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Clinical psychology getting lost?

Clinical Psychology Forum

Clinical Psychology Forum is circulated to all members of the Division monthly. It is designed to serve as a discussion forum for any issues of relevance to clinical psychologists. The editorial collective welcomes brief articles, reports of events, correspondence, book reviews and announcements.

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News

Survey on personal health budgets in mental health

The NHS Confederation and National Mental Health Development Unit are collaborating on a study to inform national policy on personal health budgets.

The survey is being conducted amongst each of the major groups of professionals working in mental health, and the two bodies are keen for psychologists working with mental health service users in England, to complete a short survey.

They say that acting upon professionals' feedback, views and opinions is a vital part of the work we are undertaking. They are interested in your views even if you have not yet

had any direct experience of personal health budgets.

The survey should take no more than 10 minutes to complete and your answers will be totally confidential. To access the survey, please go to <http://bit.ly/bAf1et>.

The NHS Confederation is the independent membership body for the full range of organisations that make up the modern NHS. The National Mental Health Development Unit, funded by the Department of Health and NHS, provides national support for implementing mental health policy.

Clinical psychology getting lost? A survey

In an attempt to further extend the format of this special issue, we have designed in collaboration with the authors of the target article, a brief survey to ascertain your views. All you have to do is to answer the seven or so questions on the questback survey which can be accessed through the following website address:

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The survey will be active for four weeks following publication and then in the following few months, we will publish a brief analysis of the responses, together with some possible actions and ways of taking the debate forward.

So please make your views known about the future of the profession by taking 10 minutes now to complete the survey.

Correspondence

Clinical psychology around the world

I just wanted to pay my compliments on putting an extremely interesting issue of *Forum* (CPF215, November 2010) together. I've read it from front to back cover and learnt a lot about clinical psychology training in other parts of the world. So well done and thanks a lot for all your hard work!

Dr Katrina Scior

University College London

Just to say how much I enjoyed the recent Around the World issue of *CPF*. The different articles illustrated a number of exciting developments in which British psychologists are involved, and the special issue brings these together in a very helpful package.

Which brings me to 'What next?' As Graham's editorial points out, there are a number of implications of these developments, both for training and for the forging of mutually beneficial partnerships between British and other national clinical psychology training and practice systems.

Muhimbili University at Dar Es Salaam in Tanzania has last week started their new clinical psychology course with seven students. It has been possible to create an Oxford-based local syndicate, I suppose you could call it, to support the course, and I have been very pleasantly surprised at the number of people willing to contribute to the course. In my view the special issue is itself a valuable resource - I would like to be able to give copies to my Tanzanian colleagues, both as an educational resource, but also as a bit of advertising with the senior officials in the Ministry of Health. Is there any possibility that copies could be made available for purchase, perhaps as a PDF with the other material omitted, as a stand-alone document?

A second obvious suggestion is to set up an open informal face-to-face meeting to take some of the issues implicit and explicit in the issue forward, in line with Gary and Steve's excellent initiative. I suspect that the

authors of the other articles would be interested in such a meeting. Following an open meeting in Oxford last month, at which Lydia Stone spoke about her work in Dodoma, I suspect that trainees would also welcome wider opportunities for training placements 'around the world'

I hope and expect that you will have had similar responses to the issue. There are other steps that could be taken. How about the DCP Committee taking this forward?

John Hall

Oxford Brookes University

Asylum: The Magazine for Democratic Psychiatry

I'm a member of the editorial collective of a magazine called *Asylum: The Magazine for Democratic Psychiatry*. *Asylum* began in 1986 as a collaboration between Sheffield psychiatrist Alec Jenner, some of his patients, Lin Bigwood (a nurse) and Phil Virden. It has long been a forum for debate about psychiatry, over the last 24 years publishing articles by psychiatric service users, critical mental health professionals and academics. After the sudden death of the last editor in 2007 *Asylum* had a hiatus, but it has now been relaunched and is being published by PCCS books. *Asylum* appears quarterly and three issues have appeared so far this year. The first issue was a special issue on paranoia (including articles by Alec Jenner, Peter Bullimore, Eleanor Longden and me). The second issue was devoted to medication (and included articles by Joanna Moncrieff, Phil Virden, Guy Holmes and Peter Lehmann). The third issue was a general one and included articles by Thomas Szasz and Marius Romme.

My reason for writing to *Forum* is to ask that readers consider subscribing and contributing. It takes a lot of money to publish a regularly appearing magazine and *Asylum* has no big financial backers - the magazine will exist only if it finds enough subscribers. Its lively editorial stance is not to everyone's

taste but, I'm sure *Forum* readers will agree that, in these difficult times it is more important than ever that there is an independent outlet which does not have to engage in self-censorship for fear of losing its funding. Those who have subscribed in the past will know that the sudden death of the editor Terence McLaughlin meant that details of subscriptions were lost. However, if people are still owed issues of *Asylum* please contact me d.harper@uel.ac.uk and we will endeavour to replace them.

Now that the magazine is published by PCCS, however, the subscription side of things is much more efficient. Readers can find details on how to subscribe by going to www.pccs-books.co.uk and follow the link to *Asylum* magazine. Individual subscriptions begin at £14 per year for four issues (£12.93 including VAT if you subscribe to the digital version only). It could make an ideal gift!

Please also consider contributing articles, poetry or artwork/illustrations and invite others, especially service users and

their loved ones, to do the same. Copy can be sent to any member of the editorial collective or to Phil Virden (the editor) at: tigerpapers@btinternet.com

To get an idea of the content of the magazine you can see archived articles at our old website www.asylumonline.net, which is currently being updated.

Dave Harper

University of East London

The pioneers of behaviour therapy

In the maelstrom evoked by IAPT, it seems that one way of ensuring one's bonafides would be by declaring a commitment to formulation, as both Marzilier and Johnston have done (**CPF213**), as would presumably high intensity therapists. However, a formulation was an essential feature of behaviour therapy. One tenet of Vic Meyer was, to forget techniques until a proper formulation had been developed. Moreover, Wolpe was also a stickler for specificity so that an accurate

Books Reviews on the Web

You can now find a growing selection of book reviews on the Division's website. Some will be published here in *Forum* too, but because of the pressures on space and the number of excellent reviews we have in hand, it is likely that many will appear only on the web.

You can find the reviews at <http://tinyurl.com/cpfbooks>

The list of Books Available for Review can also be found via that page.

understanding of the case could be achieved. A good illustration of this was his view of agoraphobia which he stated could assume many different forms e.g. fears of physical distance from 'safety', of a medical emergency, of social disapproval, of being trapped, of a failing marriage or of other fears. Of course it is now cognitive therapy which is associated with this degree of nuanced specificity. In fact Gurnani and Wang (1991) had argued that it was the disillusionment resulting from the practice of a naive, symptom-based behaviour therapy as was then emerging, for example from the Maudsley, that provided one impetus to cognitive therapy.

Moreover, Wolpe regretted not so much cognitive methods as cognitivism – i.e. the assertion that misappraisals underpinned every psychological difficulty. Accordingly, Gurnani and Wang (1991) recommended against overplaying the cognitive card. This view received some echo in Longmore and Worrell (2007) who argued that there was little empirical support that specific cognitive interventions increased the effectiveness of therapy. Whilst this will provide some succour to those dismayed by the dominance of cognitive therapy, it has hardly caused a ripple

in cognitive therapy circles as this view runs counter to the prevailing *zeitgeist*.

At least David Clark in *The Psychologist* (June 2010) admits that cognitive therapy is a bit like a magpie appropriating the best from other therapies.

Interestingly, Barlow (2010), who had trained with Wolpe, now advocates the adoption of both nomothetic and idiographic procedures to enhance treatment effectiveness. This accords with Wolpe's view that therapy should be based on an 'idiographic adaptation of empirically derived procedures'.

Perhaps knowledge of our history might not come amiss in remembering to give credit where it is justly due, viz. to the pioneers of behaviour therapy.

Prem D. Gurnani
London W2

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Back numbers of *Clinical Psychology Forum*

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Notes from the Chairs

Well! My final Chair's Notes... It's been a very eventful three years, and I am honoured to have had the opportunity to represent you all as our Divisional Chair.

During my time as Chair I've had the privilege of attending events and meeting members in all four nations of the UK, and from several of our specialist Faculties. I've also received direct correspondence from a number of you that has been very helpful in ensuring I'm abreast of what matters to members.

Key events over the last three years have been the move to regulation by HPC (and all the work to ensure that this move maintained our existing standards, including our Doctoral qualification, and that we retained our membership, which we did – in fact it has grown!), the change in government in Westminster (which has meant the need to engage in a new mental health strategy, and create relationships with new key government figures), and the changes in and consolidation of our own Division, with the ongoing development of our Service User & Carer Liaison Committee, our four nation structure and our five clinical leads.

During the last few years, I also think we have moved to a much closer working relationship with other professional bodies, and with other Divisions within the BPS. I remain hopeful that this latter development will yet culminate in the consolidation of an Academy of Colleges of Practitioner Psychologists within the Society, with the DCP becoming the British College of Clinical Psychologists. In my role as your Past Chair, you are still employing me to work on the committee one day a week over the next year, and this will be one of the areas I will continue to work on.

Those who know me personally (or indeed have heard me speak) won't be surprised when I say that I have now already gone over my word limit for this piece, as I was determined to just say a brief goodbye and hand you over to my successor, who I can now name as Professor Peter Kinderman, who, being a glutton for punishment

has returned for a further term as DCP Chair!

Congratulations on being elected to the position of Chair for a second time Peter – anyone can get elected once, but being elected again after the members know what you're actually likely to do, well that is impressive. So, I'll end here with my grateful thanks to all the members and elected officers and the Society's office staff who have supported me in my role as Chair over the last three years, and with my best wishes to Peter for his coming term of office. Over to you Peter!

Jenny Taylor

Thanks Jenny.

It's a privilege to take over as DCP Chair from Jenny Taylor. In my opinion, she's been an outstanding representative of our profession, and she will be a very hard act to follow. During her time as Chair, we've seen – and successfully negotiated – major challenges to clinical psychology's role and identity. Jenny has steered the professional body confidently though some significantly troubled waters, and I feel we should look forwards with some optimism.

My vision is for a DCP effective as a professional body for clinical psychology and clinical psychologists. A DCP fit for the world after statutory regulation by the HPC, prepared to argue for high-quality, evidence-based, psychology-led services, capable of bringing psychological perspectives to the public and national media and able to support individual members in a variety of ways.

For me, first, I need to do some rapid learning – of the challenges that people are facing in the NHS as well as in academia. I need to find out what people are doing: what activities are already underway in the DCP. And I need to find out what DCP members feel are the priorities for the next few months and years. I look forward to working again with friends and colleagues, and I hope I will be able to match Jenny's success.

Peter Kinderman

From the Editor's Chair

Three years ago the *Clinical Psychology Forum* collective decided to introduce a new special issue format consisting of a target article, together with a number of invited commentaries. The first of these examined the service model underpinning the IAPT Pilot Site at Doncaster and was judged a particular success as evidenced by the responses to the online *Clinical Psychology Forum* survey conducted in the following year. It was decided, therefore, to repeat this format, if a suitable article was submitted.

Some months ago Richard Hassall and John Clements presented an opinion piece about the future of the profession specifically in relation to the provision of learning disabilities services but also more generally by a perceived dominance of the profession by the need to deliver psychological therapies. We decided that this would constitute an ideal target article and arranged for a number of commentaries to be commissioned. We are particularly grateful to Richard and John for letting us use their article as a focus for debate and also to the commentators for their thoughtful critiques.

I am very tempted to abuse my position as *Clinical Psychology Forum* editor to join in the debate. However, I have previously argued elsewhere (<http://tinyurl.com/376ulze> and Turpin, 2009) that clinical psychologists should be both very effective interventionists (i.e. psychological therapists in some settings),

as well as applied psychological scientists contributing to activities such as advocacy, audit, clinical leadership, clinical outcomes measurement, governance, need assessment, R&D, social engagement, etc. Indeed, it can be argued that these non-psychotherapy activities constitute the added and unique value that clinical psychology brings to services, and are specific competences that other psychotherapists seldom can offer or have acquired as part of their training.

But what do you as a reader of *Clinical Psychology Forum* think about this debate? In an attempt to further extend the format of this special issue, we have designed in collaboration with the authors of the target article, a brief survey to ascertain your views. All you have to do is to answer the seven or so questions on the questback survey which can be accessed through the following website address:

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The survey will be active for four weeks following publication and then in the following few months, we will publish a brief analysis of the responses, together with some possible actions and ways of taking the debate forward. So please make your views known about the future of the profession by taking 10 minutes now to complete the survey.

Finally, as we move into yet another year, can I wish all DCP members a successful and productive new year.

Graham Turpin
Coordinating editor

Reference

Turpin, G. (2009). The future world of psychological therapies: Implications for counseling and clinical psychologists. *Counseling Psychology Review*, 24, 23–33.

Please send all letters for publication in *Clinical Psychology Forum* to:

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Clinical psychology getting lost? Accident, strategy or symptom?

Richard Hassall & John Clements

Clinical psychology is increasingly evolving as a psychotherapy profession, in contrast to its previous interest in environmental determinants of human behaviour. We explore the factors leading to this shift and how the profession is consequently losing its relevance for more disadvantaged groups.

