Introduction
Psychology, Therapy, and Society

Much is said these days about the importance of mental health. It has risen as a policy priority internationally, reflected in and furthered by wider public and political interest across many countries. Associated epistemic and practical projects have likewise flourished, including the wide-ranging field of 'global mental health' (Ecks, 2016; Jain and Orr, 2016; Littoz-Monnet, 2022). This often takes as its focus a purported need to reduce the so-called treatment gap – the number of people deemed to require treatment minus the number in receipt of such – with this 'gap' playing a role in the consolidation of the field itself (Lovell et al., 2019; Mills, 2014; White et al., 2017). At the national level, policymakers, health professionals, and wider publics across much of the world are also staking clinical, moral, and economic claims to the need to enhance access to care for (some) people understood to be living with mental ill-health (Béhague and MacLeish, 2020; Crespo Suárez and Machin Suárez, 2021; Fassin, 2012).

This ethic of access in relation to mental healthcare is part of a broader set of activist, clinical, and political discussions about care and treatment more generally. Calls to improve access to therapies for different kinds of ill-health resound internationally, propelling changes to policies, practices, and people's lives. 'Therapy' is often taken to mean 'drug treatments', with campaigns and initiatives commonly associated with pharmaceuticals like antiretroviral therapies (ART) for HIV (Biehl, 2007; Cloatre, 2013; Greene, 2011). Often heated debates around the accessibility – or otherwise – of therapies are constitutive of the operations of global health and national healthcare. Concerns around access to mental healthcare, are not just about drugs, however; psychological modalities have attracted widespread interest and support, especially cognitive behavioural therapy (CBT).

Within the United Kingdom, psychological therapy came to particular attention over the past two decades or so, with political interest intensifying rather than reducing. First, it has been regarded by politicians and others as an important tool to address the 'societal burden' of mental

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ill-health. Second, it has been characterised as a major intervention to which patient access is deemed to require enhancement, with advocacy groups and clinicians making this point forcefully and repeatedly. Enhancing 'access' is generally rendered as developing additional mental health services, increasing the numbers of therapists available to provide care, offering a greater range of psychological therapies, and lowering waiting times for clinical assessment and treatment (with this latter point a matter of significant concern and activity) (Mental Health Foundation et al., 2006; Mind, 2024; Mind et al., 2013). There is also a growing emphasis on enhancing access in ways that address considerations of equity by explicitly focusing on the needs of a range of populations disadvantaged through structural prejudice and discrimination (Mad Youth Organise, 2025; Mind, 2024; Mind et al., 2013; National Collaborating Centre for Mental Health, 2023).

In this book, I examine how economic and social concerns, political and legal operations, and national and local policies interrelate with clinical knowledge, norms, and processes in relation to psychological therapy. I show how the interactions between these configure the broader contexts of healthcare, and the orientations and activities of those who deliver it. These configurations collectively shape the conditions of possibility for entry into – and exit from – therapy. Accordingly, I elucidate some of the wider effects of an ethic of access; in particular, I articulate the impacts on clinicians themselves. Finally, I reflect on what some of the implications of those could be for people seeking care.

Over the last two decades, the fields of the sociology of mental health, survivor research, and mad studies have grown significantly. Analysts within them have advanced important works focusing especially on lived experiences of distress – scholarship that holds both intellectual insight and normative force (Beresford, 2005; Beresford and Brosnan, 2021; Beresford and Russo, 2022; Broer and Chandler, 2020; Brossard and Chandler, 2022; Chandler, 2016; International Mad Studies Community, 2022; Lane, 2020; LeFrançois et al., 2013; McWade, 2020; Rogers and Pilgrim, 2021; Spandler, 2006; Staddon, 2013; Sweeney et al., 2009). I take a different path through the thicket of mental health and society here. I am principally interested in health professionals, and the profession of clinical psychology especially.

Clinical psychologists in the United Kingdom are doctorally trained psychological practitioners (generally holding a DClinPsy degree) specialising in the treatment of mental ill-health. They are often employed within the National Health Service (the NHS, which is devolved across England,

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Northern Ireland, Scotland, and Wales), as well as in private practice. Yet, unlike their medical colleagues, psychiatrists, studies of the professional development and practical foci of clinical psychologists are rather rare (though see Pilgrim and Treacher, 1992). This is despite the fact that alongside psychiatry, clinical psychology holds considerable prestige within the landscape of mental healthcare. Entrance into the profession is extremely competitive, and by national standards clinical psychologists are well paid. They also often hold managerial roles within the NHS, such as leading services provided by other professions, including those associated with the prominent NHS Talking Therapies initiative (a significant endeavour to roll out psychological therapy at scale). Clinical psychologists contribute to shaping national and international debates about the meaning and practices of mental health and psychological therapy, and hence of wider understandings of the psychological. They surely merit our attention.

The Social Life of Psychology

The importance of clinical psychology is itself a function of the wider societal significance of psychology writ large. As a range of historians and social scientists have clearly demonstrated, psychological findings, ideas, and terminology flow through societies across the world (Brinkmann, 2008; De Swaan, 1990; De Vos, 2012; Duncan, 2018; Illouz, 2008; Jackson and Rees, 2007; Jimena Mantilla, 2023; Lemov, 2005; Madsen, 2018; Pfister and Schnog, 1997; Raikhel and Bemme, 2016; Rieff, 1966; Smith, 2013; Thomson, 2000, 2006). In so doing, they can help to animate or rework varied social, political, and therapeutic imaginaries (Armstrong, 1995; Pulido-Martinez, 2010; Grzanka and Mann, 2014; Herman, 1995; Hollin, 2014; McKay, 2016; Vaughan, 2016; Vorhölter, 2019; Whitehead et al., 2017; Younis and Jadhave, 2020). These can result in revised ways of understanding and managing subjects in the clinic, the classroom, the courts, and beyond (Barr-Haim, 2021; Erickson et al., 2013; Fassin and Rechtman, 2009; Jones et al., 2013; Ossa et al., 2021; Robcis, 2013; Weinstein, 2013; Yang, 2015; Zhang, 2020). Indeed, such arenas are important in their own right for generating psychological notions and knowledge that configure the subjects ensconced within them (Armstrong, 1983; Miller and Rose, 2008; Rose, 1996).

