CHAPTER 1

Positioning Psychology
Configuring Professional Boundaries and Identities

A whole range of ideas, practices, and institutions intersect and reciprocally shape one another to give life to the psychological. The overarching discipline of psychology itself, with all its constituent traditions (including clinical psychology), is of course key among these. Significant too, though, are fields such as psychiatry, counselling, social work, and education. These and much more – everyday notions, actions, and relations – form what Nikolas Rose (1985) has called the psychological complex. Attending to how clinical psychology is configured with respect to its close neighbours within this multifaceted and dynamic matrix offers insight into how its practitioners conceive of themselves. This production of professional identities, in turn, has ramifications for the people with whom psychologists work. Disciplinary claims making and straightforward politicking contour the psychological complex, informing the kinds of knowledge and expertise through which subjects are known about, acted upon, and configured through.

As we saw in the Introduction, the role of the clinical psychologist in the United Kingdom over the last 70 years or so has shifted from that of a psychometrician embedded in psychiatric contexts to being an autonomous therapeutic practitioner and authoritative figure within the mental health ecosystem. In considering this change, it is important to underscore that – as practitioners themselves have argued – clinical psychology 'cannot be understood in isolation' (Cheshire and Pilgrim, 2004, p. 5). Accordingly, this chapter explores how the profession engages in what sociologists term 'boundary work' (Gieryn, 1983) in relation to other psychological specialisms and psy-professions. How, for example, are boundaries drawn between the nature, remit, and function of clinical psychologists vis-à-vis these other experts (Goldie, 1977; cf. Buchanan, 2003; Schlett, 2022; Scull, 2015)? Assuming this boundary drawing can be read as a form of 'occupational identity work' (Allen, 2000, p. 345; Snow and Anderson, 1987), what kinds of claims about and understandings of clinical psychology emerge in the process?

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Boundary work is a strategy for generating and controlling status and resource (Lamont and Molnár, 2002), including through the modulation of relative prestige inside a broader professional milieu where this has economic connotations (Burri, 2008; Comeau-Vallée and Langley, 2020). Within healthcare, both inter- and intra-professional boundaries serve important roles in the configuration of specialities and practices (Goodwin et al., 2005; Jenkins, 2020; Lindberg et al., 2017; Martin et al., 2009; Nancarrow and Borthwick, 2005). In what follows, my focus is, primarily, on the relationship between clinical psychology and psychiatry – one that was vital to the consolidation of clinical psychology and which remains significant (Derksen, 2000; Hall, 2015). I attend especially to the discursive configuring of psychiatry by clinical psychology, and how this acts to demarcate the disciplines and to underscore the singularity of the latter. Towards the end of the chapter, I then move to reflect on how clinical psychology navigates boundaries between, and asserts its distinctiveness and autonomy in relation to, other psychological professions in the NHS – focusing on health, as well as counselling, psychology. This is in light of both long-standing and recent 'jurisdictional disputes' (Abbott, 1988, p. 74) between these psychological professions and clinical psychology, and various attempts to manage these by the British Psychological Society (BPS). By examining how clinical psychology positions itself in relation to other disciplines, a brighter light can be cast on how professional identities, discourses, and practices are reciprocally configured.

Clinical Psychology and Psychiatry

> That a strong, respected and highly competent profession of psychiatry is essential to the growth and flourishing of clinical psychology appears obvious; it is perhaps no less true to say that the existence of a large group of well-trained, competent, and friendly clinical psychologists can be of the utmost value to psychiatry.
>
> (Eysenck, 1950, p. 714)

These comments were made by the influential psychologist Hans Eysenck in an article outlining 'The Function and Training of the Clinical Psychologist'. Eysenck (1950) asserted that the Maudsley clinical psychology training course (discussed in the Introduction) sought 'to facilitate such a rapprochement' (p. 714) between clinical psychology and psychiatry. More than 70 years later, the kind of mutually beneficial relationship between disciplines outlined in the section-opening quote seems, more or less, to have developed. The professions work closely together within

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mental health services, as well as often within universities. However, there have been many bumps along the way as clinical psychology and psychiatry have sometimes moved apart yet remained connected (Burns and Hall, 2021; Cheshire and Pilgrim, 2004; Samson, 1995). Today, flare-ups between them remain not altogether uncommon, and within the literature and especially on social media those sometimes burn brightly.

Before examining some of those tensions, I want to step back for a moment to consider some of the salient (dis)similarities between clinical psychology and psychiatry. Within popular culture, distinctions between these professions can often be elided: the terms 'psychological' and 'psychiatrist' – not to mention 'therapist' and even 'shrink' – are sometimes used synonymously. Boundaries can inadvertently be further blurred by practitioners themselves: some psychiatrists are consultants in medical psychotherapy, for which they have received advanced training in psychological treatments (Royal College of Psychiatrists, 2019). Certainly, both professions are orientated towards intervening in psychological distress. The stated and enacted differences between them are important, however (Abbott, 1988).