‘**F**EAR I have been witness to a profession that has been losing the plot over the past 20 years or so.’ So says the author of the influential 1989 Management Advisory Service (MAS) report in a letter to *The Psychologist* (Mowbray, 2010). We present here our views on how the clinical psychology plot has developed, and in particular on its declining relevance for the disempowered and marginalised groups which it used to serve well. In our previous paper, ‘The Lost Patrol?’ (Clements & Hassall, 2008), we focused on the limited effectiveness that clinical psychology appears to be having with children with learning disabilities and their families, which we related to the profession’s drift towards psychotherapy. In this paper we explore further how clinical psychology has moved strongly towards a psychotherapy role. We highlight the implications of this for people with learning disabilities, but the same analysis could be applied to those with other ‘messy’ difficulties, such as chronic mental health conditions, the elderly, and many others. We argue that this represents an important challenge for the future of the profession.

A brief reminder of our history

Between the 1950s and the late 1980s British clinical psychology grew from a rarely sighted animal engaged primarily in psychometrics to a vibrant force having significant impact in social and health care and education. It

demonstrated its value to many groups traditionally excluded from psychotherapy – those with long-term mental difficulties, those with intellectual disabilities, the elderly with dementia, others with long-term neurological problems. It was an astonishing achievement, built on an explicit commitment to empirical research, scientific methodologies and psychological analysis based on mainstream psychological understandings, especially learning theory. Interventions were derived from these psychological analyses and so the number of interventions associated with the profession multiplied rapidly. This perspective emphasised the pivotal role of the environment over more internal variables, an emphasis in tune with the prevailing social perspectives of that era. The Maudsley, Birmingham and Glasgow were amongst the key centres from which this clinical psychology spread throughout the UK. At the same time, psychoanalysis and other branded therapies were shown to lack significant empirical support and were largely rejected as suitable competences for clinical psychologists. By the late 1980s, the profession was being taken sufficiently seriously for a significant review to be commissioned which led to the MAS Report (Management Advisory Service, 1989).

How clinical psychology turned into psychotherapy

There were broader changes in social perspectives from the 1990s onwards to which clinical psychologists, like anyone else, were subjected. The astonishing rise of genetics and neurological research, the relentless spin of the pharmaceutical industry about chemical imbalances and the dominance of the politics of individualism have led to the

Zeitgeist of brain-driven behaviour and the location of pathology within the individual. But clinical psychology has proved itself a willing and pliant partner in this change of intellectual climate.

In particular, the profession began to break from its mainstream psychology roots when it embraced branded therapies such as rational-emotive therapy and cognitive therapy, approaches that were not explicitly derived from general psychological principles. This resulted in the shift of emphasis towards protocol-based competencies rather than psychological analysis, and to the hybrid of cognitive-behavioural therapy, so strongly favoured today. The shifting climate also created space for the return of psychoanalysis and other psychodynamic therapies which steadily became more fashionable, despite the lack of improvement in the evidence base.

MAS Report and the belief in psychological superiority

This shift was further encouraged by the profession's reading of the MAS Report, which describes three distinct levels of psychological skill. Of these, level 3 requires the ability to draw upon multiple psychological theories, with the emphasis seemingly on theories rather than empirical evidence. Clinical psychologists are stated to be the only professionals who operate at level 3 and who therefore have skills in a range of therapeutic approaches (though one may wonder in passing how many actually are proficient in more than one approach). A further role identified for psychologists is that of providing consultation to other professionals delivering psychotherapy, again emphasising the therapy role. The implication seemed to be that different psychological approaches are equivalent for practical purposes, with any differences in supporting evidence being of secondary importance. Consequently, clinical psychologists began to see themselves as the key orchestrators of therapy services. Although the MAS Report made other recommendations, including particularly the need for clinical psychologists to adopt a broader healthcare and preventive role, the profession itself largely latched on to its sup-

posed uniqueness in its possession of level 3 skills as the main message. The profession seemed to cherry-pick the ideas it liked best, while other significant recommendations were mostly overlooked.

A comprehensive commitment to the NHS... but what NHS?

We should remember that although the NHS always provided much of the funding for clinical psychology training, it was not always the sole source. Also, at the time of the rise of clinical psychology the NHS served large social care functions, which it has since mostly shed. By the 1990s the NHS was almost entirely about acute medicine and the delivery of specified interventions for discrete medical problems. It was at this moment that the profession committed itself to the NHS as the sole source of training finance. The effective immersion of the profession within the NHS has meant that the demands of the paymaster of training, and the dominant employer of clinical psychologists, now determine what clinical psychology does, rather than the profession asserting its own purpose and identity. This is in marked contrast to how it sought to develop its role in the past.

Managerial changes in the NHS have placed immense pressures on the profession to conform closely to what commissioners and service managers demand of it. Recent developments include the requirement to achieve stringent performance targets set by commissioners, the progressive dismantling of professional line management, the micro-management of professionals' work, and the reduction of security and professional identity inherent in the Agenda for Change paycales and conditions. In this environment, the pressure is always to do therapy aimed at alleviating some quasi-medical disorder within the individuals referred to the service. The delivery of therapy is also a convenient performance measure readily monitored by managers.

The wilful neglect of dissenting voices

Clinical psychology has not been short of people who disagree with its direction. David Smail has long challenged the notion of dys-

function as reflecting disorder within individuals and championed the overwhelming significance of the social context at many levels (see www.davidsmail.freeuk.com for a selection of his writings). Furthermore, the profession has largely ignored persistent questions about the philosophical underpinnings of its ideas about mental disorders. These have been discussed recently by David Pilgrim (2008), who describes the 'medical naturalism' which has characterised traditional psychiatric practice. This has typically been defined by three axioms stating that mental disorders are genetically determined diseases of the mind, are classifiable into discrete categories representing real-world disorders, and are fixed, degenerating conditions. Mental disorders are thus seen as objective disease entities.

Clinical psychology emerged when other intellectual trends were questioning the basis of medical naturalism. It projected a strong environmental approach to the understanding of human behaviour and distress under the strong influence of behaviourism, though other models were also influential. However, while clinical psychology rejected other aspects of medical naturalism, it has continued to use, with little reflection, the language and concepts of disease classification. Pilgrim (2008) suggests several reasons for this, including the perceived professional advantages in using this language and the dominance of diagnostically defined groups in randomised control studies. Other well-articulated alternative perspectives, such as Bentall's (2003) deconstruction of traditional psychiatric classification and the Demedicalising Misery movement (Rapley, personal communication), have also largely been ignored. In current service environments where clinical psychologists are struggling to maintain their status, the temptation seems irresistible to talk about diagnostic categories and to offer therapy for these defined 'disorders'.

The silos of applied psychology

The manner in which applied psychologists are spread across many separate divisions within the British Psychological Society, each

with its own purposes and training requirements, is hardly designed to maximise the cross-fertilisation of ideas between different branches of the subject. Why, for example, should there be separate professions of clinical and health psychology? As currently constituted, the boundaries between the divisions are likely to reinforce a therapy focus within clinical psychology at the expense of different approaches arising from, for example health or occupational psychology. There have been suggestions that a new institution should be created with a title such as College of Healthcare Psychology or College of Applied Psychology (e.g. Mowbray, 2009) to bring together psychologists with a wider range of skills and knowledge, but the BPS has so far shown little interest in pursuing this idea. There are perhaps some signs of broader thinking in the New Ways of Working (NWW) documents, which are explicitly designated for 'applied psychologists'. Nevertheless the NWW paper on new models of training (BPS, 2007a) cannot recommend any model which would significantly alter existing professional boundaries. Similarly, the NWW paper on new roles for psychologists (BPS, 2007b) looks mainly at pre-doctoral level roles and qualifications and has little to say about a wider combination of applied psychology disciplines.

The developing impact on clinical psychology in learning disabilities

As a consequence of the factors outlined above, many clinical psychologists working in learning disabilities will be manoeuvred towards a role as diagnosticians and psychotherapists. Cognitive therapy is often proposed as suitable for people with learning disabilities, despite some critics arguing that it lacks an adequate empirical base in this area (e.g. Sturmey, 2004). However, even those who support the use of cognitive-based therapies with these clients concede that they are likely to be useful only for individuals with mild learning disabilities (Taylor et al., 2008). This practice will therefore exclude those who cannot be clearly diagnosed, are not suitable candidates for therapy or are not motivated to engage in therapy – in other

words, the vast majority of those with learning and pervasive developmental disabilities.

For children with severe learning disabilities, there is evidence that even when they receive a service many parents feel that clinical psychology input provides little useful help (McGill et al., 2006). It is difficult to see how a therapy-dominated model of clinical psychology can have much applicability to these children. Nevertheless, the therapy model is strongly reinforced by the increasing trend of placing services for children with learning disabilities within mainstream child and adolescent mental health services (CAMHSs). The assumption is that these children need a similar approach to the general CAMHS agenda, which is dominated by the provision of psychological therapy and medication, along with the activity of diagnosing various neurodevelopmental 'disorders' assumed to have some (unspecified) biological basis.

However, the broader issues facing children with disabilities and their families – for example problems of obtaining appropriate educational provision, the ongoing and pressing need for short breaks and other support, the need for support in the management of serious and long term behavioural challenges – are often far more critical for their well-being. These are not issues that CAMH services are designed to address. Clinical psychologists in this environment are inevitably conditioned by a circumscribed world of therapy and diagnosis activities, often reflecting a medical model. Psychologists expecting (and expected) to maximise therapy activities are likely to be diverted from more relevant work. For example, prevention and early intervention efforts may be obstructed by CAMHS policies, despite being increasingly recognised as essential following recent research on the development of behavioural difficulties in children with learning disabilities (e.g. Emerson & Einfeld, 2010; Richman, 2008). Similarly, clinical psychologists may be discouraged from adopting an advocacy role which, as we argued previously, should be an important part of their role in this area (Clements & Hassall, 2008).

Trainee placements in learning disability – where have they gone?

When placements in learning disability were a compulsory part of training there was good reason for this – you could learn things there that you could not learn from child and adult mental health placements. The new and convenient 'competency model' can now allow trainees to avoid doing a core placement in learning disabilities, as long as they obtain the required competencies, whatever these are supposed to be, elsewhere in their training.

A placement in learning disabilities is now, on some courses, entirely optional. Where this is the case, course directors rely on the notion that as long as trainees gain the relevant 'core competencies', then all is well. What they do not clearly explain is how clinical psychologists can be expected to understand the issues facing people with learning disabilities when they encounter them in practice, without having had such supervised experience. It is difficult to understand what vision of the profession can justify the relegation of learning disability placements to an optional status while placements in adult mental health and children's services remain obligatory. To us it indicates that the profession generally has lost interest in those needs of people with learning disabilities which do not yield neatly to therapy interventions.

Lest we forget – the environmental determinants of psychological problems

Although the intellectual climate has shifted, there remains ever accumulating evidence documenting clear relationships between the social and economic environments of individuals on the one hand and their development, well-being, and behaviour on the other. Recently, Wilkinson and Pickett (2009) have summarised evidence from many international sources establishing a clear association between high levels of material inequality in societies and mental health problems in the population which remains significant when the overall wealth of individual countries is taken into account. Looking specifically at the effects of socio-economic context, Conger

and Donnellan (2007) review a range of evidence testifying to the impact of family socioeconomic status on various aspects of children's development. Further large-scale surveys in the UK have shown that low socioeconomic status predicts the incidence of psychopathology in children generally (Flouri et al., 2010) and physical and mental health disorders in children with intellectual disabilities (Emerson & Hatton, 2007). At a more proximal level, countless studies over many years have demonstrated the impact of situational variables on both the short and longer term behaviour of children and adults. We are not alone in remembering this. Others have criticised the emphasis on promoting therapy at the expense of understanding the social and environmental causes of distress in psychiatric services (Coles et al., 2009) and the Improving Access to Psychological Therapies programme (e.g. Marzillier & Hall, 2009; Nel, 2010).

Conversely, environmental change can have a massive healing effect on children who have suffered severe neglect or trauma. Clarke and Clarke (2000) have reviewed a large number of longitudinal studies stretching back more than 50 years, which overwhelmingly demonstrate how children can recover from seriously adverse early experiences when placed in consistently supportive environments.

It seems ironic that a profession that places such emphasis on evidence-based practice seems increasingly drawn to exploring internal variables within their clients, even to the extent of diagnosing various 'disorders' for which no independently verifiable markers exist. Environmental factors maintaining behaviour may be included in formulations, but these are assigned less importance when internal variables are the main focus. Formulations which depend to some extent on an implicit medical model are likely to invite treatment responses directed particularly towards the individual. There have even been occasional suggestions that psychologists be given prescription powers. But this is all of marginal relevance for the vast majority of 'hard cases', including children and adults with more severe disabilities.

Conclusions

It is our argument that clinical psychology is evolving into a profession with an increasingly narrow focus on individual pathology and therapy. We do not, of course, argue that clinical psychologists should not be doing therapy as part of their role, but rather that the profession is now following this path as a default strategy. In so doing, it is losing sight of the pervasive social and environmental problems which generate the human distress which its members are expected to address. One of the most notable past achievements of the profession was to demonstrate how traditionally devalued and excluded members of society could experience significant and lasting benefits from environmental interventions. In successfully challenging conventional models of medicalised care, clinical psychology punched dramatically above its weight. Nevertheless, there remain many people with chronic difficulties who are marginalised by statutory services and who do not fit neatly into a psychotherapy frame. In consequence, clinical psychology now lacks a clear vision of how it might bring lasting benefits to these groups within society.