The configurations that might be implied by the advent and attempted instantiation of psychological knowledge are not, however, inevitable. Societal processes and concerns inform where and how psychological concepts and findings settle, if at all, within professional work, policy

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settings, popular media, and personal experience. Their reception depends on social circumstances and everyday epistemologies (Broer et al., 2020, 2022). Ideas about psychology configured through university research settings or inside the clinic cannot, then, be assumed to simply and straightforwardly diffuse into and instantiate within other discursive and practical sites (Capshew, 1999; Pettit and Young, 2017). In the case of specific therapies, as their use extends beyond national borders, their practices of deployment – and even the assumptions underpinning these – can shift and change (Amouroux et al., 2023; Wu and Wang, 2016). The arrival of behaviour therapy in France is one example (Amouroux, 2017; Amouroux et al., 2022). This 'American' therapy was hardly welcomed by French clinicians; however, over time, it imbricated with pre-existing imaginaries and practices, evolving in ways that saw some measure of acceptance. It is in part through ongoing transit, and via discursive roadblocks to this, that psychological concepts and practices morph, with the meanings ascribed to them rewritten in the process (Lloyd, 2006; Pettit, 2015; Turkle, 1978).

Different approaches to therapy, of the kinds practised by clinical psychologists and other psychological practitioners (like counsellors and some psychiatrists), also contain different models of the psychological. As these therapies and the ideas associated with them travel, they likewise entwine with other ideas about the self; for instance, those shaped through various biological idioms (Behrouzan, 2016; Ehrenberg, 2020; Loughran, 2016). For some therapists, this means that acting upon the psychological can be understood to take place through the brain, as well as vice versa: that stimulating the brain can sooth the soul (Brenninkmeijer, 2010; Moutaud, 2022; Rose, 2006; Vidal and Ortega, 2017). These reproachments between different ontologies and their enactments underscore the great extent to which different models of the psyche, and of being human more broadly, can sit together and articulate with one another in non-determinative ways (Craciun, 2018; Marks, 2017; Pickersgill, 2010; Pickersgill et al., 2011; Richert, 2019; Silverman, 2012; Shamdasani, 2017; Zhang, 2020).

The psychological knowledge that gives rise to and results from therapeutic intervention is also itself shaped through societal discourses and debates (Koczanowicz and Koczanowicz-Dehnel, 2021; Solovey, 2001). These impact what is researched, why, how, and by whom (Dehue, 1995; Kusch, 1999; Pandora, 1997). In turn, research contributes to configuring professional training in applied psychology, although the expertise of clinicians can by no means be reduced to knowledge trickled down from laboratories (Ashmore et al., 2005). Psychology, as Nikolas

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Rose (1996) has put it, is very much a *social* science; equally, the social is undoubtedly a product of psychological praxis.

While psychology can be popularly celebrated for its contribution to care, it is also important to underscore that the sociality Rose points to can be regressive. Discriminatory societies and social institutions inflect the knowledge produced within them and the uses to which it is put (Asante and Vandi, 1981; Harding, 1986; Martin, 2022; Schiebinger, 1993). Psychology, then, has not merely been impacted by discrimination and oppression: it has been constituted through these processes (Caplan, 1993; Guthrie, 1976; Howitt and Owusu-Bempah, 1994; Morawski, 1994; Richards, 1997). As a range of academics and activists have pointed out, including many psychologists themselves, psychology both inscribes and contributes to social ills and structural violence (Capella Palacios and Jadhav, 2020; Fine, 1985; Henriques et al., 1984; Morawski, 1997a; Parker, 2015; Rutherford, 2018; Spandler and Carr, 2020; Tyson et al., 2011) such as homophobia, transphobia, racism, and sexism (Chaparro and Prado, 2022; Cokley and Garba, 2018; Hegarty, 2018; Hird, 2003; Hubbard, 2017; Hubbard and Griffiths, 2019; Kitzinger, 1987; Parlee, 1979; Pyne, 2020; Spandler and Carr, 2022; Valasek, 2022; Waidzunas, 2015; Young and Hegarty, 2019). Psychological knowledge has also long been instantiated within, and generated through, practices of colonialism, war, and torture (Balfe, 2016; Capshew, 1999; Linstrum, 2016; Oakes, 1994; Orr, 2006; Reyes, 2008; Rohde, 2022; Samelson, 1977; Soldz, 2011). Clearly, psychology cannot be neatly separated from the social and normative practices through which it is configured.

As historians like Danziger (1997, 1990), Morawski (1997a), Richards (1996), and Smith (1997, 2013) have discussed, the traffic between psychology and wider society puts psychologists in a particularly tricky position in relation to their role as authoritative crafters of knowledge about, and technicians of, the self. If psychological knowledge is constituted through social and interpersonal processes, and if the outputs of psychological research impact societies, subjectivities, and how we come to know them, then the self-making potential of psychology as a science and practice is dizzying. Likewise, the associated responsibility and reflexivity required from practitioners is considerable, not least given the issues outlined earlier (Brinkmann, 2005; Hearnshaw, 1987; Morawksi, 1997b; Richard, 1996). Many psychologists take seriously both the power of their discipline and the need to wield it thoughtfully. Nevertheless, there can be gaps between laudable therapeutic goals, for example, and the lived realities of those who encounter psychological knowledge and expertise.

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Today, discriminatory logics continue to be discernible within psychological research and practice (Adams et al., 2018; APA, 2021; Riggs et al., 2019). They have ramifications for how therapeutic practitioners come to understand and relate to those with whom they work (Carr, 2010; Charura and Lago, 2021; Constantine, 2007; Hodges and McManus, 2006; Pilgrim and Patel, 2015). With regards to access to psychological therapy, for instance, it would be unwise to assume that assessments of whether someone is 'ready' for therapy, as various clinical psychologists put it, are somehow free from raced, gendered, and classed assumptions that might pave the way to access to care and treatment for some and not others. Better understandings of both how psychologists enact clinical decision-making and the wider context in which therapy is delivered can provide evidence and insight for activists and campaigners lobbying for more equitable access to care.