In the United Kingdom, prospective clinical psychologists must study for a Doctorate in Clinical Psychology (DClinPsy). This is achieved through a combination of teaching, research, and therapeutic provision. Applicants for doctorate programmes are commonly only successful after some years working as an assistant psychologist or in a similar role, usually within the NHS (following undergraduate training in psychology and often an MSc degree as well). For their part, psychiatrists are, by definition, medically qualified. After a degree in medicine, further training is then undertaken in psychiatry. Following examination, this eventually leads to membership and then later perhaps fellowship of the Royal College of Psychiatrists. As medical practitioners, psychiatrists can legally prescribe pharmaceuticals; clinical psychologists cannot. They also tend to be more diagnostically orientated than clinical psychologists. Nevertheless, the differences between professions with respect to diagnosis can sometimes be overstated, and – as we will see – also deployed to underscore the distinctiveness of clinical psychology.

Prescribing is a useful starting point to think about the discursive boundary work that helps to configure clinical psychology. Perhaps unsurprisingly, debates about whether psychologists should have some kind of prescribing rights occasionally foment. The legal authority to prescribe would bring clinical psychology in line with other key health professions, such as nursing. However, opinion on this matter varies greatly (BPS,

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2020; Cohen-Tovée, 2020). Rebecca Courtney-Walker, Chair of a BPS Group charged with considering this issue, reflected during her work that the question of prescribing rights for psychologists has long 'been a controversial topic with strong views on both sides of the debate' (Courtney-Walker, 2019, p. 2). Responses to a 2019 consultation with psychologists about prescribing 'showed', in her view, 'considerable passion' (Courtney-Walker, 2020, p. 3). Some judged prescribing rights as representing an opportunity for 'evolution' – 'especially as other professions have evolved and now routinely practice as psychological therapists, which was previously one of our unique selling points' (Courtney-Walker, 2020, p. 3). Concerns were raised by other respondents, though, 'that prescribing rights would mean psychologists may become more medicalised, posing a potential threat to their identity and practice as a profession' (Courtney-Walker, 2020, p. 2).

Alison Clarke, then Chair of BPS Practice Board, noted in 2020 that the diverging views about prescribing rights suggest 'the need for a wider debate about the future shape of our profession and what our trajectory towards that future may look like' (Clarke, 2020, p. 4). As Courtney-Walker's summary of consultation responses indicated, this is because negotiating a consensus on prescribing rights also involves negotiating what psychology is and what it should be doing. Discussions around pharmaceuticals are particularly volatile in this respect, since debates about their potential or proper roles within clinical psychology invite – and for some, even many, demand – deep reflection on what their use implies for how the profession conceptualises the ontology of psychological distress. If clinical psychologists are to prescribe the same drugs as psychiatrists, for example, does it mean that they must regard the targets of that intervention in the same way? Should clinical psychologists be urged to think more like psychiatrists?

This question speaks to a bigger concern within clinical psychology about what many practitioners see as the quintessentially biomedical epistemology shaping psychiatric thought and treatment. Unease about, critique of, and explicit opposition to this has been increasingly evident within a range of reports and commentaries over the past decade or so. This includes a high-profile BPS report produced by the Division of Clinical Psychology (DCP) and led by Anne Cook, titled *Understanding Psychosis and Schizophrenia*. In it the authors write that there is a 'need to shift from seeing ourselves as treating disease to seeing ourselves as providing skilled help and support to people who are experiencing understandable distress' (BPS DCP, 2017, p. 102). Accordingly, clinicians 'need to

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move beyond the "medical model"' (BPS DCP, 2017, p. 103). It seems likely that for the authors of this report, the answer to the question 'Should clinical psychologists be urged to think more like psychiatrists?' is a 'no' – as it is for a significant number of others as well.

We can see, then, that while clinical psychology and psychiatry can have broadly similar professional foci, the former can express considerable unease about mimesis with the latter. This is both despite and because of what Eysenck (1950, p. 714) referred to as the 'inseparable destinies' of these professions: what happens to one has implications for the other. Professional tensions between psychiatry and clinical psychology can at times be deeply felt. These can reflect much deeper ontological and epistemological disjunctures that through their proclamation and rehearsal come to be further enacted and more deeply entrenched.

Diagnosis and the 'Medical Model'

Clinical psychologists critical of medical approaches to mental healthcare sometimes posit that their profession works with a fundamentally different ontology of distress compared with ostensibly diagnostically orientated psychiatry. For these psychologists – and, it should be noted, quite a few psychiatrists – the complexities of subjective experience escape straightforward categorisation through diagnostic terms such as *bipolar disorder* or *schizophrenia*. Indeed, two of the authors of the aforementioned *Understanding Psychosis and Schizophrenia* report have argued that 'psychiatric diagnosis has the potential to be particularly damaging' when deployed in relation to experiences associated with psychosis (Cooke and Kinderman, 2018, p. 47). Such comments articulate with other statements around diagnosis in outputs from the BPS, and especially the DCP, in recent years. These assertions have occasionally been to the chagrin of some clinical psychologists who judge them to be made as part of intellectual debates and professional turf wars in which they profess varying degrees of disinterest.