We cannot tell whether the profession wants to change its current focus. But if it does, there are many steps that could be initiated, some with immediate effect:

- moves towards a broader professional purpose along the lines of healthcare psychology (e.g. Mowbray, 2009);
- a commitment from university clinical psychology departments to engage in more research into the needs of marginalised groups and to provide a renewed intellectual lead to the profession;
- the development of mechanisms for our profession to engage with commissioners to advocate for adequate resources and contracts that reflect the real needs of the populations we serve;
- a renewed requirement for learning disability placements to be a compulsory part of training.

Doubtless some of our colleagues could generate further suggestions, whilst others will disagree with our conclusions. This would sug-

gest, at the very least, that a widespread debate is needed about whether the therapy mission can sustain clinical psychology into the future. In the absence of this, those psychologists unhappy with the current trajectory will continue to urge a reconfigured form of applied psychology with more ambitious aims.

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Not sure about the past, but certainly recognise the present

Eric Emerson

THE PAPER BY Richard Hassall and John Clements covers much ground. But at its core lies a simple story; that the profession of clinical psychology in the UK has undergone a metamorphosis. In the 1980s it was 'a vibrant force' based on 'an explicit commitment to empirical research, scientific methodologies and psychological analysis' that 'emphasised the pivotal role of the environment'. It is now portrayed as some kind of low-rent franchise operation for pre-packaged therapies. Furthermore, it is a profession that pays no regard whatsoever to the broader social determinant of health and well-being. It's a nice story. My problem is that I just do not recognise their (to me wildly romanticised) version of the past.

The past

I was trained in the 1970s (though not at the Maudsley, Birmingham or Glasgow, so maybe that's why my experience was so different). I was trained how to be a therapist. The therapies were slightly different (behaviour therapy accompanied by a smattering of behaviour modification/analysis and the newly emerging cognitive therapies), but they were therapies first and foremost. Any underlying psychological science came a distant second. I was employed as a therapist/assessor. That is what the profession did then, and that is what it does now.

Did our interventions emphasise 'the pivotal role of the environment'? Not really, and certainly not in the way that Richard and John come to talk about the environmental determinants of distress. Behaviour therapy always held much greater sway in the UK than applied behaviour analysis (and it is very hard to sustain a claim that behaviour therapy emphasises 'the pivotal role of the environment'). But what about applied

behaviour analysis? It is, of course, a radically environmental approach to understanding behaviour, but it has always been 'environment' with a very, very small 'e'. As an approach it has proved itself utterly incapable of looking beyond the importance of immediate proximal influences on behaviour (contingencies of reinforcement, proximal setting events). You will certainly not find any references to Wilkinson and Pickett, Marmot or Conger in the *Journal of Applied Behavior Analysis!* (Perhaps I should point out that I used to be a card carrying behaviour analyst in the seventies and eighties, but have recovered quite well, thank you).

I do agree that there was a bit of a 'golden' era (well, maybe more 'bronze' than 'golden') in learning disabilities in the seventies and eighties. At that time clinical psychologists like John, Derek Thomas, myself and many others were given the opportunity to engage with broader issues. The scandals and inquiries of the seventies and eighties helped create the conditions under which major reform of services for people with learning disabilities became a realistic possibility. Psychiatrists, of which there were few and of highly variable competence, were often seen as being too closely aligned with the old ways of doing things. This created a significant leadership vacuum in health services (at that time clinicians still had some credibility), and that created the opportunity for clinical psychologists (and behaviourally oriented researchers like David Felce, Jim Mansell and Roger Blunden) to influence issues ranging from the design of residential settings to complete service systems. They were heady days, but let us not fool ourselves: the opportunity was there as a result of external sources and some entrepreneurial folk (including some clinical psychologists) grabbed

that opportunity. It was certainly not a phenomenon driven by the 'vibrant force' of the profession of clinical psychology.

Anyway, enough of the past.

The present: Clinical psychology and the social determinants of health

As Richard and John point out, there have always been critics of clinical psychology's relentless individualism and preoccupation with therapy (David Smail perhaps being the most consistent and articulate). Community and critical psychology groups in the UK and organisations such as Behaviorists for Social Action in the US can be added to their list. But they have always been voices in the wilderness.

As Richard and John also point out, the evidence to support the notion that common psychological problems (along with many other health problems) are inextricably linked to inequality and exposure to disadvantage and discrimination is simply overwhelming (Fryers et al., 2003; Graham, 2007; Lund et al., 2010; Marmot & Wilkinson, 2006; The Marmot Review, 2010; Wilkinson & Pickett, 2009; World Health Organization, 2008). Equally compelling, to some of us at least, is the argument that we will only begin to make significant progress in addressing the current levels of, and stark inequalities in, health and well-being (including mental health) when we begin to move away from our preoccupation with therapy and the proximal causes of distress and begin to address what Professor Sir Michael Marmot calls 'the causes of the causes' (or 'upstream' determinants of health) (The Marmot Review, 2010; World Health Organization, 2008). What would this mean? Well, let's take the three overarching recommendations from the World Health Organization's (2008) Commission on the Social Determinants of Health. They really are quite straight forward:

1. improve daily living conditions;
2. tackle the inequitable distribution of power, money, and resources;
3. measure and understand the problem and assess the impact of action;

Notice that there is no mention of increasing access to psychological (or any other) thera-

pies. And while 1 and 2 are pretty challenging, at least the profession could (and in my view should) contribute to 3.

And make no mistake; the importance of this view is rapidly gaining credibility in high places. After chairing the WHO commission Michael Marmot was brought in to review UK policy (The Marmot Review, 2010). He is now doing a similar task for the European Union. We have also, as some of you will have noticed, recently had a major review of inequality in the UK (National Equality Panel, 2010).

And what role did the profession of clinical psychology play in these key initiatives? Now, given our 'explicit commitment to empirical research', I thought I'd find out (I still have a clear memory of John presenting at a King's Fund event in the eighties wearing a t-shirt with DATA NOT DOGMA emblazoned across the front ... always a snappy dresser, John). The methodology was simple. I read the reports and contacted the Policy Office at BPS High Command. The answer? Zilch.

While the British Naturist Society got off their (naked) backsides to make a submission to the National Equality Panel Review (good on you naturists), not so the BPS. No submission to the Marmot Review either (which is deeply worrying). And, to cap it all, we are being outdone by the BMA (and how embarrassing is that?) Way back in 2006 they were saying that 'the reforms outlined in the Child Poverty Review must be implemented to end child deprivation and therefore reduce risk factors for mental health problems' (BMA Board of Science, 2006).

So, while I do not recognise that past as portrayed by Richard and John, I certainly join them in lamenting the self-serving individualism that currently (and as far as I can see has always) dominated the profession of clinical psychology.

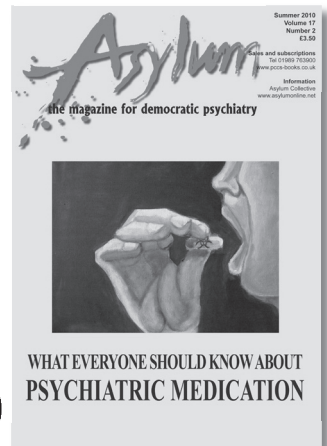
What can be done? Yes, training is important; and wouldn't it be interesting to map the curricula of our Doctoral programmes against the WHO's 'overarching recommendation? But so too is selection into training (and just about every applicant I have ever interviewed really wanted to be either Cracker or do talking therapy). Also important are

the alliances the profession builds. And, by the way, when was the last time you talked to anyone in your public health directorate?

(PS I'm also making a reasonable recovery from being a clinical psychologist, though I do have the occasional relapse.)

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Expanding what we do without getting lost: Some reflections on Hassall and Clements and the provision of psychological therapies to people who have learning disabilities

Nigel Beail

WHEN I STARTED clinical training in the early eighties the main paradigm in clinical psychology was behavioural with an emphasis on functional analysis. Most of my clinical work during training was behavioural in orientation. My learning disabilities placement was in a long-stay hospital. For my research thesis I used the behavioural models of the day to investigate naturally occurring contingencies on a long-stay ward for children who have learning disabilities.

Prior to clinical training I had been exposed to personal construct psychotherapy through my research in the civil service and I completed a training course whilst completing my PhD. When on my learning disabilities placement I was encouraged by my supervisor to provide individual personal construct psychotherapy for one client who had been admitted to the hospital. This proved successful for the client and suggested to me that psychotherapy might be appropriate for other adults who have learning disabilities. I then moved to a new placement and had a psychodynamic supervisor and also took up the option of supervision from a psychoanalyst. Then, towards the end of my training I was introduced to cognitive therapy.

My exposure to personal construct psychotherapy and psychodynamic psychotherapy led me to reflect on the internal world of my research participants who had learning disabilities; at the time I was carrying out hours of observations on the hospital ward. Oswin's (1978) earlier study inspired my own. Her research exposed that lack of

mothering given to children living in long stay hospitals; my research replicated her findings showing the children to receive very low levels of attention and poor quality interactions (Beail, 1985). I then went on to show this was in stark contrast to the levels of attention their class mates, who lived with their parents, received. (Beail, 1988). I became concerned at the lack of attention to these children's emotional needs and I became increasingly aware of the lack of psychotherapy available to all people who had learning disabilities. Also, I could find few who would take the idea of delivering psychotherapy to people who have learning disabilities seriously.

When I looked into this I found that a correspondence had been taking place in the *Bulletin of the British Psychological Society* following a symposium on psychodynamic psychotherapy with people who have learning disabilities at the BPS Conference. In one letter Church (1982), a clinical psychologist, argued that 'such therapy with these people would produce as much a useful result as an engineer using a watch maker's tools to build a bridge'. However, Chris Cullen, a clinical psychologist with considerable credibility amongst the behavioural community, responded stating 'that if it is available to the rest of the population, is there really any good reason for it not being available to mentally handicapped people?' (Cullen, 1982).

When I took up my first post as a clinical psychologist with children and adults who have learning disabilities I did not rule out offering psychotherapy. Money for posts in

long-stay hospitals was no more; I took a post in a new community learning disability team. I soon had a list of patients largely referred for behaviour modification. Behavioural work did seem to be the treatment of choice for some, but not all. Many of the clients being referred bore no resemblance to the client group I had been trained to work with. In the hospital most clients had severe and profound learning disabilities and there was an evidence base for the effectiveness of behavioural interventions. This was largely single case and you had to find papers relevant to the presenting problem. These were subsequently submitted to meta analysis but showed that the evidence base in the eighties and early nineties concerned behavioural interventions for children who had severe or profound learning disabilities, engaging in high frequency internally maladaptive behaviours in segregated settings (Beail, 2005).

Those of us working in the new community teams found we had to try and adapt this way of working to a range of community settings but also work with clients with mild learning disabilities engaging in low frequency behaviours or with problems no different to people referred to mainstream adult mental health services. We also had to face the emerging recognition of sexual abuse in the lives of people who have learning disabilities and an increase in referrals for offending behaviour.

I was one of a small group who started to work psychodynamically with some clients. Then, as cognitive therapy developed, others started to explore the applicability of that approach (Kroese et al., 1997). I would like to think that Hassall and Clements would not oppose this development in our field. But then why should they as in learning disabilities we still work with a range of models and approaches. I still work with clients who have severe and profound disabilities who are engaging in severe internally maladaptive behaviour.

My approach with these clients is largely based on behavioural theory working directly with the client and their carers. At the same time I also work psychodynamically with clients who present with severe emotional

problems, trauma or who offend. My promotion of psychodynamic psychotherapy still attracts the most scepticism, but as a scientist practitioner I have carried out practice-based research over the years hopefully to demonstrate the effectiveness of the approach. My colleagues who have offered CBT have done the same. It is interesting to note that virtually all the research on outcome for the psychological therapies with people who have learning disabilities has been carried out by clinical psychologists in routine practice (Beail, 2003).

Expanding what we do

I would like to think that delivering psychological therapies to people who have learning disabilities has been a consequence of clinical psychologists expanding what they do and not stopping doing what they did before. I would like to argue for a balance of provision in services for people who have learning disabilities. No one intervention or model has all the answers; we need a range of approaches.

However, I share Hassall and Clements concern about the wider drift towards psychotherapy in the profession at the expense of everything else in our armoury. The expansion in clinical psychology training places and the more recently investment from government in improving access to psychological therapies (IAPT) has largely gone to services for the general population. These developments have had little if any impact on the lives of people who have learning disabilities. Children who have learning disabilities seem to have been particularly neglected. Another factor which has contributed to this has been the decision to provide services to children who have learning disabilities by generic child services. This occurred at the same time that the focus of funding moved away from child development to child mental health and, within children's mental health services, the shift to therapy. Thus clinical psychologists working with children became located in child and adolescent mental health services and children with learning disabilities did not seem to fit this provision. Sadly no one else

provided anything for them. The profession has consequently become deskilled at delivering interventions for children who have learning disabilities. Urgent action would need to be taken to rectify this.

I agree with Hassall and Clements that the broader range of needs of children who have learning disabilities are being neglected. As they point out, research on behaviours that challenge has promoted the early intervention approach. Sadly, I see young people who come into adult services who have had no effective intervention for their behaviour and families who are doing their best to cope. My colleague's express their frustration at the lack of appropriate psychological work when they were children, but children who have learning disabilities are also excluded from psychological thera-

pies such as cognitive behaviour therapy. To me this is equally scandalous. If children are children first and 'every child matters', then they should have the same right as all children in society. Thus we should be training clinical psychologist to work with all children and all adults and there should be services provided to all children and adults.