Introducing Clinical Psychology

What today is referred to in the United Kingdom as clinical psychology has its origins in a range of traditions, not least educational and industrial psychology (Stewart, 2015). Over its existence, the profession has been configured through – and helped to configure – wider initiatives in the NHS, health policy, and academia. Early training programmes included initiatives at the Maudsley Hospital and the Tavistock Clinic (both in London, England) alongside the Crichton Royal (Dumfries, Scotland), the scope and intent of which were shaped by the inauguration of the NHS in 1948 (Stewart, 2015). The Maudsley programme has long attracted particular attention, not least because of the significance of its founder to the history of psychology: prominent and controversial psychologist Hans Eysenck. Established in 1947 at the behest of psychiatrist Aubrey Lewis (Buchanan, 2010; Derksen, 2001; Yule, 2015), the programme developed in the context of a wider professional buoyancy for psychiatry and psychology following the Second World War (Jones, 2004; Loughran, 2016; Thomson, 2000). Psychological medicine, often practised by physicians, had for some time been institutionalised within the United Kingdom (Crichton-Browne, 1861; Jones, 2010). However, Eysenck's programme was a significant moment in the consolidation of clinical psychology as a distinct discipline that long exerted influence on the nascent profession (Derksen, 2000).

The style of clinical psychology fostered by Eysenck drew from the influential field of educational psychology (Rose, 1985). It underscored the import of psychological testing, the cultural traction of which had been a

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key mechanism for the professionalisation and expansion of psychology (Thomson, 2000). This focus on testing purposely framed out therapy (Buchanan, 2010; Derksen, 2000); Eysenck (1949, 1953, 1959) was especially critical of the kind of therapy expounded by Freud and psychoanalysts, noting often and at length its limits as a scientific practice. This was in contrast to some of the early members of the British Psychological Society (BPS), founded at University College London on 24 October 1901 as the then and still principal professional society for UK-based psychologists (Hearnshaw, 1964). Many BPS members were physicians orientated to psychological treatment, including psychoanalysis (Pilgrim and Parry, 2015). Consequently, the establishment and rollout of the Maudsley programme over its early years entailed a slightly rocky relationship with the BPS (Yule, 2015), before the highly influential Eysenck gained traction there too (Buchanan, 2010).

The focus of psychological testing via psychometrics, rather than therapy, had professional as well as epistemic advantages. Serving as a form of practical boundary work (Gieryn, 1983) between the disciplines, it ensured that psychology avoided a direct contest with physicians (Pilgrim, 2010) while also contributing to the reification of psychological science (Stewart, 2015). By framing their identifies around testing, psychologists could demarcate an increasingly autonomous space for themselves in ways that highlighted their unique skills and utility. Since this zone of praxis did not overtly threaten the far more powerful profession of medicine, there was plenty of scope for it to further expand.

Still, professional context changes over time, in a dynamic interrelationship with the epistemic content that fills it. Eventually, Maudsley psychologists came to engage in therapeutic practices as well. This was, in part, through the rising influence of Eysenck's colleague Monte Shapiro in the early 1950s, with whom he had a somewhat challenging relationship at times (Buchanan, 2010). Shapiro had a rather different approach to psychology than Eysenck (Derksen, 2001) and helped to initiate psychological treatment within the Maudsley (Yule, 2015). As the years went by, the import of a more overtly therapeutic emphasis for psychology was increasingly asserted across the profession. Eysenck himself ended up becoming a vocal supporter of empirically orientated behaviour therapy (Eysenck, 1959; Yule, 2015), following long-standing interests in behavioural conditioning, and in 1965 he co-authored the first major textbook in this area with Stanley Rachman (Marks, 2012).

At the same time, the BPS more generally was embroiled in what historian Roderick Buchanan has called 'the somewhat tortuous process

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of professionalization' (Buchanan, 2010, p. 220). To this end, it engaged extensively with the government and with the evolving NHS. In 1965, a Royal Charter was granted to the Society, and then, in 1966, the BPS Division of Clinical Psychology (DCP) was founded (Hall and Wang, 2015). That year saw membership of the Division stand at only 163, while the BPS as a whole had 3,300 members (Hall et al., 2015). As the 1960s progressed, psychologists working clinically only numbered in their hundreds (Buchanan, 2010). Nevertheless, alongside the establishment of the DCP, the 1960s saw a range of other clinical psychology programmes develop within the United Kingdom, and the demands for psychologists within the NHS grew (Hall et al., 2015). In the 1950s, aside from the London Institute of Psychiatry, the Tavistock Clinic and the Crichton Royal were the only 'approved' training courses for clinical psychologists seeking work within the NHS (Hall et al., 2015). By the end of the 1960s, however, the BPS had formalised a Diploma in Clinical Psychology, and 'in-service' NHS training programmes were also operating (Lavender and Turpin, 2015).

The lot of clinical psychologists improved further in the 1970s and, to an extent, into the 1980s. The call for clinical psychologists, and psychological practitioners more generally, continued, including within both primary care and outpatient settings (Burns and Hall, 2021). Clinical psychology separated further from psychiatry, heartened in this respect by a significant 1977 Department of Health document, the Trethowan Report (DHSS, 1977). Led by William Trethowan, a psychiatrist at the University of Birmingham, this entailed a significant review of clinical psychology services. Clinical psychologists were, for instance, regarded as fully competent to accept referrals from general medical practitioners (GPs; what some countries refer to as family doctors/physicians), with recommendations made to expand service provision (Hall and Wag, 2015). By the end of the decade, clinical psychology training was provided through either two-year Masters programmes, or the aforementioned in-service diploma route (Lavender and Turpin, 2015). At the same time, psychologists also themselves became involved in the training of physicians and psychiatrists via the establishment of posts within medical schools (Hall, 2015). Through this, psychological knowledge became increasingly interpolated within medical curricula. The therapies these emboldened psychologists were delivering, and the theoretical debates to which they contributed, also became increasingly heterogeneous (Parry, 2015; Pilgrim and Patel, 2015). This heterogeneity tended not to result in particularly seismic professional ructions, although the applications of behavioural

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techniques in relation to the ethically troubling aversion therapy became increasingly contested (Carr and Spandler, 2019; Marks, 2015).