Clinical psychologists who position themselves against biomedical – or, more specifically, diagnostic or pharmaceutical – approaches to mental health have held powerful roles within the BPS. Although many BPS documents suggest that psychologists should not be "anti" diagnosis in any straightforward way, these figures have helped to inflect wider debate within the Society and the profession. Peter Kinderman, for instance, is a professor at the University of Liverpool who has held a range of BPS leadership roles, not least BPS President (2016–2017) and, for two terms,

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DCP Chair (2004–2005 and 2010–2011). He is also the author of a range of texts critical, to varying degrees, of biomedical approaches to mental health, including the books *A Prescription for Psychiatry* (2014) and *A Manifesto for Mental Health* (2019). For Kinderman, 'diagnoses are often unreliable, invalid and separate inappropriately the person from their experiences' (Kinderman, 2015, p. 156).

Other high-profile clinical psychologists, such as Richard Bentall (2009) and Mary Boyle (1997), have also written critically, and sometimes for a wide audience, about psychiatry, psychiatric diagnosis, and pharmaceuticals. Probably one of the best-known critics in clinical psychology of psychiatric diagnosis is Lucy Johnstone, a senior practitioner in Bristol. She is a key contributor to, and occasionally an architect of, a variety of highly visible BPS policy statements and guidance (including some described later here). In a range of writings, such as her monograph, *Users and Abusers of Psychiatry* (Johnstone, 2021), she has set out clearly and powerfully the harms that can result in the adoption of a disease-focussed conception of subjective distress. Johnstone has sought to actively further the separation of clinical psychology from diagnostically orientated approaches to mental health. In her view, 'We are close to recognising the traditional psychiatric model of "mental illness" for the failed paradigm that it is' (Johnstone, 2016, p. 732).

Beyond Diagnosis

A particular focus of psychological critique has been the American Psychiatric Association's *Diagnostic and Statistical Manual for Mental Disorders* (the DSM). This is widely judged to be emblematic of a diagnostic approach to psychiatry with which many in clinical psychology take issue. The fifth edition of the DSM, the *DSM-5*, was released in 2013. Over the course of its writing, and immediately following its release, there was a proliferation of critical discourse centred upon this text (Kinderman et al., 2017). As we will see, this critique was a key feature of the boundary work that informed the positioning of clinical psychological within the psychological complex.

Prior to its release in 2013, the BPS, among others (Kamens et al., 2017), wrote to the American Psychiatric Association to express concern that by classifying 'problems as 'illnesses'', the *DSM-5* 'misses the relational context of problems and the undeniable social causation of many such problems' (BPS, 2011). Subsequently, and a matter of days before the manual was released, the DCP released a Position Statement titled

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'Classification of Behaviour and Experience in Relation to Functional Psychiatric Diagnoses: Time for a Paradigm Shift' (BPS DCP, 2013). If the title of this document left some room for interpretation, the opening sentences made its point crystal clear:

> The DCP is of the view that it is timely and appropriate to affirm publicly that the current classification system as outlined in DSM and ICD [the World Health Organization's International Classification of Diseases], in respect of the functional psychiatric diagnoses, has significant conceptual and empirical limitations. Consequently, there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system which is no longer based on a 'disease' model. (BPS DCP, 2013, p. 1)

The Position Statement garnered considerable attention – including, and in advance of its release, from the left-leaning broadsheet, *The Observer*. An article therein framed the BPS document as an 'attack' on a 'rival profession', noting that it 'effectively casts doubt on psychiatry's predominantly biomedical model of mental distress – the idea that people are suffering from illnesses that are treatable by doctors using drugs' (Doward, 2013).

Unsurprisingly, this coverage and framing were not well received by many in psychiatry, but also generated concern, frustration, and even anger from some BPS members. Prominent academic psychologists Essi Viding and Uta Frith, for example, rebuked the authors of the DCP Policy Statement for 'attacking the *DSM-5*' and biomedical approaches. They wrote in a letter to *The Psychologist*,

> The DCP representatives in the media appear to predicate their argument on a false dichotomy between genes and environment, which seems to presume that search for genetic risk factors equals drive for medication and that demonstration of environmental risk calls for psychological therapy. We do not know of any informed researchers who would make a simplistic proposal like this. (Viding and Frith, 2013, p. 382)

Viding and Frith went on to outline links between genetics, psychology, and environment – conclusions about which, apparently, 'anyone who has done their homework in keeping up with the research in the past 20 years should be able to draw'. As far as they were concerned, 'representatives of the DCP should know better' (Viding and Frith, 2013, p. 382).