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Clinical psychology getting lost? Accident, strategy or symptom?

Jan Burns

THE QUESTION 'has clinical psychology been losing the plot?' begs the response 'did it ever have a plot in the first place'? To get to this place in the unfolding story of our profession the authors provide a history of our travels thus far. I have to say that it is not one that I feel particularly comfortable with as it does not accurately reflect my reading and, later, my experience of the history of our profession. Firstly, it suggests a creeping individualism and focus on psychotherapy which has culminated recently in the domination of CBT, squeezing out and obliterating all other forms of clinical psychology. Whilst I feel a certain sympathy and frustration with what feels to me a preoccupation with the current foregrounding of CBT and general adult mental health, I feel this is not the whole story and I can look around the landscape of our profession and see many other communities alive and well. It is perhaps a matter of where the public gaze is most often directed rather than one of inactivity. But, just to return to the history, I have two issues, one being the suggestion that psychotherapy has not always been a travelling companion of clinical psychology and the second a rather 'rose-tinted' view of the 'good old days' when learning theory was central to the profession and all was fine.

Firstly, regarding the companionship of psychotherapy and UK clinical psychology, this relationship has not always been easy and in some ways each has grown in relationship and tension to each other, but historical accounts would suggest that the debate over this relationship has loomed large since the early developments of the profession (Lavender et al., 2002). It may also be argued that individualism has always been at the root of the profession with an early definition of clinical psychology, attrib-

uted to Bruce Witmer in 1907, being 'the study of individuals, by observation or experimentation, with the intention of promoting change' (Compas & Gotlib, 2002).

Secondly, one might ask 'what has learning theory done for us as a profession?' Whilst I agree that it may have contributed a lot in helping to determine the profession as evidence based and driven by well-articulated theory, the application through behavioural interventions has not always shown clinical psychologists in their best light nor always treated disadvantaged, minority groups, especially people with learning disabilities, in the best ways. I can remember a time, with the rise of Normalisation, when clinical psychologists within the field of learning disabilities were seen as major contributors to the poor state of affairs, and the revolution was certainly not coming from our profession, but despite our profession.

Interestingly, the arguments put forward remind me a little of Eysenck's influential text of 1948 *The Uses and Abuses of Psychology*, which firmly positioned psychology within learning theory, being fiercely critical of psychodynamic psychotherapy and soundly beating the drum of positivist 'science'. The difference with the argument set out in this paper is that, unlike Eysenck, the authors strongly call for the social context to be taken into account and rightly so. However, they perhaps do not give enough credence to the impact of critical and community psychology is having on training our profession. It is my experience that newly qualified clinical psychologists are extremely well versed in a social understanding of distress and the dangers of individual pathologisation, and are well able to critique the sources of our evidence. I agree that there is a problem of how this then gets enacted within practice in

the NHS. Our health services are provided in a current context of economic restraint ruled by certain sorts of evidence being acceptable, translated through NICE guidelines. This is unlikely to change, so perhaps we need to add two further competencies to the portfolio of clinical psychology, namely basic health economics and how to influence NHS policy.

I have to respond to the comment on *New Ways for Working* in relation to the training model. I wholeheartedly agree about the 'silos' of applied psychology and this position is reflected in recommendation 4, 'The applied Divisions and their training committees should explore jointly areas of their curricula where generic or unified training might be feasible' (BPS, 2007, p.2), and the models put forward suggested either a one-year or a two-year generic training. To my mind, had this proposal been taken up it would have significantly changed the boundaries of applied psychology.

Finally, to training clinical psychologists to work with people with learning disabilities. I too share some concerns about the future of services and the dangers of merging specialist learning disabilities services with generic CAMHS and adult services, but for different reasons.

Fundamentally, I do not see it as a coherent model that we pick out people with learning disabilities as a completely different group of people and order our training largely around a developmental model of children, adult and older people and then add on people with learning disabilities. This serves to 'other' and pathologise, suggesting that what might be appropriate to the majority might not be appropriate to people with learning disabilities. This includes therapy, where many people with learning disabilities have been excluded access for a long time, and here I would point specifically to family and systemic therapy. Whilst arguments might rage about more environmental and social interventions versus individual psychological Elastoplasts, the therapeutic hinterland of the person and his or her family has been too long neglected.

Nevertheless, given the way that our cur-

rent society and services work I would be naive to believe that the best services are going to be delivered through integrated services. Currently, the sources of distress and needs of people with learning disabilities are not going to be best met by services that do not value these people, were not originally set up to service them, lack experience and are unlikely to be influenced by a weaker 'users' voice. Would it be too much to suggest we push for specialist services for specialist needs whilst also keeping open generic services for generic needs?

In terms of training the issue of 'learning disability' placements is a familiar one to course directors. However, the evidence presented does not stack up in relation to the arguments articulated. The essence of the argument goes like this: now that learning disability placements are not compulsory, fewer people will do them, hence fewer people will enter the specialty, and also if you do not do a specific learning disability placement you will not acquire the necessary competencies. The competency model has been in place for over a decade now. In my experience if there are good learning disability placements available programmes will use them, placements are in too short a supply not to. What the competency model has allowed us to do is expand our numbers and not be held back due to a shortage in one specialty. Surely more numbers are a good thing? What it has also allowed us to do is provide some quality assurance and allow us not to use placements that do not come up to the quality required. In terms of what gets people to enter the speciality evidence suggests that a bad experience on placement is likely to put people off entering that speciality (Roth et al., 2001). Through the competency framework, now regulated by the HPC, it is not possible to complete training without gaining competencies of working with people with learning disabilities, surely to be able to ensure that this is a positive and inspiring experience is better than pushing all people through a placement of an arbitrary length which will vary in quality. It is also not my experience that trainees try and avoid learning disability experience, indeed

over recent years it has been difficult to find enough jobs for all those within my local region wanting to enter the specialty. To also add further evidence to the myth that you always need core placement experience to build and maintain a specialty, clinical health psychologist is now the fourth largest speciality, closely following learning disabilities (BPS, 2005), given very few people experience a health psychology placement whilst training, how has this occurred? I would offer a different formula to getting newly qualified people into posts:

- a) they get good quality and inspirational clinical experience (though a placement or integrated experience) and likewise

teaching;

- b) there are ambassadors on the programme team to push the specialty and supervise research (another extremely useful way of building clinical experience and understanding);
- c) there are also jobs at the end of training in functional teams with good supervision.

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Clinical psychology and intellectual disabilities: A promise never kept

Peter Sturmey

IN 1978 I was excited to take an undergraduate behaviour modification class and learned that psychology studied learning and developed interventions based on learning theories. The next year I took an undergraduate mental handicap class and did a final year project on staff-resident interactions in a local mental handicap hospital. Between 1980 and 1983 I then did a research PhD on training staff to run activity periods for adults with severe and profound intellectual disabilities and learned how readily behaviour was a function of the social environment. I concluded that psychology had a powerful understanding and technology of behavior that could help people who were disadvantaged and discriminated against lead better, happier more independent lives.

Imagine my disappointment when, as a student on a clinical psychology Masters program between 1983 and 1985, I learned that clinical psychology had already become something different. Classes claimed that clinical psychology was unlike other applied mental health disciplines: it was supposedly scientifically based, empirical and its practitioners were research-practitioners. Yet on placement practitioners were already abandoning evidence-based practice, such as exposure therapy and social skills training, to engage in more convenient, office-based, wasteful and ineffective talk therapies such as psychotherapy and play therapy; indeed clinical training in such inappropriate activities was abundantly available and encouraged as examples of theoretical and clinical flexibility. Supervision was also verbal and office-based: rarely did any supervisor observe me work or give me any effective training in evidence-based professional skills, but we did have some very cosy chats over departmental coffee where I told supervisors what I thought

I may have done with clients; they seemed quite impressed and gave me good grades for my verbal behavior.

Applied Behavior Analysis (ABA) was allegedly part of clinical psychologist's skill set, although in the United Kingdom it was more commonly referred to as behaviour therapy or behaviour modification. Unfortunately, it was typically taught as a rag-bag of therapeutic tricks and techniques, but with little or no references to behaviorism or its scientific foundations. I recall receiving a 10-hour class on behavior modification that did what it could. (My current Masters and Doctoral students receive approximately 90 hours of theory classes and hundreds of hours of practicum in their first year of study.)

Dissatisfied with both British clinical practice and professional training I moved to the USA 20 years ago and for the last 10 I have taught mostly graduate classes in ABA, driven largely by the demand for effective services for children with autism. So, for the last 20 years I have observed British clinical psychology at a distance, interacting with many British colleagues along the way.

Not enough practitioners then and now

From the beginning it was clear that clinical psychology professional training did not meet service needs. Most districts had one or perhaps two clinical psychologists in Intellectual Disabilities and a number of vacant posts, and sometimes a small army of eager psychology assistants doing the day to day work. Many districts had lone practitioners swamped with too many difficult referrals or at liberty to indulge their professional whims. Despite calls to arms to train more practitioners, clinical psychology training has never responded effectively in 30 years; indeed its abandonment of required training

in learning disabilities probably makes things even worse.

Currently, some districts have modestly adequate number of clinical psychology practitioners, at least some of the time. Many have few and some have none. Here and there are clinical psychology services for people with Intellectual Disabilities – either in house or contracted out – that do make a difference in the daily lives of some people with intellectual disabilities. Many of these services, though, are reliant on one or two key practitioners and so are fragile and fall apart when these people leave. But when I talk to some British service providers they sometimes tell me that they rarely see clinical psychologists and, on the whole they do not miss them. The insistence of some practitioners to engage in oddball professional activities, such as attempting to engage adults with profound intellectual disabilities in psychotherapy and their inability to have any significant impact on the large numbers of problems at great cost, undermines their credibility and, frankly, just makes clinical psychologists not worth the effort and cost for many services; in any case, the money from vacant positions can often be spent on productive staff.

The consequences for clients are severe. Few British clients with Intellectual Disabilities now receive the basic ABA services such as training in important life skills, functional assessments and analyses and effective ABA interventions for behavioral and psychiatric disabilities. (*Pace*, eager critics, yes, skills alone are not enough for a better life, people need opportunities and well run services too to provide opportunities.) Instead, too many clinical psychologists retreat to their offices to talk to clients with a few clients with mild intellectual disabilities, go to many seemingly important meetings and abandon clients with more severe disabilities who cannot participate in office-based verbal therapies. A recent analysis of the use of personal and mechanical restraint and PRN medication in some contemporary British community settings indicates that such inappropriate practices are common (Sturmey, 2009) and two Healthcare Commission (2006, 2007) investigations confirm that this

also occurs in trusts within failing services. This reflects many things, but in part, the absence of effective clinical psychology practitioners (Healthcare Commission, 2006, 2007). Psychotropic medication, though disavowed by some psychiatrists for the treatment of severe behavior disorders, continues to be doled out liberally in British community settings, again in part, reflecting the absence of available alternate interventions.

The impact on the profession of clinical psychology is also severe. A weak or absent clinical psychology service opens the door for others to step in and they have eagerly done so. Twenty years ago British psychiatry and intellectual disabilities was weak and in disarray. The Royal College of Psychiatrists stepped up to the plate, established chairs of psychiatry and intellectual disabilities throughout the country, increased training requirements and promoted research in intellectual disabilities. A good example of the impact of this strategy is that the most recent interesting evaluation of community-based behavioural interventions does not come from clinical psychologists – who had been running community behavior support teams for over 20 years without convincing experimental research validating their practice – but from psychiatrists and community psychiatric nurses (Hassiotis et al., 2009).

Where was the profession of clinical psychology in the current community scandals in Cornwall and South London? The Healthcare Commission (2006) noted that in Cornwall there was only one psychologist in post when the BPS recommended rations would require eight positions. They noted that ‘clinical psychology was very limited’ (p. 35) and ‘Staff ... did not welcome ‘outsiders’, such as psychologists ... The clinical psychologist was also concerned about the way in which staff responded to a person who was exhibiting challenging behavior. However, he did not raise this concern with the appropriate managers as he did not believe they would take action’ (pp.31–32.) Clinical psychology receives a more positive review in the Sutton and Merton primary trust investigation – at least they could implement

restraint fading (Healthcare Commission, 2006, p. 4) – but the lack of services was again a common theme.

Clinical psychology will never deliver

Professional training in clinical psychology training has been aware of this problem for at least 30 years: it has never made any effective response. Periodically crises are declared, there are special issues of journals and nothing much happens. Clinical psychology professional training is managed largely by academics working in acute adult mental health and that is where their interests and priorities lie. The current movement to roll out evidence-based practice has stimulated still further interest in training clinical psychologists as purveyors and managers of psychotherapy for acute adult mental health, but not in learning disabilities services. Currently, NICE has not identified and promoted any evidence-based practices for people with intellectual disabilities, reflecting their inappropriate exclusion of small *N* experiments, even though most other standards for evidence-based practices include them (Chambless & Hollin, 1998). So, again there is little external pressure to adopt evidence-based practices.

Many service managers are unaware of the potential impact of clinical psychology

on their clients' lives. Most have not seen a good clinical psychology service and so do not know what they might be missing. In any case, from their side of the desk, the world consists of budget crises, staff shortages and many important meetings. Clinical psychology is but a blip on a distant horizon overshadowed by real and immediate threats.