During the 1980s, clinical psychologists continued to enjoy a significant degree of professional autonomy in the NHS (Hall et al., 2015), despite the challenges of NHS reforms and budgetary issues under a Conservative government. So-called deinstitutionalisation through the closures of 'mental hospitals' (Scull, 2021) meant that, in theory, clinical psychologists were better integrated into the wider NHS workforce. With the rising influence of managerialism in the NHS, they also came to occupy sometimes powerful positions leading large, multidisciplinary teams (Pilgrim and Patel, 2015). The BPS supported this through DCP management training (Hall and Wang, 2015). Professional debate and knowledge production were also furthered via periodicals such as the *British Journal of Clinical Psychology* (first issue 1981), which evolved from the long-standing *British Journal of Social and Clinical Psychology*; *Clinical Psychology Forum* (first issue 1986), developed from its forerunner, the *DCP Newsletter*; and, *The Psychologist* (first issue 1988), a rebranding of the *Quarterly Bulletin of the British Psychological Society* (established in 1948) (Hall and Wang, 2015). The reconfiguration of these texts reflected an increasingly ambitious profession of psychology in general and of clinical psychology especially. The ambitions of the latter were also furthered through the Manpower Planning Advisory Group of the Department of Health (Richardson, 2015). Under the leadership of psychologist Derek Mowbray, this produced a key report foregrounding the importance and expertise of clinical psychology for the NHS (Management Advisory Service, 1989), galvanising many hopes and expectations about the future (Pilgrim and Treacher, 1992).

The authority and autonomy of clinical psychology were further consolidated in the 1990s through the reconfiguration of core training from a two-year Masters qualification to a three-year doctorate (although not without considerable debate; Lavender and Turpin, 2015). In a medically dominated NHS, much benefit was seen to be afforded through the title of 'Dr' in relation to prestige and professional recognition (Cheshire and Pilgrim, 2004). Following the 1997 general election and the coming to power of a Labour government, investment in mental health services also improved and the numbers of clinical psychologists employed within the NHS grew (Richardson, 2015). During this decade, it also became clear that some clinical psychologists were beginning to engage in more dialogic ways with people to whom their therapeutic expertise had been applied (Foster, 2015). This move was powered by an increasingly organised and influential advocacy sector and service-user movement (Beresford and

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Brosnan, 2021; Campbell, 2005; O'Donnell and MacLean, 2019; MacLean, 2021; Rogers and Pilgrim, 1991), even if this itself faced a range of obstructions and practices of relegation (Carr, 2007; Lambert and Carr, 2018; Lewis, 2009, 2014; Sweeney, 2016). While engagement with people who use psychology services was not a significant feature of clinical psychology in the 1990s, subsequently there has been a gradual shift in this respect (Foster, 2015; Soffe et al., 2004). That said, organisations and individuals involved in mental health advocacy and the user and survivor movements continue to demonstrate that too many of their critiques of existing services and concrete suggestions for reform go unheeded (Farmer and Blackshaw, 2021; Russo and Sweeney, 2016; Sapouna et al., 2019).

Other challenging matters around which the profession is increasingly concerned are the stigma and marginalisation of a range of groups within and by clinical psychology, including in relation to race and ethnicity as well as gender and sexuality. Since the 1990s there has been an intensification of attention within psychology to the forms of prejudice that can exist in the profession (Adetimole et al., 2005; Hodges and McManus, 2006; Wood and Patel, 2017). Some progress has been made to address this: for instance, the much campaigned-for Lesbian and Gay Section of the BPS was finally established in 1998 (Kitzinger et al., 1998), which became the Psychology of Sexualities Section in 2009 (Hubbard and Griffiths, 2019). In the face of ongoing structural, institutional, and interpersonal forms of racism that impact access to mental healthcare (Bowl, 2007; Burr, 2002; Haarmans et al., 2022; Halvorstud et al., 2018; Nazroo et al., 2020), there is also increasing problematisation of the fact that clinical psychologists are overwhelmingly a white, middle-class (Palmer et al., 2021) workforce (Odusanya et al., 2018). With this, there has been some recognition too of how a lack of demographic diversity within clinical psychology configures the logics of healthcare delivery and the subjects of therapy (Wood and Patel, 2017). However, discourse in relation to the whiteness of psychology has often been articulated through the idiom of diversification rather than the more direct register of discrimination or racism (Pilgrim and Patel, 2015; Wood and Patel, 2017). While the volume of calls to address power and privilege within clinical psychology is increasing, much work remains to be done (Cohen-Tovée, 2020; Fernando, 2017; Wood and Patel, 2019).

Professional competition and relationships with other disciplines also continues to be a challenge for clinical psychology. Besides psychiatrists, clinical psychologists have long worked with other health professionals, not least of which are other kinds of psychological practitioners, such as counselling psychologists. Maintaining good relations while securing

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professional autonomy and advancement can involve some delicate organisational and personal manoeuvring. This relationship work became more pressing as policy in the late 20th century (notably the Department of Health's (2007) 'New Ways of Working' agenda) came to emphasise the important place of clinical psychologists within multidisciplinary teams, as well as supervisors of other kinds of therapists, for example people with a diploma in CBT who were specifically hired to deliver that particular therapy (Cheshire and Pilgrim, 2004). Clinical psychology also found itself in a slightly tricky position with the formation of the Health Professions Council (now the Health and Care Professions Council (HCPC)) in 2003 as a legal regulator of professional practice. While the formal regulation of psychology was in many respects welcome – and legal restrictions on who could use the 'protected title' of clinical psychology particularly so – worries circulated, and still do, that more bespoke regulation for psychologists remained lacking.

