Clinical Psychology Forum 271 (January 2011) contains an article by Richard Hassall and John Clements, together with a series of invited responses. The article explores the antecedents and effects of clinical psychology's transformation from a discipline exploring the environmental determinants of human activity to one concerned more with the provision of psychotherapy. This is the Midlands Psychology Group response to the article: numbers in square brackets [p.xx] indicate page numbers in the published version.

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Response of the Midlands Psychology Group to Hassall and Clements

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, in press).

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, P. & Kelly, P. (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 *CP Forum* (Midlands Psychology Group 2006) 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 recognizing 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', etc.), or of altogether [p.33] 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 naïve 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, etc.).

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 wrong-headed, 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 hand-wringing 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 [p.34] of solidarity. Our own Midlands Psychology Group is a modest example. Another is to recognize that psychologists are part of a democratic structure which can be influenced and shaped: the BPS 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.

References

Midlands Psychology Group. 2006. Special Issue. *Clinical Psychology Forum* **162**, June.

Midlands Psychology Group (In Press). Welcome to NICEworld, *Clinical Psychology Forum*.

Moloney, P. & Kelly, P. (2004). Beck never lived in Birmingham: Why CBT may be a less useful treatment for psychological distress than is often supposed. *Clinical Psychology*, **34**, 4-10.
Passmore, J. (1970). *The Perfectibility of Man.* London: Duckworth.
Smail, D. 2006. Is Clinical Psychology Selling its Soul (Again)? *Clinical Psychology Forum***, 168,** 17-20

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