Clinical psychology could improve its impact in a number of ways. It could reinstate training requirements during initial professional training and through required continuing education for practitioners in Intellectual Disabilities. It could take the model of the Royal College of Psychiatrists and establish centers of excellence in clinical psychology and Intellectual Disabilities headed by researchers and scientist-practitioners as regional centers for training and consultation. The failure of the profession to act over 30 years and the current economic climate make such possibilities unlikely.

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Glory days and the future of clinical psychology: A reply to Richard Hassall & John Clements

Tony Lavender & Roslyn Hope

JOHAN CLEMENTS and Richard Hassall offer a thought-provoking analysis of what they see as the rise and demise of clinical psychology as it 'sold out' to psychotherapy. Both the profession and the NHS appear to get blamed for this state of affairs. Whilst reading the article the Bruce Springsteen song 'Glory Days' kept coming to mind in a rather tormenting manner. Glory Days is about what can happen to people as they get older and tells the story of a guy who meets up with pals from the past and in spite of themselves find that they 'had a few drinks and all they kept talking about was glory days' (Springsteen, 1982).

The NHS

As far as historical analysis goes, the history of British clinical psychology has been closely interwoven with the history of the NHS from the start and since has certainly heavily influenced the development of clinical psychology (Hall et al., 2003; Pilgrim & Treacher, 1992). The roots of British clinical psychology were grounded in the Maudsley Hospital around the time of the formation of the NHS in 1948. From that base Eysenck (1949) spelled out his vision for the development of clinical psychology. As Pilgrim and Treacher point out, Eysenck saw the role of the clinical psychologist as occupying a place between the roles of the psychiatrist (therapy) and social worker (working on social issues) and whose role was to provide diagnosis (personality-based assessment) and research.

For Eysenck there was no place for therapy mainly because the most influential therapy available at that time was psychoanalysis or psychoanalytically informed psychotherapy about which he had little good to say

(Eysenck, 1952). He also spelled out a vision for clinical psychology about which Hassall and Clements (and we) almost certainly would disagree: that is, 'clinical psychology cannot go where social need requires. A science must follow more germane arguments than the possibly erroneous conception of social need' (Eysenck, 1949).

In those early years two circumstances had a profound influence on the development of clinical psychology. First the emergence of behaviour therapy (late 1950s and 1960s), based on experimentally derived psychological principles of learning theory (Skinner, 1953) and the outcomes of which could be evaluated scientifically. The success of the interventions indeed prompted Fromm (1970) to write *Crisis in Psychoanalysis* as people with psychological problems, thought to be 'untreatable' began to respond positively to behaviour therapy. Second, the development of the NHS as the main employer of clinical psychologists (on Whitley Council terms and conditions, first negotiated and agreed in 1957). In the NHS psychologists were inevitably led into trying to address social familial needs as many of the psychological problems they encountered appeared to arise because of social and familial difficulties.

Confronted with these often complex psychological problems psychologists responded by using behaviour therapy, and indeed other psychological therapies (e.g. person centred, personal construct) to help solve the problems that they encountered in the organisation in which they were employed (the NHS). Thus the influence of the NHS on clinical psychology is therefore not new, as Hassall and Clements imply, or only

recently related to therapy, but has been there from the outset.

Only psychotherapy

The response of psychologists in the past (as acknowledged by Hassall and Clements) was not limited to 'psychotherapy' but neither has it been in recent years. They recall a past where psychologists responded to the needs of people with learning difficulties, dementia and long-term neurological problems with a commitment to empirical research, scientific methodologies and psychological analysis. Yes they did, but again there are many still doing so; in fact, numerically there are far more now than there were in the past. The survey of psychologists in Health and Social Care found that 11 per cent of the 3360 psychologists' time was spent working with people with learning disability, 6.3 per cent with older people and 5.4 per cent with people with neuropsychological problems (Lavender et al., 2005). Indeed most of the good practice examples in the New Ways of Working team working report by Steve Onyett were concerned with psychologists working with seriously disadvantaged groups of people (BPS, 2007). It is tempting to produce a massive list of psychologists who have, and still are making, significant contributions to seriously disadvantaged groups and to non-psychotherapy oriented work, including social inclusion, recovery, user and carer involvement, consultation work with teams and organisations and dementia services, to name but a few areas that in recent years have been the subject of articles in *Forum*.

Psychotherapy and empirical evidence

There is an implication in the article that alongside the adoption of psychotherapy there has been an abandonment of empirical research and scientific method. In the early years, as psychologists struggled to address the needs of their clients, they did turn to other therapies including person-centred (Rogers, 1961), personal construct based therapy (Kelly, 1955) and these were added to in later years with cognitive therapy (Beck, 1975) and other brief psychodynamic

therapies (Malan, 1979). Empirical research was not, however, abandoned alongside these developments. Indeed, Roth and Fonagy's (2005) critical review of psychotherapy research shows that many psychologists have made a substantial contribution to the empirical evidence base. Further, psychologists have played a significant role in both the development of evidence and the use of that evidence to inform policy and service developments on a national scale (Clark et al., 2008).

It is also important to point out that psychologists have remained amongst those dissenting voices. Richard Bentall (1990, 2004) and Mary Boyle (2002), in the field of psychosis, have had considerable influence on the practice of psychologists and the wider thinking about the appropriateness of diagnosis. They have also been influential in the development of psychological therapy for people with psychosis, with its emphasis on working with specific experiences/symptoms (Fowler et al., 1995). There are plenty of other examples of psychologists both paying close attention to dissenting voices and continuing to approach problems and develop evidence using psychological theory and scientific methods.

The continuing tension

Hassall and Clements do point out very clearly that there is no room to be complacent and indeed the above is not intended to be an overly defensive response - an accusation sometimes aimed at psychologists. They raise a number of significant problems with which psychologists need to continue to struggle. To name but four:

1. The continuing domination of medical diagnostic systems with its explicit acceptance of the predominance of genetic, biochemical and neuro-anatomical explanations and chemical interventions. The revision of *DSM-IV* threatens to extend these categories to an increasing area of our lives (Wykes & Callard, 2010). Indeed the acceptance of categorical over dimensional ways of classifying our psychological worlds remains problematic. It would seem that

our way through this is to place increasing emphasis on psychological formulations (Kuyken et al., 2009) rather than diagnosis.

2. The context of the NHS is dominated by the medical model, albeit with an increasing acceptance of both psychological and social explanations about the aetiology of 'mental health problems'. However finding ways of increasing the acceptability of psychological explanations and the accessibility of psychological interventions remains a challenge.
3. There is a need to continue to develop and evaluate a broad range of psychological work, beyond psychotherapy including work with families, organisations and communities.
4. Finally, there is a problem for people with a learning disability in accessing psychological care when many of the services for those people have moved away from the NHS. The private, local authority, charitable and social enterprise organisations that now provide these services have created few positions for clinical psychologists and psychologists have been reluctant to move away from the NHS. There has undoubtedly also often been a level of uncertainty about the future of these services which has added to the

difficulties. Burns takes up these issues in her contribution to this special issue and it has meant training courses have experienced difficulties finding placements in learning disability.

Conclusion

Whilst there are some points of disagreement with Hassall and Clements, we have a great deal of sympathy with the spirit of their challenge to clinical psychology. It must continue to offer services beyond just psychotherapy and we hope that they could agree that the purpose of applied psychologists, as expressed in the New Ways of Working report, is 'to improve the psychological wellbeing of the population through working with individuals, families, teams, organisations and communities'.

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Mixing radical protest with Eysenckian angst: A reply to Hassall & Clements

David Pilgrim

THERE IS NEVER a bad time for professionals to reflect on their role, but this is a particularly good one for British clinical psychology and Hassall and Clements have presented us all with a useful provocation. They are correct: the profession has become a psychotherapeutic one; but whether that is seen as a good or bad outcome depends on where one stands. The original ambivalence (or duplicity) from Hans Eysenck reminds us, even today, that psychologists, particularly in the tradition of naive British empiricism, are not sure whether they want to help people or understand them.

The first requires an active human engagement with patients in an empathic leap of compassionate identification, whereas the second can still frame them as objects of inquiry, with the seduction of deluded disinterested objectivity and comfortable personal protection. Eysenck (1949) initially favoured the second course but from expediency, and probably some collegial pressure from those psychologists like Monte Shapiro, who actually saw patients, turned to the first approach within a decade (Eysenck & Gwynne Jones, 1958).

One reading of Hassall and Clements stance is that they are returning to Eysenck's original ambivalence as a conservative professionaliser. In this sense, little has changed. British clinical psychology has made its bed of naive empiricism and now it has to lie on it. When Hassall and Clements lament the profession's declining interest in 'environmental determinants of human behaviour', the phrase has more than a residual whiff of confident scientific positivism, complete with their disdain for Continental models like psychoanalysis (cf. Eysenck, 1952)

However, Hassall and Clements' article

can also be read as more than neo-Eysenckian angst. They now protest about the professionalisation of psychological therapy by psychologists, whereas Eysenck himself led its original charge (provided of course that behaviour therapy defined its legitimate limits). In the 1950s, with a post-War metropolitan British culture being rejuvenated by conservative émigrés like Eysenck, the problem of atheoretical empiricism, without a capacity for personal and social reflection, had come home to roost, leading to the paradoxical situation of the need for foreign intellectual labourers to reinvent its conceptual justification (Anderson, 1969). We now have its legacy: mindless behaviour therapy, without a trace of irony now called the 'first wave' of cognitive behavioural therapy, and its lineage of magpie eclecticism and pragmatic meandering.

Notwithstanding their forgivable scientific allusion to 'environmental determinants of human behaviour', I presume that Hassall and Clements' insistence on attending to the 'messy' difficulties, such as chronic mental health conditions, the elderly (*sic*), and many others' reflects a goal which Eysenck would not recognise, with his blinkered scientific curiosity about embodied examples of 'abnormal psychology'. The groups of patients seen by clinical psychologists are disproportionately poor and oppressed. Not only are they socially marginalised, they defy the 'inverse care law' that the poor usually have the least access to healthcare (Tudor-Hart, 1971).

Seeing NHS patients from deprived backgrounds with complex problems and ongoing conditions of daily adversity can create a sort of bemused paralysis for practitioners. As one colleague, now retired, said to me a few years ago in this recurring

scenario 'CBT that one!' (Guinan, 1998, personal communication).

And talking of the NHS, I am not sure what Hassall and Clements want to recollect about its influence. Yes, it has been the dominant shaping force in British clinical psychology and certainly the NHS and Community Care Act (1990) ensured a robust cultural separation of the burdensome welfare-dependent patient with chronic problems (*them*) from the acute patient as a worthy choosing consumer (*us*; see Carpenter, 2000). However, structures (such as mental health Trusts) remain part of the NHS and the funding arrangements for clinical training were linked to other NHS structures (especially Regional Health Authorities) in the 1970s and 1980s. (What is to happen to that tradition now in the context of financial retrenchment is a topic for a separate paper, probably, as I write, being submitted by someone to CPF.) There was never a golden age of full collective autonomy for a profession that has more than others followed the contours of the NHS in the past 60 years.

What Hassall and Clements correctly highlight, though, is the tension between labour discipline and professional autonomy, especially the value the latter places on critical intellectual thought. NHS clinical psychologists are agents of the state and so must comply with the state as an employer, including, for now, being obliged to sacrifice their stimulating and pluralistic training at the altar of IAPT and 'stepped care'. Professions are Janus-faced switching, depending on the context, between self-interest and progressive critiques on behalf of others.

To be a wage slave in the technocentric world of IAPT might be a necessity to pay the mortgage for those entering the profession, but my impression, when teaching these newcomers, is that many of them understand and resent that grey compromise. My hope is that their efforts at critical resistance will be a corrective to the one dimensional world of CBT that tolerates a limited pluralism on the supply side (you can practise first, second or third waves, though preferably the first two!) but is less amenable about diversity on the

demand side, with its range of 'messy' difficulties and variegated cultural requirements (Pilgrim, 2009). Indeed, if young clinical psychologists do not resist this new order then they will, in my view, not only put the whole future of their profession in jeopardy, they will break their alliance with the oppressed groups Hassall and Clements are keen to foreground in their paper.

Finally, I note the problem that the legacy of the 'medical model' has, according to the authors, continued to pose for clinical psychology. Naive empiricism has left clinical psychology with no consistent alternative (because conceptual critique requires confidence and competence in critical reflection, not an acceptance of concepts left to us by those with the power to do so). In psychology, it is still the case that the case has to be made to reject categorical descriptions in favour of context-dependent formulations. If we now find ourselves having to sell the principle of formulation within our own ranks (whether to trainees or experienced practitioners) and to reject psychiatric categories, then something is seriously amiss (Carey & Pilgrim, in press). Those academic clinical psychologists who have built their careers on research about CBT 'for' 'depression', 'schizophrenia', 'PTSD' or any other discreditable putative neo-Kraepelinian 'natural category' of psychopathology, have made their particular contribution to this sorry manifestation of intellectual laziness (Pilgrim, 2007).

My second and final reflection is that clinical psychology is not the only profession in crisis and going through a period of soul searching. The same could be said of psychiatry (Pilgrim & Rogers, 2009). Recently I presented a paper at the Royal College of Psychiatrists and noticed that many of them are now acknowledging that the game is up about unassailable medical expertise. Might the new order of IAPT lead the profession by the nose into a cul-de-sac, in the same way that the conservative wing of psychiatry has dug itself into the black hole of bio-determinism and the false dawn of the technological fix (Moncrieff, 2008)?