Today, clinical psychology is firmly established as a therapeutic profession – one necessarily engaged, to varying degrees, with policymakers, academia, other mental health professions, and advocacy groups. Clinical psychologist David Harper (2010, p. 13) reads the shift away from testing to therapy as 'a bid for autonomy from psychiatry'. In this respect, clinical psychology has had clear success. With a distinct doctoral training route which can result in a well-renumerated, relatively autonomous, and commonly secure job in or beyond the NHS, clinical psychology will look to many like a profession that has done well for itself. No longer simply an adjunct to psychiatry, through contributing to healthcare policymaking and clinical guideline development, clinical psychologists now shape the work of psychiatrists themselves (Parry, 2015). Still, the originating purpose of the Maudsley programme is not without contemporary impact. Furthermore, for all its evident import, and to the understandable chagrin of some practitioners, the social and economic standing of clinical psychology is not parous with psychiatry. These issues appear to reverberate in some of the discord that can at times remain discernible between the professions, and which contributes to the professional politics – and thus instantiation within healthcare services – of the psychological disciplines.

Introducing (Cognitive Behavioural) Therapy

If clinical psychology is a therapeutic profession, what therapies are practised, where, and with what foci? As noted, many clinical psychologists work in the NHS, where they draw on a range of therapies to address a variety of forms of disease and subjective distress: addiction, eating disorders, low

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mood, psychosis, and more. Different therapeutic approaches can be used alongside each other, and the assumptions underpinning these are wide-ranging. Take, for example, cognitive-analytic therapy: this draws on elements of psychoanalysis and cognitive psychology in ways that might be anathema to some specialists in either tradition.

The ontological variety and complexity between and within therapies generally does not, however, get in the way of actual therapeutic work. Rather, clinical psychologists take what they need, interweave what they regard as helpful, and leave the rest behind (cf. Luhrmann, 2000). As such, practitioners of clinical psychology commonly describe their therapeutic style as 'integrationist'. Implicit to this characterisation of professional practice is an epistemic claim to know about a range of techniques, and to know (best) how to braid and deploy them in different ways for particular patients. This claim itself helps to support the position of clinical psychologists within the wider NHS ecosystem, within which there exists a great many other providers of psychological therapy.

At the same time, many clinical psychologists also draw significantly on the widely regarded, if also sometimes hotly contested, technique of CBT. This is one of the most popular psychological treatments in the world, used in diverse ways in a range of contexts (Marks, 2015). A preference towards CBT is marked out from training onwards, if not before – for instance, during pre-doctoral work within psychological services. While students on clinical psychology doctorates must acquire competencies in two therapeutic modalities, one of these has to be CBT (BPS, 2019). Consequently, although CBT is by no means a therapy clinical psychologists can uniquely claim as their own, it is nevertheless central to their work – with that centrality enjoined by the BPS itself.

CBT entails psychological and behavioural strategies aimed at lessening the subjective impact of what are considered 'maladaptive' patterns of thinking about and relating to the self and the world. It has developed over successive 'waves' and builds on various pre-existing therapeutic approaches, including rational therapy (Craciun, 2018; Pilgrim, 2011; Stark, 2017). As its name indicates, it has origins in both behaviourist and cognitivist traditions of psychology (and psychiatry). CBT consequently represents an amalgam of approaches that draw from figures such as Hans Eysenck, psychologist Albert Ellis, and psychiatrist Aaron Beck (both trained in the Eastern United States) (Marks, 2012; Pilgrim, 2009). The conjoining, and even blurring together, of the 'C' and the 'B' of CBT became essentially taken granted in the United Kingdom by the early 1990s, and the influence of the therapy grew and grew (Marks, 2012).

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Professionals who centre CBT within their practice commonly locate as their primary concern 'patient's thoughts and actions' rather than placing emotions as salient (Craciun, 2018, p. 985). Relatedly, CBT tends to have a relatively immediate temporal focus as compared to a deep dive into distant personal histories that characterises many other therapies (although childhood experiences, for instance, are not necessarily disregarded) (Craciun, 2017). It is generally a more targeted and shorter-term modality than techniques such as psychodynamic psychotherapy or psychoanalysis. Within the United Kingdom, this temporal structure has contributed to the consolidation of CBT within an overstretched NHS (as well as in public and private healthcare elsewhere; Lakoff, 2005; Scott, 2006; Zhang, 2020), where psychologists and other practitioners are often asked to undertake their work within fewer therapy 'sessions'.

Many professionals regard this situation as undesirable – as do numerous people who are asked to engage in such 'brief interventions' as the sum total of their psychological care (Greener and Moth, 2022; Moth et al., 2015). Likewise of concern has been the alignment of the temporalities of CBT with managerialist approaches to organising services. For instance, when a certain number of sessions are commonly anticipated by NHS managers as being appropriate for a particular presenting issue – for example, anxiety or low mood – targets can be set for professionals in relation to how many sessions of CBT should take place. Consequently, CBT is also easily aligned with the kind of audit culture (Power, 1999) that anthropologist Paul Brodwin (2013) has characterised within US community mental health, and which many clinical psychologists and other therapeutic professionals in the United Kingdom frequently lament. This is not least because extended modes of audit and accountability contribute to the reconfiguration of that which is to be audited (Miller and Rose, 2008), ostensibly impacting the autonomy of practitioners and underscoring in turn how this is itself always shaped through relations of power (Dingwall, 2016).

