thinking?
- ✓ Do we teach them clinical counselling and crisis intervention? If we teach them psychotherapy, do we teach psychotherapy for people with disabilities?
- ✓ Do we show advantages of team work? Do we encourage students to make diploma thesis in co-operation with quantitative researchers (e. g. medical sociologists)?
- ✓ Do we teach our students to care for medical staff and for themselves?
- ✓ What type of practice is obligatory during pregradual study? Do our students really meet good practice? Do they have supervision?

Last week I could see a movie in which Richard Gere worked as clinical (forensic) psychologist. He examined (observed, was with) a patient **five days two hours a day** before he could say something about diagnosis.

I was sorry that I had to introduce good practice via American movie until I have met Slávek Hubálek in the Congress. He told me that he had spent with an accused man **five days four hours a day** before he could say something about diagnosis and responsibility for the offence.

- ✓ How is contracted the triangle of cooperation among the university – the workplace offering practice – and the student? Is there any controllable contract?
- ✓ Do we and our students know legal context in which we and our patients live? Are we and our students able to advocate rights and interests of our patients? Do we encourage our students (not) to co-operate with (health) policy makers?
- ✓ Do we teach our students to reflect the influence of sociopolitical situation upon their **professional identity and values**? Do we teach them to reflect distribution of power between them and patients and to reflect how they deal with their power?

Once – maybe two years ago - a man came and told me that he still could not accept the way we had treated him twenty years ago during group psychotherapy: we – therapists - had been talking about the responsibility for one's life; whereas he himself had felt responsibility for his wife's life; responsibility itself had been very important for him.

I agreed with him. Yes, our psychotherapy had some totalitarian characteristics at this time. And then I asked: „Maybe now we are blind again and make our patients think and do something without respecting their values. Do you know about anything like that?“ „Yes,“ he answered. „Nowadays psychologists tell people to be assertive.“

4. What is young clinical psychologists' experience and how are they supported during first weeks, months and years of their new occupation?

I asked three of my young colleagues: experiences are from

- **mental hospital for a**
- **dults:**

“I am not professionally prepared enough for working with staff. How can I solve the situation when the patient complains of the nurse? And in the same time I know that nurses are exhausted?”

“I did not want to mention a year spent at gerontopsychiatric ward. It is still painful. I think that the situation in the health care system can improve if a client has more power. If s/he obtains an advocate from outside. I am looking forward to this future.”

“We have a group supervision once a month. I lack individual supervision and I am going to manage it outside the hospital. Both supervisions are due to my initiative and I pay both of them of my own.”

- **mental hospital for children:**

“Literally horror. I think that the clinical psychology should be released from bonds to the health care system as soon and much as possible. Then the position of clinical psychologist could be compared to the position of a priest - chaplain.”

- **general hospital:**

“Medical staff and patients require information, advice and counselling. Nevertheless, there is a hidden desire to have a support and possibility to tell the other person what they experience. Medical staff – that is to say besides their hard and poor paid work – live in very bad team relationships.”

5. Some considerations and conclusions

One can notice a shift in clinical psychology thinking during the eighties of 20th century: George L. Engel describes his „new medical model“ (biopsychosocial paradigm) in 1977, Tom Beauchamp and James Childress launched their *Principles of Biomedical Ethics* in 1979, Joseph D. Matarazzo defines psychology of health in 1980, Carol Gilligan published her „different voice“ in 1982; „resiliency authors“ began to coin their theories during these years, too.

This movement from nearly thirty years ago was (and is – hopefully) directed towards democracy, towards partnership between a psychologist and a client and an autonomy of both of them. It prefers health over illness, equal opportunities and inclusion over social and sexual hierarchy, huge variety of human values over ethnocentricity of „normal behavior“.

But we are just a bit frozen. In our republic, seventies and eighties were years of deep „normalization“ that means de-valuation mainly the social and spiritual needs and values of people (slogans as: „If you do not rob the state, you rob your family“ etc.).

We lived in splendid isolation of small „positively deviated“ islands.

Now there is a capitalism and we are free to decide how to do our beloved clinical psychology. We have no Chamber of Psychology and sometimes we seem to be free too much.

Clinical psychology is privileged thanks to its position in the Law of the Health of People. On the other hand there is no need to develop skills and ethics as it is needed in good handicraft. The Law wants an evidence of education and developing knowledge as it may be needed in good science. Applied standards are personal, not procedural.

Besides, the efforts to reform our psychiatry still fail. The estimated delay comparing the situation e.g. in Great Britain is about thirty years. And it may be more in future: The Crisis center for psychiatric patients in Prague was disestablished last month.

*We have to ask again: Do we teach our students to reflect the influence of **sociopolitical situation** upon their **professional identity and values**? Do we teach them to reflect **distribution of power** between them and patients and to reflect how they deal with their power? Are we and our university students of clinical psychology prepared for **partnership** and co-operation with clients and patients, medical staff and whole community? **What are our skills and ethics**?*

Despite doubts and scepticism I have to admit that I still – almost every day - meet nice honest devoted colleagues. Our clinical psychology is based on caring people, not on caring system.

And it may be first good message: we have still a lot to do.

The second good message is: the position of nurses, chaplains and social workers will strengthen in future. What will we do then? Hopefully, we will be forced to be good in clinical psychology, no matter what it is.

Literature

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