Viding and Frith's letter stimulated, in turn, its own spirited responses. Refuting claims made within Viding and Frith's contribution, Mary Boyle, for one, found it 'surprising' that they 'should use the words "attacking the DSM"', given 'the importance they attach to evidence' (Boyle, 2013, p. 466). Other psychologists also defended the Policy Statement, including a letter by Mel Wiseman and 209 other signatories which stated their clear

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'support [for] the DCP's call for a paradigm shift in how we think about mental distress and the need to move away from psychiatric diagnosis' (Wiseman, 2013, p. 469). As far as Wiseman and colleagues were concerned, 'We need to step out from the shadow of biological reductionism' (Wiseman, 2013, p. 469). Richard Pemberton, Chair of the DCP, also contributed to the debate. He noted that the Statement was not seen by the DCP 'as an "attack" but as a thoughtful critique based on a two-year process of reviewing the evidence and consulting within all the DCP Faculties, where it has widespread support' (Pemberton, 2013, p. 467). He did, however, 'regret that some of the reporting has badged this as a psychiatry versus psychology battle'.

Pemberton's comments reflect a wider rhetorical position in some of the critique of biomedical approaches to psychiatry emerging from the BPS and, especially, the DCP; specifically, that it is not psychiatry per se that is being criticised, but rather a particular approach within that profession. However, some psychiatrists (and clinical psychologists) see diagnosis as so quintessential to psychiatry that flare-ups can and do happen, contributing to the demarcation of boundaries between these professions.

Since 2018, a focal point of frictions has been the *Power Threat Meaning Framework* (hereafter *PTMF*), which itself embeds and extends critical discourse around the DSM. Led by Lucy Johnstone and Mary Boyle, the *PTMF*, as it is commonly known, drew from and developed a range of long-standing activities and agenda-setting texts produced by the principal and contributing authors (including Peter Kinderman). Rather than serving as another kind of handbook for clinical practice, it sought to provide 'an over-arching structure for identifying patterns in emotional distress, unusual experiences and troubling behaviour, as an alternative to psychiatric diagnosis and classification' (Johnstone and Boyle, 2018, p. 5; see also Boyle and Johnstone, 2020; Harper and Cromby, 2022). Concerned with distress in its social and political contexts as well as individually experienced, and as the outcome of interactional 'relational, social, cultural and material factors' (Johnstone and Boyle, 2018, p. 8), the authors cast the *PTMF* as distinct from a more DSM-orientated approach. Johnstone, Boyle, and colleagues noted, for example, that the Framework 'allows provisional identification of general patterns and regularities in the expression and experience of distress and troubled or troubling behaviour, as opposed to specific biological or psychological causal mechanisms linked to discrete disorder categories' (Johnstone and Boyle, 2018, p. 8).

The *PTMF* has attracted considerable praise alongside a great deal of critique, much of which has played out across social media. The authors

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have reflected on concerns raised around their text (Johnstone et al., 2019), for instance in relation to how, and the extent to which, it focuses on trauma. Some criticism has also related to an assumed orientation of the *PTMF* towards 'anti-psychiatry' – although its authors appear keen to eschew accusations that the document is part of a strategy for asserting professional dominance (Johnstone et al., 2019). Indeed, psychology itself is taken to task by the authors, along with psychiatry, including for its 'reluctance to acknowledge positivism as a philosophy rather than a set of self-evident rules for discovering facts about the world' (Johnstone et al., 2019, p. 49). Still, it is hard not to read the *PTMF* as a kind of strategic resource for enacting boundaries between clinical psychology and psychiatry, given the latter is so often understood to have diagnosis at its heart.

Formulating Clinical Psychology

A primary concern for many psychological critics of psychiatric diagnosis – and, it should again be noted, for some psychiatrists (Pickersgill, 2024) – is that it represents a 'loss of meaning' (Johnstone, 2017, p. 31). As Johnstone summarises,

> By divesting people's experiences of their personal, social, and cultural significance, diagnosis turns 'people with problems' into 'patients with illnesses.' Stories of trauma, abuse, discrimination, and deprivation are sealed off behind a label as the individual is launched on what is often a lifelong journey of disability, exclusion, and despair . (Johnstone, 2017, p. 31)

As a counterpoint to this, the BPS supports the practice of psychological formulation. This is a skill in which the regulatory body, the Health and Care Professions Council (HCPC), requires all varieties of practitioner psychologists to be proficient (HCPC, 2023). 'Formulation' has increased in prominence over the last two decades; however, it has a much longer history – as the DCP themselves point out (BPS DCP, 2011). Indeed, this history is itself deployed by proponents to emphasise its importance (Johnstone and Dallos, 2014).

The central role of formulation in clinical psychology was underscored through the 2011 DCP *Good Practice Guidelines on the Uses of Psychological Formulation*. The development and writing of the Guidelines were led by Johnstone herself, and they attracted considerable attention and celebration. According to Johnstone, formulation 'is considered to be the core skill of the profession of clinical psychology' (Johnstone, 2018, p. 31). Through such statements, formulation can be leveraged as an important means of bounding and defining the profession.