As a highly standardisable intervention, CBT has been particularly valued within the international move towards 'evidence-based medicine' from the late 20th century onwards (Craciun, 2018; Pickersgill, 2019a). At the same time, CBT is flexible enough to be worked up as a specific treatment for particular kinds of formally recognised psychiatric disorders. This has meant that clinical trials could be conducted on its efficacy in ways that rendered it comparable with pharmaceutical interventions (Harper and Townsend, 2021; Sadowsky, 2021), in turn helping to ensure its wider acceptability in the NHS and in privatised healthcare systems

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beyond the United Kingdom (Craciun, 2018; Lester, 2019; Zhang, 2020). This ambiguous existence as standardised yet flexible means that it is well suited for use by practitioners with a range of trainings and ontological commitments. While some regard CBT as a fruitful treatment for psychiatric disorders, many in clinical psychology are wary of, and sometimes antagonistic towards, what they see as a medical model of ill-health. These practitioners would be disinclined to position CBT as a specific, tailored treatment for a discrete, defined disorder, even as they might make use of the therapy for their own ends.

With its focus on recasting rather than deciphering patterns of thought, it has been feasible to constitute CBT as suitable for practitioners to use via the telephone, as well as through online modalities. It is in this computerised form that the therapy is sometimes recommended as a first step to people seeking psychological care through the NHS (Pickersgill, 2019b) – as well as to divert people away from stretched face-to-face services (Lane, 2020). Apps for managing experiences of anxiety and depression can also make use of CBT, and are used in a context where some people are electing or being encouraged not to seek access to NHS services due to concerns about long waiting lists for therapy (Crosby and Bonnington, 2020). Self-directed delivery both online and through handbooks is also common (Zeavin, 2021), and 'CBT-like' conversations with generative artificial intelligence such as ChatGPT are now feasible (Ellis and Tucker, 2021). CBT has escaped the confines of the clinic in other ways as well, and in a range of countries: for instance, it is deployed as an ostensibly humanitarian intervention within resource-restricted settings internationally; is a feature of the criminal justice system; is situated within or accessed through employment centres; and is inscribed within popular self-help texts (Armstrong, 2002; Brownlie, 2004; Frayne, 2019; Friedli and Stearn, 2015; Madsen, 2018; Torre, 2021). All these settings and uses have elicited a range of concerns from within and beyond the psychological professions, not least clinical psychology.

Initiatives to enhance access to psychological care often emphasise the provision of CBT. But this does not always sit well with clinical psychologists, nor with some other professionals. Concerns circulate widely that CBT is sometimes used as a quick and, in the eyes of some, even simplistic approach to therapy orientated primarily towards the rapid movement of people into and then out of services, rather than at substantively addressing their individual needs. Prominent arguments around its economic effectiveness as a treatment modality (Layard et al., 2007) have raised alarm bells for many; as senior clinical psychologists John Marzillier and John Hall

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(2009, p. 399) put it in BPS periodical *The Psychologist*, 'Psychological therapy should be not be travestied as routine application of particular methods or techniques that can somehow deliver happy, adjusted people at low cost' (see also Binnie, 2015; Dalal, 2019; Mollon, 2009; Moloney, 2013; Ratnayake, 2022, among a range of other critiques from within and beyond psychology). Clearly, while some practitioners, such as the highly influential clinical psychologist David Clark (Clark, 2018; Layard and Clark, 2014), speak often of the benefits of mass CBT, not everyone agrees.

Descriptive and normative statements can easily blur together within the professions (Dingwall, 1977). As such, criticisms from clinical psychologists especially cannot be neatly separated from wider disciplinary politics (Cheshire and Pilgrim, 2004). Claims made about the limits of CBT often implicitly and sometimes explicitly underscore the importance of other varieties of therapy (and therapists), and the need to go 'beyond' CBT, especially in cases deemed to be particularly 'complex'. Consequently, they lend important support to clinical psychologists as well as counsellors and other practitioners who generally prioritise a longer-term therapeutic relationship than an exclusively and narrowly CBT approach is usually supposed to enjoin. This relates back to my earlier point about the epistemic claim of clinical psychology to be expert not only in CBT but also in knowing how and why to go beyond it and entwine other therapeutic approaches – to be 'integrationist'. None of this is to say that clinical psychologists' concerns reduce simply and straightforwardly to professional self-interest. Rather, these overlapping forms of claims-making illuminate how ideas about who should receive therapy, what kind of therapy should be administered, what services are for, who should deliver psychological care, and what makes a good therapist are synthesised together and reciprocally configured.

Taking a Step Back

I have used the word 'configure' and its derivatives several times now – including, of course, in the title of this book itself. Some readers will have spotted that I employ it in a similar way to how humanities and social science scholars tend to use the word 'construct'. Historian of psychology Kurt Danziger (1990) provides a key example of this in his pathbreaking book, *Constructing the Subject*. Why, then, use 'configure' at all? For one, I appreciate its connotations of ordering or rearrangement so as to get something to work. This aligns with how I think about clinical psychology. I understand this field to operate through an assemblage of material

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and semiotic entities and devices – policies, guidelines, waiting lists, and so on. Changes to them reorder or rearrange the nature of professional work, how it is delivered, and thus what psychology is (cf. Woolgar and Neyland, 2013). My view of therapy is that it is a form of praxis largely geared towards (re)configuring the psychological in ways that aim to ease distress – and, in so doing, (re)frames and (re)configures subjectivities (rather than building these up from scratch). In effect, and in line with the writers I drew upon earlier, I see psychological power as transformative but not unlimited, nor completely determinative.

I am also drawn to the word 'configure' because of its association with technologies (alongside its use within the sociology of technology). Consumers and/or users configure technologies, and professionals also configure the infrastructures within which these are employed – and are themselves also configured in the process. Think of the configuring of a computer, for instance, and the circuits and networks that enable its operations for purposes of work, leisure, or both. Most users do not build or construct these from scratch; rather, they configure what already exists for their own ends, and there are material and practical limits to what these might be. These artefacts likewise contour how users themselves operate and relate to technologies (Woolgar, 1990). Further, configuration does not necessarily have a clear endpoint: software is updated, and computer usage changes over time, resulting in an interplay between use, user, object, and the contexts within which all of these are situated. Processes of configuration are consequently non-linear and potentially multidirectional, since they always happen within social and economic milieu which shape what is imaginable and actionable (Mackay et al., 2000; Oudshoorn and Pinch, 2003; Oudshoorn et al., 2004; Suchman, 2012). Similarly, psychological praxis is configured and made manifest through particular organisational and epistemic environs, while at the same time psychologists can contribute to shaping the semiotic and even material settings within which configuration occurs.