Maybe clinical psychology might again look to medicine for some ideas, but this

time with good reason. We do not have the baggage of the drug companies or bio-determinism but we have an equally disabling legacy dominated by naive empiricism, short-term pragmatism and a fear that examining our own social context might in some way undermine our scientific integrity and plausibility. Hassall and Clements have done well to challenge this fear and encourage a dis-

cussion about the future of the profession (if it has one).

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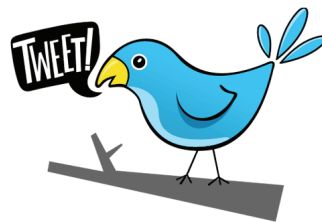
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Response of the Midlands Psychology Group to Hassall and Clements

Midlands Psychology Group

HASSALL AND CLEMENTS are very kind in attributing to clinical psychology a past in which it sought to develop its role by 'asserting its own purpose and identity', arriving at 'an astonishing achievement, built on an explicit commitment to empirical research, scientific methodologies and psychological analysis based on mainstream psychological understandings, especially learning theory'. Although we would not want to dispute this view in every detail, and while we would certainly agree that clinical psychology has in the past made its most valuable contributions in working with people with learning difficulties, children, older adults and so on, there is all the same a less heroic tale to be told of how this all came about, how it changed and how it is further changing now (see, for example, Smail, 2006). We do not wish to rehearse the details of that tale again here, but it can be summed up as the quest of clinical psychology to align itself with what it saw, and sees, as the ruling discourse of the times, whether 'scientific', professional (therapeutic) or managerial (Midlands Psychology Group, 2010).

It is no doubt understandable – even necessary – that clinical psychology in Britain should always have kept a vigilant eye on the source of its bread and butter, which in practice has meant serving, or at the very least appearing to serve, the powers it identified as essential to its survival. There are thus powerful environmental reasons why clinical psychology has gradually turned itself into a kind of neo-astrology, replete with untested assumptions and fake constructs, all based on an essentially oppressive authority. Indeed, the intellectual flaccidity of the dominant 'therapeutic' model of CBT is positively embarrassing to those of us who were brought up to aspire to a scientific account

of the relation between people's subjective experience and the world they live in (Moloney & Kelly, 2004). This model is not just irrelevant to groups such as those with learning difficulties: it is simply untenable in every aspect save that of self-interest.

We have documented our unhappiness with and critique of this state of affairs in a previous special issue of *Clinical Psychology Forum* (CPF162) and it would be superfluous to reiterate the arguments here. More relevant, perhaps, though certainly not easier, is to consider whether clinical psychology could indeed now find a way of 'asserting its own purpose and identity'.

Hassall and Clements identify four bullet-pointed areas in which they see beneficial change as possible. We would not disagree with the desirability of these, but as always, making a diagnosis is much simpler than effecting and maintaining structural change.

Making learning disability placements mandatory during training might be the least difficult change to make. It would have the merit of recognising that there is no substitute for experience and that the gobbledegook of 'core competencies' etc. owes everything to business-management-speak and nothing to psychological reality. Exposure to the actual environments in which people struggle with health, emotional, social and practical difficulties should certainly take precedence over authoritarian instruction in the unsubstantiated doctrines of CBT and the associated 'therapeutic' notions which it engulfs as it seeks to absorb the competition.

The other steps suggested by Hassall and Clements are likely to be more difficult to achieve because they challenge the interests either of competing groups, some within psychology itself (e.g. health psychologists, counselling psychologists), or of altogether

more powerful political and managerial groups whose concern is with anything but the elaboration of a scientific demonstration of the environmental origins of so much of the distress we deal with. The looming 'reform' of the NHS will, to put it mildly, throw up some interesting challenges to anyone trying to establish reasoned alternatives to the profitable sale of packages of 'treatment'.

The idea that university departments might come to our rescue by developing appropriate research programmes and providing a 'renewed intellectual lead' overlooks the fact that they are subject to exactly the same business-based constraints as the rest of us. Academic psychology is increasingly driven by crude quantitative measures (journal impact, grant income, h-indices) promulgated by managers who, ever more often, are not themselves academics. These measures favour shallow empiricisms, the reductionism of neuropsychology and the impoverished 'theorising' of cognitivism. Interdisciplinary and theoretically-informed research is being marginalised, and sub-disciplinary boundaries (e.g. between social and biological psychology) hardened. The ensuing intellectual vacuum is being filled by specious micro-paradigm wars and an overweening concern with the purely technical aspects of investigation, wherein precisely how a question is addressed matters far more than its wider social significance. Hence, the university departments – albeit somewhat unwillingly – have actually helped create the predicament in which we find ourselves.

The intellectual basis of clinical psychology, woefully depleted over (at least) the past two or three decades, needs to be repaired and expanded. Trainees, at present for the most part drilled in the simplistic and embarrassingly naive routines of 'cognitive behaviourism' need a developed awareness of the history of psychological and related disciplines and the problems these have always encountered with trying to establish the 'perfectibility of man' (Passmore, 1970). They need to develop their critical faculties and to be encouraged to challenge the received notions of the status quo as well as to initiate research into the inevitable questions their

clinical experience, which should be as wide and intense as possible, will throw up. Creativity and originality should be valued way beyond conformity to altogether doubtful 'professional' standards. Understandings of 'clinical' problems, let alone solutions to them, are far from having been established, and it must surely be the central task of clinical psychology to investigate the issues intelligently rather than to promulgate half-baked solutions in order to satisfy a spectacularly ill-informed market. It is essential that training courses in clinical psychology grasp the initiative and ensure that critical reflective enquiry is embedded in the future development of our profession, otherwise our days as a professional discipline are numbered.

Where techniques or procedures can be demonstrated to be helpful, they should be pursued with courage and tenacity as they will often challenge established interests (e.g. drug companies, other professional groups).

The development of a profession such as this would require enormous skill in diplomacy and Realpolitik on the part of its leaders as well as knowledge and wisdom: qualities that are perhaps only rarely found amongst the members of a small and not hugely significant profession. Above all, perhaps, would be the ability to keep sight of what is desirable while settling for what is possible without resorting to self-deception. It may be, for example, that head-on confrontation with the wrongheaded, politically uncongenial but powerful interests that control our profession would constitute professional suicide, but this should not mean that we have to convince ourselves of the validity of the nonsensical ideas we have to appear to tolerate.

It may be that Hassall and Clements, in their wish for us to assert our own purpose and identity, are asking more than can reasonably be hoped for. But maybe there are one or two things we can do before succumbing to the impotent handwringing which may indeed eventually be our lot. One is to identify and form association with like-minded colleagues: one of the very few powers available to people in our situation is that

of solidarity. Our own Midlands Psychology Group is a modest example. Another is to recognise that psychologists are part of a democratic structure which can be influenced and shaped: the British Psychological Society is not an inexorable power which determines our professional fate, but an established, relatively (to the individual) powerful institution that is constitutionally open to the political activity of its members. If, for example, we don't like what the DCP

is doing, we can form alliances to influence it.

The Midlands Psychology Group

The members of the Midlands Psychology Group are Bob Diamond, John Cromby, Paul Kelly, Paul Moloney, Penny Priest, David Smail and Janine Soffe-Caswell.

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Connecting for Health: Request for Volunteers

Connecting for Health, one of the groups responsible for implementing NHS patient record systems, is in the process of creating standardised clinical content for IT systems.

This work is being carried out by a large group of clinical staff who act as either subject matter experts, peer reviewers or clinical leads for a particular specialty.

The team at Connecting for Health running this work are very keen to have more Allied Health Professionals available to engage in this work as a number of the areas they are covering are pertinent to the activities of AHPs. Currently most of the work is being decided by Nursing colleagues.

If you are interested in participating, please contact Dr Adrian Skinner, Chair, DCP Informatics Subcommittee at adrian.skinner@nhs.net in the first instance.

Finding clinical psychology (again)

Derek Mowbray

HASSALL AND CLEMENTS suggest a widespread debate about 'whether the therapy mission can sustain clinical psychology in the future'. This paper is a reflection on the steps I, and others, have taken since the clinical psychology profession took the money and ran after the MAS Review (1989) without implementing the justification behind supporting its continuation and expansion. Those responsible for the future of clinical psychology couldn't see that the strategic professional self interest would be best served by meeting the public interest in improving health. This meant an expansion from the narrow confines of clinical therapeutic activities – hence the need for greater numbers of psychologists, and a sharing of level 2 skills with other disciplines to cover the demand, thereby releasing level 3 psychologists to focus on the complex issues of health.

The plot was lost the moment the MAS Review was published. As one of the eight 'best' pieces of research conducted in the 1980s (*The Psychologist*, 1990), it is possible to imagine the results might feature high on the scientific-practitioner's implementation list. The fear that this would not be the case was explained in 'Derek Mowbray: Turbulent visionary' (Kitzinger, 1989) and 'Towards a College of Healthcare Psychology?' (Mowbray, 1991). Two years after the MAS publication virtually no progress towards implementation had taken place (Kat, 1991). In 2002 Gray and Cate (2002) discovered the vacancy level for clinical psychologists was 17.6 per cent, not a million miles away from the vacancy level of 20 per cent in 1989. The gap between demand and supply was a principal reason for the work of the New Roles Project Group (2007a). Twenty years after the MAS review I wondered what had gone wrong (Mowbray, 2008a). The MAS Review was a 'big picture' review; it spoke to those who

could see the wider landscape; it was interpreted by those who couldn't or wouldn't.

At this point I am reminded about what happened to Martin Baro whose view that

Psychology must stop focusing attention on itself, stop worrying about its scientific and social status, and instead propose an effective service to the needs of the population.

In the year of the MAS Review Baro was taken into the quadrangle of the University of Central America and executed (Thomas, 2007).

Context is everything

The flipside of Hassall and Clements's description, in the 1980s, of 'the profession being taken sufficiently seriously for a significant review to be commissioned which led to the MAS Report' was a growing unease about any future for clinical psychology. Psychological scientific advances, compared with others applied within the NHS, were relatively slow, and psychologists were seen then, as now, as a significant cost to the taxpayer without a corresponding benefit. There was a shortage of clinical psychologists, apparently caused by the lack of training places, and a substantial amount of psychological therapeutic work was being undertaken by unqualified psychology and other staff (Parry 1989). In addition, the attrition rate, whilst low, combined with 18 per cent of newly qualified clinical psychologists not taking up posts in the NHS, contributed to a threat of extinction as losses were not being replaced quickly enough for the numbers to grow in real terms to meet the demands for more services. Watson (2003) reckoned that by 'the 100th anniversary of Freud's death, in 2039, psychology, like him, would be six feet under' unless something dramatic happened to restore the fortunes of the (wider) profession; and he

was writing 14 years after the MAS review publication. The scene was already set in 1988 that psychotherapy could be performed by non-psychology staff. The case for more psychologists was in danger before the review commenced, despite the increasing number of new established positions being created in the full knowledge that there were no clinical psychologists to fill them. There was a question as to whether it mattered if clinical psychologists filled these new positions, as there was widespread uncertainty about what clinical psychologists actually did. I would argue that the answer to that question arrived in the post in the 21st century with the Improving Access to Psychological Therapies initiative.

The plot

The outcome of the Review of Clinical Psychology Services (MAS, 1989) was my attempt at elevating the significance of psychology applied to health in the eyes of both psychologists and those who pay for their services. There was ample evidence to support this position (see, for example the first comprehensive review of the efficacy of clinical applications of psychology; Appendix MAS Review; Watts 1989), although, interestingly, some clinical psychologists criticised the methodology of the study (revealing a narrow appreciation of the range of research methodologies) whilst applauding the result.

The focus, however, was not only on psychological therapies. The focus was on wider issues relating to health and healthcare, combined with, as I saw it, a need to capture the responsibility for supervising the application of psychological theories and principles by others, and to take a leadership role in all aspects concerning psychology applied to health.

This clearly meant raising the psychological head above the parapet

In seeking to redeem the disappointment of the impact of the MAS Review I tried, with others, to keep the original MAS plot going and to fill the gap of inadequate strategic thinking by repeating the purpose of clinical psychology, as I see it, and thinking how best to deliver that purpose. This direction has

been visited 20 years after the MAS Review by *A New Ethos for Mental Health* (BPS, 2009).

I have proposed a College of Healthcare Psychology in 1990 (Mowbray, 1991; not an original idea, as something like it had been proposed in 1977 by May Davidson), later an Institute (Mowbray, 2008a, 2009b) to draw together all aspects of psychological science to focus on health. Not only would this provide a broader foundation of psychological knowledge applied to health, it would stimulate applied and basic research, be a beacon of light that the world might see and support initiatives across the whole spectrum of health, including influencing health policy. It would raise the psychological head above the parapet, and, if properly run, would guarantee the focus was on all psychological theories and principles being applied to all areas of health and healthcare. It would, also, break down the artificial barriers created by the BPS divisional system that have been so damaging to so many aspirations of psychologists and detrimental to their reputation as credible strategists.

With John Taylor, and building on previous work in this field and the MAS Review, we proposed the role of associate psychologist (MAS, 2003; Taylor & Mowbray, 2004) to help nudge chartered and suitably experienced psychologists towards practising at level 3 (see MAS 1989) by suggesting a role to undertake activities at level 2, now overtaken by Improving Access to Psychological Therapies that achieves the same purpose but leaving clinical psychologists where they were.

