Patients and Impatience (Part II)

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In last month's column, I wrote about the National Institute of Mental Health's, or NIMH's, recent proposal to redirect a portion of its extramural research investment away from basic behavioral and social science research into research that more directly addresses issues of mental health and illness. This development reflects increasing impatience with the extent and pace of applying basic research to reduce the burden of mental illness. Ironically, the greatest burden that mental illness places on patients, families, and caregivers occurs in those areas where basic psychological scientists have the greatest skill in measurement, understanding, and producing change (i.e., decision-making, social attachments, emotion regulation, stigma, etc.). The column ends with the observation that most psychological scientists will spend their entire research career without studying a single seriously mentally ill individual. All of that suffering and all of that highly relevant talent – and never the twain shall meet?

As promised, this month I will discuss how we got to this point and what we could do if we wanted to change things. I believe the disconnect between basic psychological science and mental illness derives from a history of balkanization in which clinical psychology became isolated from the other areas of scientific psychology.

- Scenario 1: Clinical psychology is viewed by other areas of psychological science as less committed to basic research and more concerned with producing applied practitioners. In addition, the special courses and practicum training required of clinical students are blamed for keeping them out of the laboratory and out of the classes taught by faculty in other areas of psychology. Finally, the additional financial costs to departments related to applied clinical training breed concern and resentment.
- Scenario 2: The demand for clinical psychology training is so high that clinical training programs go to great lengths to protect against "back-door" admissions. Thus, exposure of students in other areas of psychology to clinical courses, issues, and populations is strictly limited.

These scenarios became increasingly prevalent as the demand for clinical psychologists grew exponentially in the decades following World War II. Fortunately, they have recently become less commonplace with the advent of the free-standing professional schools (which began training an increasing proportion of the nation's practicing clinicians) and the Clinical Science movement (which reaffirmed the commitment to science in all aspects of clinical psychology). However, a great deal of damage was done. A number of top graduate programs dropped their clinical psychology programs entirely, and many others were cut back in size. This isolation of clinical psychology meant that generations of psychological scientists who received their training in non-clinical areas never had any real exposure to clinical issues and populations. Not surprisingly, these scientists rarely think about mental illness or the mentally ill when they are honing and applying their measures and methods, testing their theories, or looking for natural experiments to deepen their understanding of basic psychological processes.

Even in clinical psychology there has been a drift away from studying and working with the severely mentally ill. The shrinking of the state mental hospital system and the dwindling of inpatient populations at Veterans Administration hospitals have sharply reduced the exposure that clinical graduate students have to schizophrenia and other forms of severe mental illness during their training. Reflecting this, many clinical scientists go on to pursue research on basic psychological processes (e.g., emotion, attachment, social relationships) that is virtually indistinguishable from that of their non-clinically trained colleagues, including rarely or never conducting research using patient populations.

This is indeed a striking state of affairs. A phenomenon at the very center of psychology – diseases that produce major abnormalities in thinking, feeling, relating, and behaving – is falling outside of the purview of those who spend their lives studying these very processes. One need not look far to see the incredible research yield that has come from studying patient populations in the medical sciences. And psychology has also had stellar success studying some kinds of patients as well. For example, where would our science be without the studies of Patient H. M. and Phineas Gage? This leads to an intriguing question: Where would the study of cognition, emotion, social bonding, personality, etc. be today (as well as our understanding of mental illness) if our best and brightest psychological scientists of all stripes had conducted at least some of their research on patients whose mental illnesses produced abnormalities in these areas?

A Modest Proposal

Now appears to be an optimal time to do something to change this longstanding state of affairs, since: a) the isolation of clinical psychology within psychological science is on the wane; b) the severely mentally ill are no longer all locked away in back wards of state mental hospitals, overly medicated, and only available for study by the select few; and c) changing funding priorities at NIMH are providing both a huge carrot and a big stick. To this end, I suggest we at least consider the following:

1. Provide graduate students in all areas of psychological science with exposure to relevant patient populations early in their career and encourage them to incorporate these populations in at least some of their graduate research. I am not suggesting traditional clinical training (e.g., in assessment and intervention) for everyone, but rather a systematic exposure aimed toward fostering comfort and competence in using clinical populations in basic research; and
2. For this purpose, forgo the hegemony of the Diagnostic and Statistical Manual and focus more on the newer transdiagnostic approaches. Many DSM diagnostic categories are so heterogeneous and so vaguely described that they can quickly become scientific quagmires. I believe that a basic researcher interested in a particular psychological phenomenon would be best served by drawing a sample of patients from a range of diagnoses with variants of a particular symptom (e.g., someone interest in emotion regulation examining emotional blunting in autism, schizophrenia, and frontotemporal dementia).

Highly talented and creative psychological scientists working with clinical populations and problems can produce fresh perspectives, new insights, and novel hypotheses. Moreover, their nuanced view of particular areas of psychological functioning may help them see important similarities and differences in patient populations that might otherwise be overlooked. Inherent in any change in NIMH funding priorities is the notion that you move a field by getting the attention of its most established, most successful scientists. However, for the long haul, a change in behavior of the funded few will have less

payoff than would a change in the scientific culture. For this to occur, efforts need to be directed toward graduate students, postdoctorals, and those still in the early stages of their careers. These are the psychological scientists who are not yet fully locked into particular paradigms, topics, theories, and populations. Exposed to mental illness and the mentally ill early in their training, young psychological scientists would be most likely to revisit these issues throughout their scientific careers.

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