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What, though, is formulation? Like many questions within psychology, the answer depends in part on who one is asking, why, and in what contexts. Further, as Johnstone, writing with Rudi Dallos, has described, there are also a multitude of ways through which psychologists can produce formulations (Johnstone and Dallos, 2014). In the aforementioned DCP Guidelines, formulation was defined as 'a hypothesis about a person's difficulties, which links theory with practice and guides the intervention' (BPS DCP, 2011, p. 2). In a 2019 leaflet aimed at people undergoing psychological therapy, the DCP described it as 'a joint effort between you and the psychologist to summarise your difficulties, to explain why they may be happening and to make sense of them'. A metaphor of a jigsaw was used to further articulate this process:

> Working on a formulation is like two people putting together a jigsaw. The pieces of the 'jigsaw' are pieces of information such as:
>
> - How you feel at the moment;
> - What's going on in your life now;
> - When the difficulties or distress started;
> - Key experiences and relationships in your life;
> - What these experiences and relationships mean to you.

Formulation was presented as providing 'a starting point' for psychological therapy, which 'can be updated to respond to new information or changing circumstances'. Accordingly, 'a formulation is never static – it will keep evolving throughout your work with a psychologist as you find out more about yourself'.

Depending on how and why it is used, the practice of formulation may or may not align with diagnostic approaches to mental health. It does, however, have a particular resonance for clinical psychologists who seek to move away from the use of diagnostic categories, and is increasingly recommended in place of diagnosis (Bowden et al., 2020). Lucy Johnstone, for instance, has argued that formulation is a 'credible alternative' (Johnstone, 2018, p. 30) to diagnosis; indeed, best-practice formulation is deemed to be 'based on fundamentally different principles from psychiatric diagnosis' (Johnstone, 2018, p. 39). Peter Kinderman, too, has urged the use of a formulation-based approach rather than diagnosis (e.g. Kinderman, 2015; Kinderman et al, 2013). In his words,

> [W]e must move away from the 'disease-model', which assumes that emotional distress is merely symptomatic of biological illness, and instead embrace a model of mental health and well-being that recognises our essential and shared humanity. (Kinderman, 2015, p. 160)

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Since, for Kinderman (and others), 'diagnostic entities lack validity, it is much easier and more appropriate to develop formulations' (Kinderman, 2015, p. 157).

An enhanced focus on formulation also aligns with wider moves on the part of some psychologists over the last decade or so – including Johnstone, Kinderman, and more activist groups like Psychologists Against Austerity – to revitalise a focus on social and economic inequality as part of psychological work (indeed, the BPS Annual Conference 2019 was specifically themed around 'The Psychological Impact of Inequality'). McClelland (2013, p. 121), for instance, argued that attention to inequalities within the process of formulation 'goes beyond the traditional boundaries of psychology in emphasising the role of social and cultural contexts in shaping problems'. This focus on inequality itself speaks to concerns within clinical psychology that mental health practice can individualise patient distress – with psychiatric diagnosis commonly seen as a key mechanism of reifying such individualisation.

Despite its historical and more recently underscored role in clinical psychology, formulation has not necessarily been a consistently significant strand of psychological discourse. As Harper and Moss reflected at the turn of the century, while 'formulation is now considered central to the professional practice of clinical psychology' neither recalled 'it being mentioned in any detail during our training as clinical psychologists in the late 1980s and early 1990s' (Harper and Moss, 2003, p. 6). Drawing on Crellin (1998), they likewise noted that formulation had been presented as rather distinct to clinical psychology and 'this, no doubt, serves a function of promoting clinical psychology as a unique discipline' (Harper and Moss, 2003, p. 6). To rewrite their proposition through a more explicitly sociological idiom: presenting formulation as both central and (reasonably) distinct to clinical psychology is a form of boundary work. In particular, it acts to distinguish the profession from other forms of psychological expertise within an economically challenging context (i.e. the NHS) which drives different therapeutic practitioners to compete for status and resource.

Yet, although clinical psychology dominates much discourse in mental health in relation to formulation, many psychiatrists – as well as other mental health professions – also engage in formulation (Pickersgill, 2024). A senior psychiatrist once described to me his surprise at what he saw as some clinical psychologists presenting formulation as a radical break from diagnosis. This particular interlocutor, a clinical academic specialising in biological research, noted that he had been formulating for decades and that it had been central to his training (see also Armstrong, 1980). Other

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psychiatrists I have spoken with have likewise invoked this term and its importance to their clinical practice, and the potential to engage in formulation alongside diagnosis (Baird et al., 2017; Owen, 2023). Indeed, there are those who regard claims-making about formulation as sometimes comprising a rather unhelpful form of assault on psychiatry (Mohtasshemi et al., 2016). These contemplations and assertations are also a kind of boundary work, however. Specifically, they act to buttress against, and to an extent dismantle, claims of clinical psychological exceptionalism, and so serve their own professional ends as well.

Clinical Psychology and Other Psychologies of the Clinic

While clinical psychology is a significant focus of the work of the BPS, the membership of the society goes far beyond this profession. Currently, the BPS recognises several branches of psychology, and the Society is structured along 11 divisions that reflect these. Alongside the Division of Clinical Psychology, which as we have seen is very active in terms of producing policy statements and practice guidelines, there are also the Divisions of Academics, Researchers and Teachers in Psychology; Coaching Psychology; Counselling Psychology; Educational and Child Psychology; Forensic Psychology; Health Psychology; Neuropsychology; Occupational Psychology; Sport and Exercise Psychology; and the Scottish Division of Educational Psychology.

