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THIRTY YEARS OF CLINICAL PSYCHOLOGY

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EDNA I. GORDON, M.A.**

During 1956 clinical psychology will be celebrating the sixtieth anniversary of its founding as a separate psychological group. Thus it is young among the professions, but since the first psychological clinic was organized at the University of Pennsylvania by Lightner Witmer in 1896 much progress has been made. The scope of clinical psychology has been broadened, and the rapid advances up to 1946 have been reported by Brotemarkle and numerous others in recent books and current psychological journals. Both authors of the present paper have been doing work in clinical psychology for more than 30 of these 60 years, one for approximately 30 years, and the other for 13 years at this Hospital. Hence, most of the material for this paper has been drawn from accumulations of data in our psychology section here during the period from early 1926 to 1956.

Historically, the first patient of which there was a record at Witmer's Clinic was that of a "chronic bad speller" referred by a school teacher asking for help. In addition to various psychological difficulties, this boy was found to have poor vision and other physical troubles for which he was referred to a physician. From this sort of simple beginning, clinical psychology has grown and expanded to include not only the mentally retarded or handicapped individual, but also those of normal or average ability, the superior, the precocious, or any other children, adolescents, or adults who might present educational, vocational or behavior problems or other troublesome deviations calling for psychological adjustment. Thus all kinds of schools, courts, guidance clinics, homes, industries, agencies, and hospitals have become psychological laboratories for men and women working with people in accordance with this new method termed clinical psychology.

Although the term "clinical" was borrowed from medicine, clinical psychology was not meant to be merely medical psychology. In fact, Witmer and his associates pointed out that just as clinical medicine is not what the term literally implies,—namely the work of a practicing physician at the bedside of a patient, so clinical psychology is a method and not a locality. Then, as now, patients were presented to professional groups or to advanced students of medicine or psychology as "clinics" to illustrate symptom syndromes or to help in clarifying diagnostic categories and planning appropriate therapy. Throughout the years clinical psychologists have been interested in observing and studying the individual to determine the cause of his deviations, and with a basis in the science of normal development, to work out treatment methods to help adjust the individual within his environment, or when this is not feasible, transferring him to an environment more suited to his needs. Individuals have been examined at intervals to determine their reaction patterns and capacities so that the next steps in their development or in the modification of their behavior could be planned. The main objective of these studies, supplemented in later years by formal psychological tests and inventories, has been to point the way toward the production of preferred patterns of human behavior in certain individuals stressing
not only corrective, but also preventive, directive, and creative phases as well. The process of psychological evaluation, counseling and therapy applied so as to effect a desired change in the persons studied, has thus become known as the "clinical" method.

Since there were few psychologists in general hospitals when we began our work as the first one here in 1926, one of our duties was to explain to the staff some of the possible areas of usefulness of psychological services. A paper which we presented at that time, besides referring to some of the foregoing background of clinical psychology, listed ten different specific uses which we were beginning to make of psychological evaluations of hospital patients. Other contributions which we have made along this line have appeared by request in connection with various symposia setting forth specific material on the work of a psychologist in a division of neuro-psychiatry and in a general hospital working with psychiatrists and other physicians. In each of these articles, and a number of others of a research nature, we have emphasized various phases of general and specific work covering psychological interviewing, counseling or psychotherapy, testing of all kinds, which might include any one of 45 or more different tests, and a group of miscellaneous duties. It was estimated by three psychologists then working full time in our section that time spent in these four areas was distributed approximately as follows: interviewing, 40 per cent; counseling, 30 per cent; testing, 25 per cent; and miscellaneous, 5 per cent.

From a tabulation of 10,000 unselected patients seen for psychological studies, with approximately 333 drawn at random, from each of thirty years, it can be noted in Table 1 that about twice as many children as adults were seen. The male children outnumbered the female children about three to two, and the female adults outnumbered the male adults by only a slight margin. Thus it is emphasized that hospital psychologists must be thoroughly familiar with a variety of tests and techniques applicable to children. At the same time they must be familiar with a similar range of tests and techniques applicable to adults because the ratio of patients seen in this large sample during these thirty years was approximately one adult to two children.

At present our list of available psychological tests includes approximately 45 different ones which can be classified in the following major groups:

1. Individual and group intelligence tests, ranging from infant scales through the adolescent and adult levels.
2. Personality tests and inventories for various age levels.
3. Projective techniques for both children and adults.
4. Achievement tests ranging from reading readiness tests through a variety of school subjects of different levels.

