

So What Is So Special About Clinical Psychologists?

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A recent article by Steve K. D. Eichel (2005, 24, 1, p. 9) in *The Specialist* outlined what it means to be a counseling psychologist. He recognized the significant overlap in knowledge base, treatment methods, and populations served between counseling and clinical psychology. Many of us in clinical psychology might feel at home in what he said. We might particularly appreciate his reference to the individual as a "nexus" at which past, present, and future, as well as individual, family, and society come together. Many of us are also especially partial to Eichel's emphasis on thinking about and treating the client pluralistically and holistically, with less emphasis on diagnostics and manualized treatments specific to diagnostic syndromes. We, too, treat persons with symptoms and not merely symptoms. In my reading, Eichel regards counseling psychology as offering something of a brake on the wheels of the medical model's reductionism, in which all context is reduced to the abstract status of "stressor," without intrinsic coherence or narrative meaning. Eichel's article prompted me to think about what it is to be a clinical psychologist, because the epistemological tensions he addresses are felt in our field as well.

The question of what clinical psychology is may be addressed with more descriptive concreteness than is typically found in definitions. Definitions are so broad as to be bland beyond belief; Division 12's (2007) definition of clinical psychology hardly quickens the blood.

Trying to describe specific core competencies in clinical psychology is also asking for trouble. I think that there are some core competencies, but I understand that that is legally dead in the water. (Should one be able to call oneself a clinical psychologist if one has never interviewed a psychotic? Apparently so!) So here are my thoughts on what differentiates

clinical psychologists from our colleagues in other specialties, on sale for free in the market place of ideas.

Clinical psychologists are the specialists at integrating information from diverse sources into a comprehensive case formulation, and at recommending and planning treatment accordingly.

Clinical psychologists are trained in psychodiagnostics, but we treat persons with symptoms, not symptoms as though the persons are incidental. As APA's (2005) *Report of the Presidential Task Force on Evidence-Based Practice* put it: "It is important to know the person who has the disorder in addition to knowing the disorder the person has" (p. 16). We recognize the usefulness of the DSM but also its limitations. Even those of us who do not take a social constructivist view of the DSM understand the political and economic interests involved in its development, and can recall, for instance, the political history of the DSM and homosexuality.

Clinical psychologists are always interested in *when* problems emerge. We understand the significance of the patient's developmental history, as well as his or her current developmental stage and concerns, and we are interested in formulating problems in these developmental contexts. This is even the case when problems have an organic base; people with head injury or cognitive impairment are still persons first, at a particular time in their lives, and their difficulties emerge in that nexus where the biological, developmental, systemic, and cultural come together.

Clinical psychologists understand that human distress always occurs in a context that includes family and other systems, and that these systems are themselves embedded in cultural and socioeconomic contexts. We try to understand the reciprocal relations between the troubled identified patient and the family context that is both impacted by the patient's behavior and which might serve unwittingly to maintain that behavior.

Clinical psychologists take into account the significance of cultural and individual differences. This means more than respecting the guiding values and interpersonal structures of people in cultures other than one's own. It means appreciating that people from "other cultures" interpret their own experience in ways that might be very different from our own within the culture of clinical psychology. In these cases, the clinical psychologist tries to balance his or her own preunderstandings and those of the client, so works within a case formulation that is negotiable and often ambiguous. Otherwise how would we work with a depressed Evangelical Christian who believes that her mood is evidence of spiritual failure and abandonment by God? And yet we do.

Clinical psychologists can measure and understand the functional significance of head injury and executive and cognitive dysfunction on behavior, mood, and systems such as family. More generally, clinical psychologists are trained in the construction, utilization and interpretation of a range of psychological tests, and they integrate test results into comprehensive case formulation and treatment planning.

Finally, of course, clinical psychologists disseminate their formulations and treatment recommendations in accordance with professional ethical standards.

Our colleagues in counseling, psychoanalysis, neuropsychology, etc., may have expertise in one or more of these areas. For instance, counseling psychologists are specialists who remind us, perhaps to address the client without seeing through a diagnostic lens. Psychoanalysts are specialists in understanding and treating personality structure and, I would say, understanding the complexities and vicissitudes of the therapeutic relationship. Clinical neuropsychologists are specialists in assessing head injury and cognitive

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dysfunction. Family therapists of whatever theoretical persuasion have an exquisitely fine attunement to the family processes which perpetuate systemic and individual distress. Clinical psychologists are not expected to be experts in each of these areas, which is why many of us specialize in one or more of these disciplines. However, it is only the clinical psychologist who is trained to integrate routinely all the above factors into a comprehensive understanding of a person's difficulties and to intervene with an awareness of all these dimensions; an awareness of how they serve to resist treatment (e.g. biological chronicity, family homeostasis, characterological defensiveness), how they might be impacted by treatment, and, more positively, how they might provide resources for therapeutic change. In many cases, accordingly, we intervene across many dimensions concurrently, or work as part of a team that does so.

It should be a warning to us that this multifactorial perspective used to be the prerogative of psychiatry, which has largely succumbed to medical and pharmaceutical hegemony: a fifteen minute symptom check list once a month, with a meds adjustment. As clinical psychologists obtain prescription privileges, this danger should be clear.

The multidimensional perspective

of clinical psychology is so routine for us that it functions often without thematic awareness. I meet a client for the first time. In the initial interview I mostly listen, and I let him know that I shall take a more detailed history in our second session. As I listen to his story, with a few questions or comments here and there, I learn, without asking or even thinking about it much, that he is not psychotic, or brain damaged, or MR, or personality disordered, that his reality testing is sound, that substance abuse does not seem to be a problem, although I should probably check it out, that his concerns are consistent with many people of his age, that his family and relational contexts are painful, that his religious background and experience are meaningful for him in ways that I can understand, and that he has many symptoms of a depressive episode. He has not said so, but I imagine that his immigrant and ethnic status have been problematic too, and that he might feel an ambivalence towards Americans and me that I had better find a way to address. This seems natural to me, as it probably does to the clinical psychologists who read this journal. However, all of us who supervise beginning graduate students know how many years of training and supervision go into making this process feel "natural."

I am happy to have colleagues in

other specialties who have taught me so much: about family systems, psychological development, character structure, cognitive dysfunction, organic conditions, group dynamics, and the value of disciplined research. I read the literature in other specialties more than the literature in clinical psychology. It is in the other specialties that the cutting edges in research and thinking are found. Our expertise is not of the same order. In that regard, we are much more like the family practitioners in medicine than like internal medicine specialists, or even psychiatrists. That is one reason that our expertise is so various across the field. However, instead of that being a source of embarrassment, I take our flexibility and range of competencies as precisely what makes a clinical psychologist.

Reference

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