The DCP is the largest of the BPS divisions. Its members include clinical psychologists both in the NHS and in private practice, alongside some whose role is primarily research. The DCP is currently subdivided into 13 'Faculties', which are largely orientated to foci of particular clinical concern and expertise, such as Addictions, Eating Disorders, and Psychosis and Complex Mental Health (an outlier is the DCP Faculty of Leadership and Management). Notably, some of the Faculties overlap with the interests of other BPS Divisions: the DCP Faculty of Clinical Health Psychology and the Division of Health Psychology, for instance. Indeed, there can be some overlapping orientations at the divisional level itself, most notably between the DCP and the Division of Counselling Psychology (DCoP). These intersections can be key sites of boundary work among professional psychologists, and are a further means through which clinical psychology configures itself.

The challenge of demarcation between clinical and counselling psychology has been an issue at times for both professions. The latter has long roots in counselling in the United States and the United Kingdom;

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however, the BPS only approved a Division of Counselling Psychology in 1994 (Strawbridge and Woolfe, 2003). Even then, 'fierce resistance', as clinical psychologist Glenys Parry (2015, p. 190) put it, had to be overcome for this to happen. While technically a much younger profession than clinical psychology, counselling psychology nevertheless had considerable and long-standing evidence, concepts, and embodied experience from which to draw. Further, unlike clinical psychology, counselling psychology had always been configured around the therapeutic.

What is the difference between counselling and clinical psychology? As the authors of the introductory chapter of one handbook for the former remarked back in 2003, this question 'is not easy to answer' (Strawbridge and Woolfe, 2003, p. 4). More than a decade later, counselling psychologists Jessica Jones Nielson and Helen Nicholas argued that 'it is becoming more difficult to differentiate counselling psychologists from clinical psychologists' (Neilson and Nicholas, 2016, p. 211). Today, both groups deliver some kind of psychological intervention to a range of populations. Both, too, will be expected to have a (critical) understanding of psychiatric diagnosis, risk assessment, therapeutic relationship, and a range of other similarities.

Like clinical psychology (Cheshire and Pilgrim, 2004), counselling psychology has come to engage with a 'scientist-practitioner' model of practice (Corrie and Callahan, 2000). This is a popular phrase, if sometimes a little ambiguous. Holding it close, though, enables fully qualified psychologists across BPS Faculties to assert a keenly honed and sophisticated ability to engage closely with – and produce – research evidence about therapeutic mechanisms and efficacy. Part of this sophistication is knowing when to creatively interpret, move beyond, or elide 'the evidence' when doing so is deemed to be implied by the calculus of clinical judgement. The term also helps to draw boundaries between, for instance, both clinical and counselling psychologists and other providers of psychological care, implicitly elevating their status through the cultural, professional, and epistemic legitimacy that the term 'scientist' bestows.

Of course, despite all this there are also a range of differences between clinical and counselling psychology. Not least of these is the requirement for trainees of the latter profession to undertake personal therapy. Despite the assertions and recommendations of key figures in the DCP, there are also some in counselling psychology who feel that clinical psychologists espouse a more 'biomedical model' (Neilson and Nicholas, 2016, p. 211) through their work. The articulation of this position can be regarded as, in part, a strategy for differentiating the disciplines in ways that are advantageous to counselling psychologists. Since this group 'often compete[s] for

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similar jobs in the NHS' (Neilson and Nicholas, 2016, p. 211) as clinical psychologists, it makes good sense to present counselling psychologists as already practising in the ways DCP leaders are encouraging their own members to embrace.

The phrase 'reflective practitioner' has also been framed as perhaps especially important within counselling psychology. For Ray Woolfe (2012, p. 72), author or editor of several textbooks in this field, the notion of the reflective practitioner has 'offered a distinctive identity which articulated the special quality of counselling psychology'. It is one that is concerned with the thoughtful and critical analysis of clinical activities, with a view to ensuring that deep and open-minded reflection contributes to enhancing therapeutic and other kinds of practice (Carmichael et al., 2020). It is also a professional identity that is explicitly inculcated as part of training. For instance, the BPS *Handbook for Candidates* (BPS, 2022), for people seeking qualification in counselling psychology, describes how by the end of the qualification candidates are expected to 'embody the identity of the Reflective Practitioner' (BPS, 2022, p. 34). In contrast, while candidates are expected to be familiar with the scientist-practitioner role, no such embodiment is required. The aforementioned therapy that trainee counselling psychologists undergo is commonly framed as a key mechanism to develop and configure an identity as a reflective practitioner (Hanley and Amos, 2017).

Such an identity is not, though, one which clinical psychologists are willing to leave solely for counselling psychology. A range of writings on, training in, and encouragements towards reflective practice exist in the former field, commonly with a view that this should be imbricated with a scientist-practitioner approach (Carmicheal et al., 2020). Clinical psychologists have come to assert the values of reflection increasingly and publicly (Wigg, 2009), such as in the DCP guidelines on formulation (BPS DCP, 2011). As we can see, then, there are elements of a reciprocally iterative mimesis between clinical and counselling psychologies. This process can be regarded as powered, to a degree, by economic aims to secure posts for their members in an expanding but by no means limitless mental health workforce.