<table>
<thead>
<tr>
<th>CHILDREN (UNDER AGE 16)</th>
<th>ADULTS (AGE 16 AND OVER)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>MALE</td>
<td>FEMALE</td>
</tr>
<tr>
<td>3,742</td>
<td>2,898</td>
</tr>
</tbody>
</table>

This table shows that in this large sample about twice as many children as adults were seen, many more of the children were male, and slightly more of the adults were female.
5. Performance tests — chiefly form boards and mechanical tests.

6. Special aptitude tests such as clerical and artistic.

7. Occupational and other interest analysis tests.

8. Special tests for measuring mental deterioration.

Any of these tests alone, or in combination with others, may be of assistance in the major problems of diagnosis and planning definitive treatment for patients. Obviously a psychologist cannot be a specialist in all of these areas, but one can acquire much skill in time as the need arises and appropriate divisions of responsibility can be made in accordance with special interests and qualifications of the staff persons available.

Additional study of the records on our first sample of 10,000 patients revealed that not all of them had had sufficient studies to include in a variety of analyses of data. Hence, for other tabulations including types of patients seen, detailed age distributions and others, a total of 6,779 of these records were used. Table 2 gives a summary of these findings. These main groups chosen for use here can be divided into many sub-classifications, but the ten inclusive categories give a wide range picture more suitable for our needs in this paper. All degrees of nervous and mental stability and instability are represented. The largest group of the ten categories listed is composed of persons who were regarded as essentially normal individuals with minor psychological problems. Many persons in this group were children being considered for adoption, individuals seeking educational, vocational, and premarital or marital counseling, and others with temporary situational adjustment problems regarding which psychological help was sought.

Table 2

DISTRIBUTION OF MAJOR DIAGNOSTIC GROUPS IN AN UNSELECTED SAMPLE OF 6,779 PATIENTS SEEN FOR PSYCHOLOGICAL EVALUATION IN THE HENRY FORD HOSPITAL FROM 1926 TO 1956

<table>
<thead>
<tr>
<th>MAJOR DIAGNOSTIC GROUPS</th>
<th>NUMBER</th>
<th>PER CENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. NORMALS</td>
<td>1,347</td>
<td>19.8</td>
</tr>
<tr>
<td>2. ORGANIC DISEASES AND INJURIES</td>
<td>1,280</td>
<td>18.9</td>
</tr>
<tr>
<td>(LARGELY OF THE CENTRAL NERVOUS SYSTEM)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. MENTAL RETARDATION (IQ 70 TO 89) WITH</td>
<td>1,218</td>
<td>18.0</td>
</tr>
<tr>
<td>ASSOCIATED PROBLEMS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. BORDERLINE CONDITIONS (MINOR BEHAVIOR</td>
<td>1,172</td>
<td>17.3</td>
</tr>
<tr>
<td>DEVIATIONS, HABIT DISORDERS, ETC.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. MENTAL DEFICIENCIES (IQ BELOW 70)</td>
<td>743</td>
<td>11.0</td>
</tr>
<tr>
<td>6. PSYCHONEUROSES</td>
<td>443</td>
<td>6.5</td>
</tr>
<tr>
<td>7. PSYCHOPATHIES</td>
<td>178</td>
<td>2.6</td>
</tr>
<tr>
<td>8. SPEECH AND READING DEFECTS AND DISABILITIES</td>
<td>173</td>
<td>2.6</td>
</tr>
<tr>
<td>9. PSYCHOSES</td>
<td>168</td>
<td>2.5</td>
</tr>
<tr>
<td>10. INEBRIETIES (ALCOHOLICS AND DRUG ADDICTS)</td>
<td>57</td>
<td>0.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6,779</td>
<td>100%</td>
</tr>
</tbody>
</table>