Resonant metaphors have long existed within critical work on the history and philosophy of psychology (Derksen et al., 2018). This is exemplified by Michel Foucault's (1988) phrase 'technology of the self': as in, an operation or set of operations that people engage in alone or with others as an exercise in constituting selfhood (Esteban-Guitart, 2014). Like Craciun (2018), Pilgrim (1997), Rose (1992), and many others, I consider psychological therapy to be such a technology. As with other forms of technology, it is configured through use and configures both its principal users and the institutions wherein that use plays out.

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The arrival of Foucault into the text seems like a good point to be even more explicit about some of the concepts and debates through which this book has itself been configured. Foucault (1988, 1989) certainly influenced my work, although I owe more immediate intellectual debts to those who have experimented with and expanded his ideas, especially Nikolas Rose (1985, 1989, 1996) as well as Ian Hacking (1995, 2002). I am, however, mindful of the concerns of feminist psychologists and others that structural power relations are occluded within some writings by analysts inspired by Foucault (Busfield, 1991; Kitzinger, 1991; Morawski, 2015). Further, I am more reluctant than some post-Foucauldian scholars to characterise processes and techniques as intrinsically new or novel (given that such characterisation is itself a sociological process; Pickersgill, 2021). While not completely opposed to this, I remain wary of over-reliance on attributions of fundamental novelty as an analytic pivot. Instead, I am more interested in the social work entailed in, for instance, how, in what sense, and with what effects a given object, practice, or institution comes to be feted as novel (a disposition which perhaps also takes some inspiration from Foucault). More generally, I find myself in alignment with historians of psychology (e.g. Smith, 1988; Thomson, 2006) who have implicitly or explicitly cautioned against embracing too tightly or interpreting too literally theorists like Foucault. Such practices can constrain analyses and reproduce their own form of scholarly conservatism.

The arguments set out in these pages, then, are informed by a range of histories and sociologies of psychology specifically, and – as will become evident over the chapters that follow – of clinical knowledge and healthcare practice more generally (most notably from traditions like the sociology of the professions and the sociology of science). Such scholarship collectively demonstrates the significance of psychology to societies while also showing that the psychological does not pre-exist the social in straightforward ways. Rather, what we take to be the psyche, and what counts as expert knowledge about it, is accomplished via a range of social and technical operations (Byford, 2016; Hayward, 2014; Miller and Rose, 1988; Young, 1995). These can be regarded as forming what Rose (1985, p. 9) terms the 'psychological complex': an intersecting matrix of 'discourses, practices, agents and techniques' through which the psychological is known and understood to be. Clinical psychology and the provision of psychological therapy more broadly are vital to understand, then, not only because they are key yet often understudied elements of healthcare. They also require our attention because they have ramifications in turn for how

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the subjects of therapy – which, partly because of an ethic of access, are very many of us – might be configured.

What Lies Ahead

This book draws on a range of texts and interviews (predominantly with clinical psychologists) to examine the dynamic relationships between policy and law, norms and categorisation, and knowledge and expertise within psychology vis-à-vis the enhancement of access to therapy. I show how health research, professional politics, governmental pressures, and everyday exigencies reciprocally configure the contexts of psychological care and the experiences of healthcare workers. In doing so, I also demonstrate the troubling ambivalence of an ethic of access. First, this entails a reconfiguration of praxis in ways that create professional and affective challenges even as policy to enhance the accessibility of therapy is deemed broadly desirable. Second, it creates the conditions of possibility for an increase in care for some while curtailing it for others, in part through giving clinical psychologists both more and less power.

Clinical psychologists often play senior roles in mental health services, managing different kinds of staff. This includes within NHS Talking Therapies services, formerly the Improving Access to Psychology Therapy (IAPT) initiative, one of the key programmes to expand the numbers of people receiving therapy in England. Within these and other services based in primary care settings across the United Kingdom (i.e. places generally serving as the 'first port of call' for accessing healthcare, such as a local general medical practice), therapy is very often delivered by other, less well-paid professionals. This is part of the broader logic of cost effectiveness that configured the initial instantiation of IAPT. However, clinical psychologists also contribute significant amounts of therapy, especially within secondary care (i.e. more specialist services which generally require a referral and are commonly located in hospitals). Given the prestige the profession has worked so hard to attain, clinical psychology also shapes the psychological complex more widely through its epistemic practices, ontological assertations, and strategic activities. As such, the narrative of the book moves, in the earlier chapters, from an exploration of clinical psychology as a profession to a broader consideration of psychological therapy, before refocusing later on the experiences and accounts of clinical psychologists specifically.

Accordingly, this book is divided into two parts. Part I focuses on national shifts and debates. It is grounded primarily in textual sources:

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scientific articles, policy documents, and charity campaigns materials as well as blogs, newsletters, and other, more informal media. The analysis is also undergirded by a small number of interviews (conducted over 2012–2014) and informal conversation with various policy actors including civil servants, policy advisors, and charity leads. It is additionally informed by scores of encounters with different kinds of mental health professionals and discussions with a range of people who have lived experience of mental ill-health. I have been engaged to varying degrees for around 20 years now with different constituents of the psychological complex – including people receiving or/and contesting healthcare, as well as advocacy and campaign groups – through formal research interviews and focus groups as well as more everyday and personal interactions. Some of the people closest to me also work within the NHS delivering therapy, including as clinical and health psychologists. Further, alongside undertaking the sociology *of* the psychological complex I am also increasingly an actor *within* it through active research collaborations with psy-practitioners. The arguments made in this book are deeply impacted by all those engagements.