The Growth of Health Psychology

Just as the Divisions of Clinical and Counselling Psychology have their overlaps and potential for frictions, so too do the Divisions of Clinical and Health Psychology. The latter group are principally orientated to the study

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and mitigation of psychological issues associated with physical ill-health. Like counselling psychologists, health psychologists become chartered psychologists through a training route distinct to clinical psychology (BPS, 2021). The instantiation of health psychology within the BPS was first via the establishment of a Section in 1986, which became a Special Group in 1993, and then, ultimately, a Division in 1997- many members of which were initially trained as clinical psychologists (Bennett, 2015; Quinn et al., 2020). This gradual formalisation and growth followed interest by a small number of UK psychologists in the 1970s in the establishment of the American Psychological Association Health Psychology Division in 1978 (Wallston, 1997). Thereafter, a growing research and evidence base developed within universities and, more slowly, the NHS in the 1980s and beyond (Quinn et al., 2020).

While health psychology was professionalising in the 1990s, many clinical psychologists continued to consider physical health part of their territory. Some characterise themselves as 'clinical health psychologists' and work in services relating to, for instance, oncology, physical trauma, and pain management. The DCP supports a Faculty of Clinical Health Psychology for such practitioners, best regarded as 'a special interest group for all clinical psychologists practising in physical health settings' (Bennett, 2015, p. 304). This focus has obvious resonances with the activities of the BPS Division of Health Psychology (DHP), given its purposes to support and develop the discipline of health psychology and individual health psychologists – some of whom are indeed 'psychologists practising in physical health settings' (Bennett, 2015, p. 304), although many work in academia or public health. Given that the Faculty of Clinical Health Psychology was established in 1998 – a year after the formalisation of the DHP – it is hard not to regard its inauguration as, at least in part, a form of professional boundary work by the DCP.

When speaking informally to DHP members, I have sometimes encountered frustration about the position the larger and more established professional group of clinical psychology has held within what increasing numbers of health psychologists see today as their purview. This can centre on, for instance, the use by some DCP members of the aforementioned moniker, 'clinical health psychologist'. Notably, this is not a 'protected title' – that is, one of the professional titles legally protected by the HCPC in its role as the professional regulatory body for psychology in the United Kingdom (whereas 'clinical psychologist' and 'health psychologist' are). Some health psychologists feel that they are being implicitly, and on occasion explicitly, excluded from NHS jobs that advertise health-related

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posts through the terms 'clinical psychologist' or, more rarely, 'clinical health psychologist' (Bull et al., 2020) (despite BPS guidance about the use of inclusive job titles; Dooley and Farndon, 2021). Such advertisements can be explained, in part, by service leads who might be clinical psychologists that are perhaps unaware of the therapeutic expertise professed by some more recently trained health psychologists, or who are sceptical about the nature, extent, or potential applications of health psychology training. Regardless, health psychologists can at time feel discounted or marginalised within NHS settings where clinical psychology continues to hold considerable power and influence as compared to other psychologies (Asimakopoulou, 2022; Bull et al., 2020).

At the same time, some clinical psychologists can be disquieted by the increasing move of DHP members into what they have long seen as their domain, rather than that of health psychology: the provision of psychological therapy itself. For many years, health psychology was orientated far more towards academia than the NHS (Quinn et al., 2020). The non-therapeutic emphasis of health psychology was in fact part of the repertoire of persuasion and compromise that ensured support for the establishment of the DHP in the face of DCP members uncomfortable with the notion that health psychologists might deliver therapy (Bennett, 2015; Quinn et al., 2020). In recent years, however, ever more inroads are being made by health psychologists into the NHS and the delivery of psychological interventions (Forshaw, 2022; O'Carroll, 2014; Quinn et al., 2020).

Within BPS documents, the work of health psychologists is commonly carefully framed in terms of 'behaviour change interventions' or 'therapeutic intervention techniques' (e.g. BPS, 2021, pp. 5, 30), rather than more directly as 'psychological therapy' per se. Nevertheless, health psychologists can now be found in services orientated to, for instance, pain management and addiction, and employing psychological technologies like acceptance and commitment therapy (ACT) and CBT. Accordingly, characterising the interventions of health psychologists as lying outside of the realm of the therapeutic requires a particular framing of therapy that seems challenging to sustain. Unsurprisingly, this configuration of health psychology as a practitioner discipline can create friction with clinical psychologists.

The overlaps and tensions between clinical and health psychology, as with clinical and counselling psychology, underscore how, while psychological disciplines configure themselves through their professional self-image and foci, others in turn come to draw on similar language or practices to morph their own ontologies. A form of ratcheting is one result of this, with declarations of expertise and authority in a given field

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resulting in similar assertions from another, only to be met with fresh claims-making. Boundaries between psychologies are thus constantly being worked up through intra-professional praxis: they are built, partially dissolved, and redrawn. Importantly, this occurs within a notoriously competitive professional field, underscoring the need for psychologists within and beyond clinical psychology to stake claims to distinctiveness and significance.