In 2006 I produced a paper (Mowbray, 2006; BPS, 2007a) setting out a vision for new roles in which I expanded on the theme of clinical psychology being engaged in issues concerning the determinants of health policy, and presented a strategic model for alleviating workplace psychological distress (BPS 2007b) that found its way into the final report.

In 2007 I proposed a role for clinical psychologists in the light of *Health, Work and Wellbeing* (Dame Carol Black's review; MAS, 2007). The workplace is often a controlled community and, together, workplaces repre-

sent millions of people. Presenteeism* is the scourge of performance and productivity, and about 40 per cent of sickness and absence is attributable to psychological distress. Presenteeism needs to be eliminated for this country to compete effectively with the best workforces in the world.

In 2008 I proposed the establishment of centres for psychological health and well-being (Mowbray, 2008a, 2008b) to mirror general medical practice and provide psychological services to communities (something that would fit well with the 'Big Society' ideas). Such centres would be social enterprise franchises, owned by psychologists and others, and be the home to psychologists with different interests, and could easily incorporate others applying psychological therapies. Such centres would serve all forms of communities and the people within them.

In 2009, at the DCP Manager's Conference in October, I proposed the National Institute for Psychological Excellence as part of my idea for an Institute for Psychology Applied to Health (Mowbray 2009a). This was another attempt at suggesting the pooling of expertise and research relevant to health, and elevating the credibility of psychology in its market place.

With the failure to preserve the generic title of 'Psychologist', I urged the immediate abandonment of the divisional system of the BPS, on the Manager's Faculty blog (as the Health Professions Council was sufficient to preserve the different psychological interests of members), as I could see no way forward for the science of psychology applied to health with such a series of tribes continuing to breed more tribes with ever higher and thicker walls around their territory.

Few of these ideas have combusted beyond a spark of interest, excepting that of the 'associate psychologist', which owes its airing to the tenacity of a few who got as far as launching training programmes and employing a handful of people.

What is the effective audience for these ideas?

I have been advised that I am addressing the wrong audience; clinical psychologists employed by the NHS have a comfortable life and don't want to be bothered with fanciful ideas. Even those who are excited about these initiatives soon revert to discussing other people's opinion and the chances of any idea getting passed the various mountains inside the BPS.

Who is the right audience? In my presentation to the DCP in Scotland in 2008 (Mowbray 2008b), largely repeated at the DCP Manager's Conference in October 2009 (Mowbray 2009a), I listed 14 interested parties controlling the work of clinical psychologists. I described two characteristics of this audience – either a champion or a quick fixer. The difficulties for psychologists are those I described in my vision paper to the NWW project group – a lack of a psychological culture and the problem of language, either too simple or in-penetrable. Champions and quick fixers have little alternative but grasp the simple language; the other sort is way out of orbit for most people. Champions, therefore, have the same difficulty as psychologists in persuading the quick fixers to do anything other than fix something quickly. The appeal of psychological therapies that 'ordinary folk' can apply, and apply using computers, is heaven sent for the quick fixer, but sidelines what psychologists can do.

Despite being advised to the contrary, the profession is also an audience. The problem is – who is 'the profession'? For someone outside the DCP and BPS it is hard to find the Florence Nightingale of 'the profession' with whom I can consult and discuss wildly exciting matters. I recently asked for BPS endorsement of the new Manager's Code for the NHS that directly links manager behaviour to well-being and performance. I wonder how this will be handled and whether anything will happen. In many respects the pro-

* Presenteeism is the phenomenon of people turning up for work whilst feeling unwell. For those suffering psychological distress this often means under-performing due to concentration being diverted away from work towards the source of the distress. The estimated costs of presenteeism are one and a half times the combined costs of staff turnover and sickness absence.

profession seems to exhibit characteristics of the worst kind of democratic bureaucracy, with nominations for key leadership positions and reluctance to accept them, combined with an overwhelming desire for everyone's comment to count. This lack of clear, obvious, charismatic and vibrant leadership is no good for a struggling profession (despite the best intentions of those involved) with plenty to contribute to humanity.

Opportunity is knocking again

Today the scene is ripe for determined, tenacious and assertive development of psychology as a force to be reckoned with. Anything less will confine the profession to a dark corner. All we need is a new plot (see above for an outline) with clear, obvious, charismatic and vibrant leadership to make sure it's not lost again.

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Clinical psychology struggling against the tide: Shouldn't we be all be rowing together?

Jenny Taylor

READ RICHARD Hassall and John Clements' article 'Clinical Psychology getting lost? Accident, strategy or symptom?' with a mixture of delight and frustration. Delight at hearing passionate motivated psychologists clearly articulating the fundamentals of our discipline. Frustration at what I think is a misguided view of where their colleagues and professional body are at, and of how we should move forward together.

There is indeed a real issue in the NHS and elsewhere that practitioner psychologists get confused with psychological therapists, which is unhelpful in terms of effective planning of the workforce, and effective use of the application of psychological science for all potential service users. However, I do not believe that this issue arises from a conviction that this is the way forward for the profession or even apathy about the matter on behalf of clinical psychologists, and it certainly does not arise from either on behalf of your professional body, as I hope is clear from the below.

As Chair of the Division of Clinical Psychology, I have given numerous talks at branch and faculty events over the last three years, and looking back through them, there is not one that does not include a call to arms for psychologists to identify themselves as applied scientists, rather than therapists (in fact two of the talks were entitled 'Beyond Therapy'). My stated aims on our webpage are to support the work of clinical psychologists, in order to ensure that the communities in which we work benefit from the scientific application of psychology to problems of health and well-being (no mention of the word 'therapy'). Our leaflet 'Why be a member of the DCP?' answers the question 'Most of my work involves delivering a particular type of therapy. Shouldn't I just

join the relevant organisation for that particular type of therapy?' with:

Organisations focused around a particular type of therapy offer networking/CPD opportunities to enhance your practice in that area. But if you see yourself as a clinical psychologist, for whom delivering therapy is only one of your many skills, then the DCP remains the professional body for you.

The website and downloadable leaflet we have produced for the general public (www.clinicalpsychology.org.uk) answers the question 'What is the difference between a clinical psychologist and a therapist or counsellor?' with:

Clinical psychologists have extensive training in assessing a range of psychological difficulties and determining the most appropriate form of help, as well as being trained in providing more than one type of therapy. Therapists and counsellors, on the other hand, usually specialise in providing one particular type of therapy, like psychodynamic psychotherapy, or cognitive behaviour therapy.

Nowhere have I met resistance from clinical psychologists to the idea that we are a different type of profession to therapists, rather an overwhelming support for a description of ourselves as applied scientists. The idea that there is a general desire to operate as therapists treating discrete 'diagnoses' and that voices dissenting from this desire are wilfully neglected has no substance. Quite the reverse is true, but we do need to do more to get this message across to the wide audience of the public, managers, commissioners and the government. However, for that we need your help. At the moment, between us, the DCP

Executive committee fields the equivalent of less than two whole time equivalent people in backfilled positions, to represent a member organisation of nearly 10,000 people working across a spectrum of service environments and age ranges, across four countries, and in the NHS and in private organisations. We attempt (with the support of the hard-working but not backfilled chairs of the various faculties and branches) and clinical members for CPD events, professional practice guidelines, responses to queries, provision of *Clinical Psychology Forum*, information distribution on key changes in the profession, engagement with other professional bodies, engagement with government, with regulation etc.

We identified some time ago the need for a DCP media/communications officer to focus on accurately conveying our role to the wider community but it took several advertisements and some arm-twisting before anyone come forward to take this on. Richard, John, we didn't receive nominations from either of you despite your desire to improve understanding of our profession's true strengths! Likewise, we advertised several times before we got nominees coming forward to be the next DCP Chair even though this is a funded post. There are obviously many of you out there with clear and excellent visions as to how we should move forward, possibly much clearer than my own or those of your existing Executive committee, so why is it so hard to find people to step forward? Perhaps because it is comparatively easy to sail a ship from the shore, but another matter to get on board and navigate amidst a storm...

The idea that diagnostic classifications are not the subject of ongoing debate amongst the profession is also misplaced. We agreed as a strategic objective for the Society last year that we would produce a briefing paper on the use of formulation and diagnosis as models and the implications and ramifications of each – and indeed I received only today a paper from one of our branches (Well done East Midlands Psychosis & Complex Mental Health SIG!) on this very issue.

I would dispute the notion that 'in current service environments, where clinical psychologists are struggling to maintain their status, the temptation seems irresistible to talk about diagnostic categories and to offer therapy for these defined disorders'. In my experience quite the reverse is true – in these troubled economic times, clinical psychologists are well aware that to present themselves as overqualified technical therapists is career suicide!

A word (or two) on 'the silos in applied psychology'. Hassall and Clements describe applied psychologists as being 'spread across separate divisions', in a way that 'is hardly designed to maximise the cross fertilisation of ideas'. That is, of course, because the current system was not designed. It evolved as different groups of psychologists clustered around their interest in applying psychology in a particular way to a particular area, and then formalised training routes, codes of practice etc.

Reorganising training to develop future practitioner psychologists with more generalised skills has pros and cons, and as Hassall and Clements point out this is discussed in *New Ways of Working for Psychologists in Health and Social Care*. The Chairs of various Divisions who regularly meet at the Standing Committee for Psychologists in Health and Social Care are currently in the process of planning a day on revisiting NWW, including training models and new roles.

Our greater strength in numbers is apparent to us all, and as your Chair I have been spearheading an attempt to encourage a rebranding of the BPS Divisions as Colleges, with the Professional Practice Board becoming 'The British Colleges of Practitioner Psychologists', on the grounds that colleges have a collegiate feel whilst divisions sound somewhat divisive. Progress on this is somewhat slow as the Divisions vary in terms of what title they would like (not all like 'College'), but the will is there to look at options to present ourselves as a unified group of practitioner psychologists who differ in the focus of their practice but ground their work on the same scientific principles. But please note – it is your profession, clinical psychology, which is leading the way on this!

'Lest we forget – the environmental determinants of psychological problems.' Again, I'm glad the authors care, but I'm not convinced that any of us was in danger of forgetting. I don't observe psychologists being 'increasingly drawn towards to exploring internal variables within their clients'. As well as wider and more complex formulations of people's difficulties within their life context remaining key to psychological formulations, many psychologists lead services which focus on the non-individual, for example psychology services for looked after children, where the bulk of the work involves impacting on the systems in which children live and thus changing their environments and improving their life chances, and actively resisting requests from those around them to 'therap' the child.

In conclusion, I doubt the need for 'a widespread debate about whether the therapy mission can sustain clinical psychology into the future'. We know a 'therapy mission' – should such a thing exist within the profession – would be our undoing, therefore such a debate would be rather one-sided. We have

already achieved some important steps in clarifying the difference between our profession and that of psychological therapists, such as the separate registration categories with the Health Professions Council for practitioner psychologists and psychological therapists. The need is less to debate such questions amongst ourselves, and more to actively work together to get our shared message out there. We're not lost, we know where we are. What we need to do now is to make sure that other people know where and who we are, and for that we need a loud voice, such as comes when many speak together.

For more information on how to get involved in the work of your professional body, go to www.bps.org.uk/dcp. It's your Society, get involved!

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Reports of our demise are premature

Peter Kinderman

HASSALL AND Clements have taken a potential concern, one that is relatively straightforwardly addressed through strategic planning at local and national level, and raised a spectre of doom. Their central titular question – ‘is clinical psychology getting lost?’ – must be answered clearly ‘no’, and their subsequent question (‘accident, strategy, or symptom?’) is irrelevant.

Hassall and Clements have identified a significant issue for clinical psychology. They have raised the question of the relationship between the clinical psychologist as therapist and the clinical psychologist as a professional with a wider, broader remit. This question isn’t new. It has been posed in professions other than clinical psychology (most notably psychiatry, of course) and with respect to various forms of therapy – psychodynamic psychotherapy, behaviour therapy and, most recently, cognitive behavioural therapy. Hassall and Clements are not the first people to worry that an excessive focus on one, limited, form of therapy could pose a risk to a broader, deeper, profession. But the error in their thesis is to suppose that clinical psychology is, as they fear, concentrating exclusively in the sense they mean.

For many years, a variety of wise professionals have advocated increased government investment in psychosocial approaches to well-being (or, in older language, mental health). Recently, governments has responded in several important ways. The new framework for mental health policy; New Horizons – the replacement to the 1999 National Service Framework – specifically advocates such a focus, arguing that the prime aim for a mental health strategy should be ‘to create flourishing and connected communities through the promotion of well-being and resilience and the reduction of inequalities’. It is extremely difficult to see

clinical psychologists disagreeing with this aim, and equally difficult to see this as synonymous with a drift away from an ‘interest in environmental determinants of human behaviour’ and a loss of “relevance for more disadvantaged groups”.

For clinical psychology, perhaps seen (correctly) as a profession intimately associated with such a focus, there has been similar support and investment. Clinical psychology is unique in its entry-level doctoral status (recently re-emphasised by the Health Professions Council, see more below), in its form of funded training and professional status in the Department of Health. The number of training commissions has increased consistently year-on-year and the number of clinical psychologists employed in the NHS has increased arithmetically. At the same time, parochially, the salary of clinical psychologists has increased and, at least anecdotally, the status of clinical psychologists and clinical psychology has risen.