In Chapter 1, I elaborate further on the introductions to clinical psychology I made earlier in this Introduction. I demonstrate how professional claims-making operates as a form of boundary work that both configures and is configured by the evolving identity of clinical psychology. The keenness of many in the field to position it as different from psychiatry is illuminated, with the 'diagnostic' approach deemed particularly problematic by a variety of leading clinical psychologists. Likewise, I spotlight how some in clinical psychology also labour to differentiate it from other psychological traditions (like counselling psychology and health psychology), including through the development of a professional body solely for clinical psychologists: the UK Association of Clinical Psychologists (ACP-UK). Ultimately, these forms of boundary work help to configure the nature and practices of clinical psychology. Accordingly, they also have implications for the values and perspectives of individual therapists and the kinds of care people are (or are not) able to access.

Chapter 2 explores the rise of the English IAPT programme. This flagship initiative aimed at enhancing access to psychological therapy has drawn international acclaim – alongside critique and concern. In attending to its underpinnings, I highlight the managerial and clinical trends IAPT drew from and extended to proliferate therapy at scale. I examine how features of IAPT understood to be novel came to be regarded as vital forms of infrastructure around which other psychological services should be built.

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I also illustrate how the economic logics that underpinned IAPT initially resulted in particular kinds of therapy being rolled out for certain types of conditions experienced by specific groups, most notably CBT for anxiety and depression diagnosed in working-age adults. The chapter reflects on the ramifications of IAPT, including in relation to the understandings of the nature of ill-health that result from it.

The narrative then turns to explore and historicise attempts to review the 1983 Mental Health Act of England and Wales. In Chapter 3, I focus on the traffic between clinical affirmations about the need to enhance access to treatment – increasingly understood to be psychological therapy – for people diagnosed with a personality disorder and political aims to detain criminal offenders living under this diagnosis for longer periods. The rewriting of the Act and the significance of personality disorder among these represent a key yet underacknowledged moment in the unfolding story of access to psychological care, while also demonstrating how improved access is not necessarily an unproblematic social good. The chapter demonstrates how legal and professional discourses contoured each other such that an understanding of personality disorder as treatable through psychological intervention was produced. Doing so improved the accessibility of therapy for some people; however, this was often as a consequence of their involuntary confinement.

Part II of this book returns to focus specifically on clinical psychology and how the activities of its practitioners have been configured though an ethic of access. It attends to clinical psychologists' negotiations of patient access to their care, including via the management of waiting lists and the rejection of referrals. I draw primarily on 40 interviews conducted over 2013–2015 with clinical psychologists who worked across a range of services in both rural and urban localities in both England and Scotland. These are interpreted against a backdrop of an assortment of conferences and professional events held by or convened for mental health professionals in general or clinical psychologists in particular. I took part in these on and off for more than a decade (with some respite during and following the COVID-19 pandemic). Some I arranged myself, with the explicit aims of bringing activists, clinicians, patients, and policymakers into conversation. The interview data are further contextualised by the materials and data that informed Part I. Again, the arguments advanced are additionally shaped by my ongoing research into, and increasing participation within, the psychological complex. Unfortunately, these continuing engagements confirm that many of the concerns discussed in Part II – such as long waiting lists and associated challenges – have only worsened since the interviews were conducted.

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Chapter 4 analyses how clinical psychologists preface (potential) care through negotiations of referrals and acts of assessment prior to any kind of therapy. I regard these as key 'uncertainty moments', in which practitioners must decide whether to see a someone for therapy. This decision-making process depends on far more than an 'objective' evaluation of the person in front of them. Resolution of uncertainty entails the reciprocal configuration of at least three kinds of ontologies: the ontology of a potential patient; the ontology of the service in which they work; and the ontology of their profession. These are not necessarily stable; rather, they can be remade over time and in relation to particular service users (demonstrating how visions and adjudications of therapeutic need are highly contextualised). Such 'prefacing practices' contribute to the denial of access for some people, although even exclusions might themselves sometimes be accounted for by professionals as a form of care.

In Chapter 5 I move to consider some of the challenges of waiting lists and associated targets that configure clinical psychology. Taking the position that targets operate as a technology of government (Rose, 1996), the chapter indicates some of the affective and material consequences of their instantiation. In particular, I show how clinical psychologists rework processes of entry into therapy, and the aims and character of care, to meet – and sometimes accommodate – targets. While professional autonomy is often regarded as being constrained through these technologies of government, practitioners nevertheless find ways of performing autonomous action in a manner that can advantage some patients over others. I illuminate how shifts in psychological care in response to targets might recast clinical psychologists' relationships with their work and with people seeking therapy. In so doing, implications arise for the subjectivities that are (not) assembled through therapy.

Chapter 6 centres clinical psychologists' perspectives on and responses to 'did not attend' (DNA) policies. Patient non-attendance at clinical appointments has long been regarded as troubling within healthcare, particularly so in light of pressures and targets to see more people for therapy and more quickly. DNA policies are also an object of often latent concern by professionals and patients in relation to how they ostensibly improve access for some people through the potentially strategic exclusion of others. I analyse how clinical psychologists account for and navigate such policies, exploring how (in)formal rules around attendance can prompt the involuntary discharge of patients. DNA policies often provide space for clinical discretion and are even sometimes elided by practitioners. Their negotiations can involve highly moralised configurations of both

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patient and professional subjectivities. These contribute to legitimising exclusion from services, as well as the expertise leveraged to do so.

Finally, I conclude with a short coda. In it, I describe some of the ambivalences that come with an ethic of access. I reflect on the procedural and ethical challenges that can be propelled by ostensibly progressive healthcare initiatives, and consider what could perhaps be done about these. In light of the arguments made throughout the preceding chapters, I decline to advance discrete recommendations in what is already a crowded policy space. Rather, I urge an ethos of reconfiguration within mental healthcare that fosters variability and mutability in services through direct and ongoing engagement with communities. In so doing, psychological practitioners might be enabled to better comprehend, articulate, and serve the needs of those with whom they undertake therapeutic work.

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