This table shows that most of the major psychological and psychiatric diagnostic categories were well represented. The largest group of patients seen for psychological study was under the heading of normals, with organic diseases and injuries and mental retardation with associated problems being a close second and third.
Chart 1 gives a detailed picture of the age range of our patients. From this it is apparent that the infant and pre-school group was one of the three most important ones in our rather large unselected sample of 6,779 patients. This is because throughout the thirty years we have seen many very young children to help determine suitability for adoption, others for measurement of the type and degree of mental defect or disability so that plans for special training could be made early in life, and still others to determine their readiness to attend an organized pre-school or kindergarten. The largest number of patients was in the age group between five and ten years which is at the early school level. Many of these children presented problems because they had started to school when they were too immature emotionally or intellectually, or both, to make the necessary adjustment. Others because they had some special academic disability such as that shown by their failure to pass reading readiness tests when they were chronologically old enough to start the first grade, or even much older. Two other large groups were at both the beginning and the late adolescent periods. A logical explanation of these findings seems apparent when we think of the many educational and personality adjustment problems likely to arise at these age levels. The total number of patients in the middle age ranges was influenced by the number of adult neuropsychiatric patients seen, as well as the frequency with which patients of these ages were seen for other divisions of the hospital. Others, of course, as in the case of many of the children, came directly to the Psychology Section for specific
studies. The rapid decline in the number of patients seen for psychological study after age 50 to 55 is to some extent proportional to the number of such persons seen in the hospital.

Chart 2 shows the IQ distribution of the group of 6,779 patients. The central tendency of the distribution was within the lower part of the average or normal group. The fact that the lower end of the distribution was somewhat more heavily loaded than the higher end suggests that more sub-normals were referred for psychological studies because their problems were more obvious and perhaps more numerous. If we include the lower part of the average group down to 90 IQ, considerably more than half of our patients seen for study were classifiable as at least low average, or better, in general intelligence. However, more than seventeen percent of the total

Chart 2
DISTRIBUTION OF IQ’S AT TIME OF FIRST TEST ON AN UNSELECTED SAMPLE
OF 6,779 PATIENTS SEEN FOR PSYCHOLOGICAL EVALUATION IN THE
HENRY FORD HOSPITAL FROM 1926 TO 1956

This chart shows a moderately normal distribution of IQ's in this large sample of 6,779 patients although the curve is skewed slightly toward the lower end of the scale. The standard deviation of the total distribution was found to be 23, with the median and quartiles as indicated on the chart.

group were classified as feebleminded (IQ below 70) if we use only their ratings on the first test as the criterion. This is more than five times the expected number in a large random sample of the general population. At the upper end of the distribution we had approximately two and one half per cent of the total group with IQ ratings of 130 and above. This is closer to the frequency with which individuals of the higher IQ levels are found in the general population, but is a larger percentage than expected on a purely statistical basis. The mode of the distribution falls in the 90 to 99 IQ group, which is generally spoken of as the lower half of the average range. The next highest frequency was in the group just above this, IQ 100 to 109 inclusive, covering the upper half of the average range. All other levels of intelligence,
from the most defective to the exceptionally superior, were represented, the lowest IQ's being between 10 and 20 and the highest above 150. If we consider this material along with the range of diagnoses shown in Table 2, and age range shown in Chart 1, it is emphasized that persons of all ages and all degrees of intelligence and nervous and mental stability were seen in this hospital clinic for psychological help with their problems.

Table 3 shows the frequency with which other divisions of the hospital, exclusive of the Neuropsychiatric Division, requested psychological services for their patients. This material is based on a total of 3,597 consultation requests for such service taken at random over the thirty year period. Of these requests, the Department of Pediatrics had the largest total number, or approximately 58 per cent. During the first ten of these 30 years it was estimated that about 75 to 80 percent of the requests for psychological services on in-patients came from the Department of Pediatrics, but apparently as other departments of the hospital became aware of the possible uses that they could make of such services, the number of requests from them increased.

Summary. These data indicate that in a sample of about 10,000 unselected patients examined in the Psychology Section of the Henry Ford Hospital, about twice as many children as adults were seen for psychological study during the period from 1926 to 1956. In addition to special psychological interviewing techniques, many different formal tests, totaling about forty-five, were used for purposes of supplementing diagnosis and planning definitive treatment or psychological counseling. Patients of all ages, from infancy to beyond eighty years, were seen, the median age of the entire group being approximately twelve years. These patients were classified into ten major psychological and psychiatric groups ranging from the normal to the disturbed and psychotic. A moderately normal distribution of intelligence was represented. Although the curve was skewed slightly toward the lower end of the scale, the range was from extreme mental deficiency to the exceptionally superior
levels, and the median IQ was within the low average range. The sources of re-
ferral to the Psychology Section included direct contact by the patients or their
families, routine assignment by the Neuropsychiatric Division, and consultation re-
quests from all other divisions of the Hospital, with the Department of Pediatrics
issuing the majority of such requests.

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