Paralleling this, the New Ways of Working initiative has effectively opened up all professional avenues to clinical psychologists, including, of course, those avenues previously restricted to medical professionals. The crowning point of this has been the passage of the 2007 Mental Health Act, permitting a range of clinical professionals to take ultimate statutory responsibility for clients’ welfare. If the contribution of clinical psychologists is being marginalised, this certainly isn’t a consequence of national policies.

For many years, equally, a variety of wise professionals have studied the scientific literature on outcome effectiveness and advocated increased investment in cognitive behavioural therapies. This is for the very simple reason that there is substantial evidence for the benefit of such approaches for

ordinary men, women and children. The IAPT (Improving Access to Psychological Therapies programme) clearly represents the apogee of this. One of the worries behind Hassall and Clements' article seems to be the concern that, with such an investment, the broader and deeper aspects of clinical psychology's contribution may be minimised. This is not a new argument, but there is little evidence to support it.

First, if that concern were valid, we should see the opposite of the picture above – we should see disinvestment in clinical psychology proportionate to the investment in CBT. But in fact we see the opposite. One of the consistent arguments in favour of increasing the number of clinical psychologists is to support the IAPT programme. That point, however, tends to lead to a related concern – that clinical psychology will cease being broad and deep and become merely an adjunctive profession to CBT; we'll be asked to support and deliver CBT and ignore the wider environmental and contextual issues. This raises a second critical argument about IAPT – that, as a psychological or psychosocial initiative, it is proceeding without the input of clinical psychology. The critics, including Hassall and Clements, are arguing that CBT is both absorbing and ignoring clinical psychology.

These arguments are difficult to square with the New Horizons approach – although it may be possible to claim that the government favours a psychosocial approach without clinical psychology. It is also difficult to square with the increasing numbers of clinical psychologists and clinical psychology training commissions – although it may be possible to argue that this is merely fresh meat for the CBT grinder – and are difficult to square with increased personal salaries – although perhaps we are seeing our mouths 'stuffed with gold'. They are difficult to square with the outcomes of New Ways of Working – although perhaps the critics will point to the obvious equity in NWW, and argue that while clinical psychologists can now take on new roles, so can other professions, and take on our roles! And they are very difficult to square with the new respon-

sibilities of the Mental Health Act – although, perhaps critics would argue that again clinical psychologists are being asked to stop delivering their wider duties and to become agents of social coercion.

These arguments are not, to me, persuasive. They are, in my view, akin to the conspiracy theories awash on the internet, where everything is seen as evidence of the opposite of what it seems. But perhaps, if the data can be interpreted in many ways, we should look to how clinical psychology defines itself and is defined. We perhaps could look to the Health Professions Council (HPC) definitions of clinical psychology. Three areas leap out to me as relevant to this context, the inclusion of a social or environmental context, the use of psychological formulation and the provision of psychological therapies, including CBT. It's worth reflecting, therefore, that the HPC requires that a clinical psychologist must:

- understand theories and evidence concerning psychological development and psychological difficulties across the lifespan and their assessment and remediation;
- understand social approaches such as those informed by community, critical and social constructivist perspectives;
- understand psychological models related to how biological, sociological and circumstantial or life-event related factors impinge on psychological processes to affect psychological well-being;
- be able, on the basis of psychological formulation, to implement psychological therapy or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the client;
- be able to integrate and implement therapeutic interventions based on a range of evidence-based models of formal psychological therapy, including the use of cognitive behavioural therapy;
- understand more than one evidence-based model of formal psychological therapy.

While Hassall and Clements might quibble with the wording, it remains crystal clear that

our regulatory body agrees with them: that clinical psychologists must understand the social and environmental context of psychological practice, must develop psychological formulations in that light, and must offer integrative interventions in which CBT plays only a constituent part.

In this light, it looks as if Hassall and Clements describe a theoretical threat – that clinical psychology ignores its environmental focus and becomes merely a professional agent of CBT delivery. While understandable, this picture seems at odds with government policies stressing community-based, socially inclusive, psychosocial models of mental health care, massive investment in psychological therapies, strengthening of the professional basis of clinical psychology, democratisation of working roles in the NHS and in statutory powers, increasing investment in clinical psychology as a profession and commensurate development of the status and remuneration of clinical psychologists.

So why are Hassall and Clements worried? I don't think Hassall and Clements are entirely wrong. Many clinical psychologists – at the coalface, as it were – echo these worries. Of course, it's possible that clinical psychology, as a profession, is so foolish as to ignore this generally positive context, and to head resolutely into the wilderness. But I can't see this. I think it's much more likely to be a problem emerging from a number of quasi-political issues. The gains mentioned above have been won with very considerable investment of effort by the professional body and individuals. They have been secured at national level, and against very significant opposition from other parties.

But that isn't the end of the story. A psychosocial focus to mental healthcare is bitterly opposed by many (see Craddock et al., 2008) for obvious reasons. It is mildly surprising that the gains we have noted have indeed been won at national level. But the fact that the UK NHS is comprised of very many individual Trusts, each with its own management board and individual power structures, and the fact that the NHS cannot direct these trusts (nor, in fact, the PCTs and SHAs), mean that 'visions' at national level

need not be binding at local levels. This means that very many (perhaps a majority) of trusts do not, in fact, operate as if these gains have been made – they do not plan to deliver the New Horizons vision, they do not operate local policies opening roles to all professions (many trusts are not planning to employ clinical psychologists as Approved Clinicians, for example) and do not operate flexible, competence-based employment policies. Very few – unfortunately – see their aim as developing psychological well-being, and continue to see themselves, tacitly, as mental illness services. With powerful external forces conspiring to keep these goals hidden and ignorable (even, I'm afraid, to subvert government policy as defined in 'New Horizons'), it is perhaps understandable that clinical psychologists might continue to be either sidelined or used as delivery agents for CBT – especially since the latter is an identifiable target.

What this means, I think, is that Hassall and Clements have identified a rather different problem to the one they imagine. Clinical psychology is not, in any sense, lost. It is, however, very difficult for isolated clinical psychologists in relatively backward-looking trusts to implement the clear and positive vision extended for our profession.

So, no, clinical psychology isn't lost. It is strong and coherent and visionary. But it is operating in a political landscape where clinicians need support to implement, at a local level, the national strategy. And here, I think, there is a very clear role for our professional body to support them.

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Subterranean nostalgic blues? Our reply to the commentaries

Richard Hassall & John Clements

We were quite overwhelmed by the response to our paper ('Clinical Psychology Getting Lost: Accident, strategy, or symptom?'). We are grateful for and humbled by the quality of the contributions, which have raised too many points for us to answer fully. However, the fact that opinions were so diverse and in many ways so polarised suggests that there is an important issue for debate here.

What was it like in the past?

Despite this diversity, a fairly consistent criticism is that we have presented a romanticised view of the past, that there was a golden (or 'bronze', as Emerson suggests) era for clinical psychology. And whilst we differ somewhat from the characters in Bruce Springsteen's song (we talk more about the present and the future!), we still loved Lavender and Hope's way of characterising this. But we had not meant to create this impression, and in any case individual experiences of the past were undoubtedly more varied than we could encompass within a single paper.

What we do stand by though is that the explosive growth of British clinical psychology was driven by the 'Maudsley' model. This was a heady mix of general psychology, empirical methods and Eysenckian iconoclasm. It led to the rapid development of new interventions and opened access to psychological services for many client groups that would not otherwise have been served. Had the development of British clinical psychology been driven by the 'Tavistock' model, with its emphasis on psychodynamic theory and practice, none of that would have happened and British clinical psychology would have come to resemble much more its American counterpart. This interpretation

fuels our concern about the direction in which British clinical psychology is heading now.

The present

Of course, not everyone agrees with us about what is happening. Lavender and Hope present some persuasive data to show that clinical psychologists are doing other things beside therapy, and indeed more so than in the past. Taylor makes a similar argument, citing the work of psychologists with looked-after children as a notable example, although we wonder whether these children always gain access to helpful psychological services. Burns also notes the range of work going on in the profession whilst sharing some of our concern about the prominence of CBT and adult mental health issues.

In contrast, other commentators assert strongly that clinical psychology is fundamentally a therapy profession and that it always has been. The Midland Psychology Group, like ourselves, regret this but are pessimistic about the capacity and willingness of the profession to change. In general we certainly recognise some diversity in current clinical psychology practice, but we still believe – despite what is written in BPS and other formal documents – that the predominant narrative within the profession is about delivering therapy. Our concern is the trend and what is likely to happen in the future, and our anxieties have not been allayed.

When it comes to the specific issue of learning disabilities, most of the commentators seem to agree with us, at least to some extent. Emerson's is a strong voice here. Beail shares our concern about the dominant trend in clinical psychology, while making a cogent case for psychotherapy services to be available to people with learning disabilities,

albeit in the context of a range of professional practices. Sturmey's is another forceful account of how clinical psychology has failed to seriously engage with people with learning disabilities, to the point of becoming irrelevant in a field in which it once made a significant impact. He makes a telling point about how our profession has been comprehensively overtaken by psychiatry in its influence here. We were not reassured by Burns' arguments for relaxing previous training requirements, because it is not clear why the argument about poor quality placements applies only to learning disabilities and not to other obligatory placements.

Overall, therefore, apart from our general concern about the profession, it would seem that there is much more of a consensus that the position of learning disabilities in the profession is becoming increasingly fraught. We remain however more optimistic than Emerson and Sturmey about the possibilities for remedying this, but we make no predictions.

Pilgrim and the Midlands Psychology Group raise rather deeper issues about psychological knowledge. Pilgrim welcomes a debate about where the profession is going, but suggests we may still be partly influenced by 'naive empiricism' and 'scientific positivism'. We are not entirely clear what is meant by this, but it may imply an excessive focus on empirical findings without an adequate conceptual and theoretical framework. He may have in mind something like Wittgenstein's observation:

For in psychology there are experimental methods and conceptual confusion ... the existence of the experimental method makes us think we have the means of solving the problems which trouble us; though problem and method pass one another by" (1953, part II, section xiv).

The conceptual vocabulary of clinical psychology may have expanded somewhat since Wittgenstein wrote these words, but with little gain in theoretical coherence. The central concepts in CBT are taken virtually unchanged from everyday mental-state language

which philosophers characterise as 'folk psychology'. And clinical psychologists now seem content to have different theoretical models sitting alongside each other, unconcerned about the plainly conflicting concepts employed across these paradigms (a kind of naive post-modernism?) So we remain committed to an empirical approach which is essential in assigning serious weight to many findings, such as the association between distress and socio-economic disadvantage, as outlined by Emerson. We also see it as an important shaper of innovatory practice.

Others, notably Kinderman and Taylor, assert vehemently that the plot has not been lost. While Kinderman excuses us from the charge of being entirely wrong, we appear nevertheless to have trespassed on territory normally reserved for 'wise' professionals, so perhaps we lack the necessary sagacity. However, he seems to take us as criticising the IAPT programme, which actually we barely mentioned, and completely ignores our concern about the position of learning disabilities in the profession. The phrase about 'losing the plot' came originally from Derek Mowbray, who says more about this in his response. He offers a contrasting view to those who seem to be saying 'Crisis? What crisis?' He details various missed opportunities for clinical psychology, to the detriment of the profession itself and also the wider population who potentially have much to gain from the application of psychology to healthcare.

The future?

So is there a willingness for some searching discussion around these issues? There appears to be a widespread and marked aversion to serious debate in the profession – see for example the Midlands Psychology Group (2010) report on the paucity of debate at two recent events. Interestingly, and by contrast, both Burns and Pilgrim report experiences of trainees having a strong interest in critical issues, and Johnstone (2010) describes how the Bristol training course has given priority to critical thinking. These observations give us some cause for optimism about the future.

And is there a crisis? This depends perhaps on where you are, but since we wrote our paper much has happened on the national scene regarding the NHS. There is now every likelihood that the NHS will be fragmented with provider services distributed between foundation trusts, social enterprises, local authorities, and profit-making corporations. The consequences of this are unpredictable, but one can expect a market-driven health environment to prioritise time limited therapy services for clearly 'diagnosed' problems over preventive, early intervention and 'messy' intervention services which are harder to quantify in the short time-frame governing commissioning decisions. The threats are great, with downgrading and compulsory redundancies already happening in some places. Nevertheless Kinderman paints a picture of seemingly unstoppable progress, describing how the status and salaries of clinical psychologists have grown. He suggests our mouths have been 'stuffed with gold', although the trend now is towards 'unstuffing' the gold as salaries are forced steadily downwards. He also talks about the 'strengthening of the professional basis of clinical psychology', a picture which many psychologists simply will not recognise.

But with threats there may also be opportunities, as Mowbray suggests. We find his analysis compelling, particularly because it

offers some imaginative ways in which applied psychology might substantially increase its contribution to healthcare. Where Taylor usefully proposes the rebranding of BPS Divisions as Colleges, noting some resistance to what would essentially just be a semantic change, Mowbray proposes the more radical idea of an institute for healthcare psychology. Does the BPS have the imagination to pursue this? The kind of indifference in the BPS in the examples cited by Emerson and Mowbray is not encouraging. Both Kinderman and Mowbray, in different ways, state the need for our professional body to be more proactive in supporting the profession and moving it forwards. So we believe that something needs to change, with the BPS being a vanguard for change, not an impediment against it.

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Clinical psychology getting lost? A survey

Please make your views known about the future of the profession by taking 10 minutes now to complete the survey: <http://tinyurl.com/25yjhvo>

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