Taking the medicine

James Anderson got a shock when he went to work on an acute medical ward, and here he argues that the profession needs to examine its view of the self

My patients are sick. They occasionally die. They are delirious with fatigue, illicit substances or medicine. They are in pain and have little sense of their bodies. To sit up is to lose consciousness. The ability to attend, process information or interact with the environment is diminished and variable – on a daily or even hourly basis. Conscious processes (thinking, attribution, choice and action) become peripheral and often irrelevant; what is relevant is instinctive. Subjective mind emerges, embodied in the physical, and strives for continuity. Snippets of voice, memory and hallucination are pressed into a coherent whole, however distorted, and that which is incongruent drops away.

As a psychologist steeped in notions of autonomy, enlightenment ideas of rationality and the radical individualism of the West, experiencing people like this – following my move to an acute medical setting – was a revelation. For the first time, I understood, raw and compelling, the fragile, variable and utterly biological self. Later (when conscious process re-emerged) the import of the social became evident; as patients, many still unable to act and interact, of an old self finding passing form in many still unable to act and interact, of the social became evident; as patients, conscious process re-emerged) the import of the social became evident; as patients, many still unable to act and interact, of an old self finding passing form in.

I found my practice was lacking. Despite a wealth of physical health experience, I acknowledged the physical but I did not account for it as a dynamic factor. The professional practice of clinical psychology claims to provide a rich biological, social and psychological approach (the Boulder model: Martin, 1989). Certainly the profession's origins are integrative, with many of the pioneers being medical doctors, philosophers or biologists (Freud, James and Luria among others) as well as psychologists. Yet while the rhetoric remains impressive, current practice can be quite different. We often treat the social and biological as a stage in a theatre, invoked to provide a backdrop, and then set aside as our focus settles on intra-psychic formulations (Moloney & Kelly, 2004).

Our propensity for the individual is not counterbalanced by a pressure for integration. Clinical psychologists view grand theory with suspicion as it is seen as easily challenged or untestable. Training tends to develop bespoke models to account for the problem presented but ignoring the self as a whole (Staats, 1999).

The consequence of these errors is detachment from the history of our own profession, and the bodies of knowledge in related fields. We embrace reductionism and casual dualism. Our practice fails to consider the whole person; we cease to be psychological scientists and instead become technicians. I consider now that our profession has the balance wrong. Ideas core to much clinical psychology practice (rationality, free will, objectivity, choice and self-management) have been shown to be illusory or limited in their utility when compared to the pervasiveness of compelling physical processes (Blackmore, 2001; Flin & Maran, 2004). Yet the language we use seems to perpetrate the myth of rationality. For example, to label the sense experience of delirium as ‘cognitive bias’ assumes normal is rational; in truth, automatic processes are so ubiquitous that rationality is the aberration.

Cromby (2006, p.12) came to a similar view (that we privilege ‘conscious rational thought’ as causal) after considering the marginalisation of social processes. He considers that clinical psychology can therefore be reductionist and that a singular focus on thought risks treating ‘mind’ as entirely independent from ‘brain’ (dualism). Both dualism and reductionism are bad psychological science. Psychological models are supposed to be pluralist and the consensus is that mental phenomena are brain-based; advocates of a stark dualism being in a minority (see also Baker et al., 2002; Cromby, 2006; Jones, 2008). Problems of dualism and false or narrow attributions of causality are not restricted to psychology, and we are rightly critical of medical or biological reductionism. DeGrandpre (1999) cites studies where genes or neurotransmitters co-occur with conditions and are therefore labelled as causes (ignoring other possible causes or direction of causality). He then describes how the identification of this marker is taken as

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There were competing demands from my patients; they were also for me as a psychologist. I recognised these concepts are not solely for the patients; they are in different spaces.

But although easier, to privilege rational thought and reduce causation to the intra-psychic is to fall short of our claim to be scientists. It is to minimise the impact of drugs, alcohol, medication, fatigue, class, culture, fear or illness on people’s mental state. It is to fail to engage with the broadest range of causes and therefore approaches. We should have a constant awareness of the active physical and social architecture from which self emerges. Any flow diagram labelled ‘thoughts’, ‘behaviour’ and ‘emotion’ without reference to our physiology should be anathema to us.

Once I started to give active thought to the social and biological I quickly realised these concepts are not solely for the patients; they were also for me as a psychologist. Medical work is compelling, deeply emotional, and interactions are infused with non-verbal information. There were competing demands from my professional ethics, patients and medical system, all influenced by issues of power and position. The speed of hospital interactions is bewildering, practice terrifyingly automatic, and at times my opinion can send the system publicly cascading down one path or another. I turned to the literature looking for assistance. There was rich information on the technical aspects of intervention, though comparatively little was offered on the social processes of offering intervention in a hospital (Lloyd, 2003; Marteau et al., 2006; Mendelson & Meyer, 1960; Royal College of Psychiatrists, 2003) and even less guidance if one was a psychologist (e.g. Eisenberg & Jansen, 1987; Miller & Swartz, 1990).

This was yet another illustration of the profession’s unwillingness to engage with the biological and interpersonal. Thus far this marginalisation has largely been discussed as an intellectual or theoretical problem. I also believe that it has a very real impact on our practice and patients – both individually and collectively.

Miller and Swartz (1990) identify a variety of social processes impacting on a psychologist in medical settings. One of the processes they observe is that a psychologist can potentially become the repository for the emotion of the colleagues. These disclosures can give power to the psychologist, elevating them within the group. As they see this power was not freely given, they identify this as an ethical conflict that should be avoided.

I am not sure that is possible; as in any team, a psychologist is both an observer and participant within the dynamics of the group. Power may be given to the psychologist, but equally the mutuality of work, reciprocity and the sense of loyalty to a team can leave the psychologist humbled by trust imparted and equally indebted to colleagues; with all the complexities this entails. However I agree with Miller’s broader point that all group process must be acknowledged, or we risk being buffeted (unthinkingly) by them.

There’s no doubt these are difficult questions: psychological practice sits in a hard space, where philosophy, sociology, politics, biology, theology, economics and medicine interact. But I fear for a profession that drifts towards the technical because it is afraid of the grand. I despair of a profession that blithely states ‘core competencies’ in the physical and then (ignoring everything we know about learning) requires little actual work by trainees with the physically unwell or neurologically impaired. To not engage with the questions – to partition off parts of that complex system from which self emerges, as formulation is morally uncomfortable, theoretically difficult or personally embarrassing – comes at too high a cost, both to our integrity and ultimately our efficacy.