Clinical Competition

Competition in clinical psychology starts early: training programmes are highly oversubscribed, and have been for a long time (Cheshire and Pilgrim, 2004). Application success rates are low, and those candidates who are not rejected are predominantly white and middle class (Palmer et al., 2021). Thereafter, career progression can also be challenging, although notably easier for white men, despite their proportionally far smaller numbers within the clinical psychology workforce (Palmer et al., 2021). Yet, despite many people seeking training in clinical psychology, NHS services can still sometimes struggle to recruit for a post (e.g. due to where a service is based geographically or institutionally). When this happens, these roles can be downgraded, or in some circumstances the funding for the job can be relocated or withdrawn (Dooley and Farndon, 2021).

Different employment pressures thus articulate and encourage what some critics of clinical psychology see as a shielding of that profession's interests by its more senior members, who can hold powerful roles within academia and the NHS. Some other kinds of psychologists consider that a corollary of this is the disadvantaging of their own specialisms (and perhaps, as a consequence, patients as well). Clinical psychologists are not necessarily unaware of the conversations that can circulate about them in this regard. As one noted in their reflections on working for 25 years in the NHS, clinical psychologists 'can be perceived as being precious or protectionist' (Fleming, 2012, p. 185) in relation to how they conduct their therapeutic work. This characterisation certainly aligns with some of the comments and assertions I have heard or seen made by other psychological practitioners, and even a few clinical psychologists themselves.

Over the past few years, issues around NHS employment for psychologists have come to be a focus of activity both for the BPS as a whole and for its individual members. Clinical psychologists have sometimes lamented the aforementioned downgrading of clinical psychology posts; at the same time, some other psychological practitioners have questioned why some

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jobs are earmarked for clinical psychologists in the first place (BPS Practice Board, 2019). The BPS Workforce Planning Advisory Standing Committee has been exploring these and related issues, which have also entered into discussions at the BPS Practice Board (one of the five activity-orientated boards of the BPS, reporting to the overarching Board of Trustees). In particular, there has been a desire expressed by some psychologists to move away from using protected titles (and unprotected titles, like clinical health psychologist) in job adverts and towards 'more inclusive' titles such as applied and practitioner psychologist (BPS Practice Board, 2020). This would enable a wider range of psychologists to apply for certain posts if they could evidence relevant expertise that might not be encapsulated by their route of chartership alone.

This move to 'recruitment by competence', as it is framed by the BPS, has generated various tensions since at least 2017 when moves began to be made towards refreshed recruitment guidance. According to some of my interlocutors, the shift has had support from some prominent members of the BPS over the years. However, while jobs advertised for 'applied psychologist' or 'practitioner psychologist' are more common, not everyone supports this move – and change has been slow. Job adverts are still not always framed inclusively, and the BPS Practice Board (2022) continue to consider how movement on this front might be encouraged. At the same time, various clinical psychologists have expressed concern about guidance around competency-based advertising which they read as potentially damaging to practitioners in their field (Kat and Yang, 2021). Concerns are on occasion also articulated, often less publicly, that people seeking therapy might not encounter psychologists with the necessary range of expertise. As we might expect, this charge can be hotly contested by BPS members beyond the DCP.

Tensions around changing recruitment guidance relate, in part, to the place that clinical psychologists have within the mental health workforce. For many years now they have been the dominant branch of applied psychology within the NHS, and a greater proportion are employed at senior levels that other kinds of psychological practitioner (Palmer et al., 2021). In Scotland, for instance, about 60% of the psychological workforce are clinical psychologists (NHS Education for Scotland, 2022). Across the United Kingdom, they also represent over half of the psychologists registered with the HCPC, whereas health psychology, for instance, comprises only around 2% (Palmer et al., 2021). Still, despite this dominance, these percentages indicate that there must be plenty of other professionals competing with clinical psychologists for jobs, influence, and

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prestige. We can see why clinical psychologists might want to defend their position within the NHS, despite widespread respect and regard for the knowledge and skills of – and a frequent management role in relation to – other psychological practitioners.

Therapeutic techniques common to clinical psychologists, particularly CBT, are also increasingly practised by other professions, including counsellors and psychotherapists (Parry, 2015). These groups are not necessarily BPS- and HCPC-recognised counselling psychologists, but instead tend to be members of the British Association for Counselling and Psychotherapy (BACP, founded in 1977 as the British Association for Counselling) and/or the UK Council for Psychotherapy (UKCP, founded in 1993). The additional boundary work between clinical psychologists, counselling psychologists, and counsellors (and, indeed, between the BACP and UKCP, and between both and the BPS) represents another means through which the psychological complex is further torqued (see, e.g. Hall, 2015; Parry, 2015).

However, the ramifications for clinical psychology of the place and role of counselling and psychotherapy within the NHS (and private sector) seem generally not to be felt so acutely as those associated with psychiatry and other BPS divisions. One possible reason for this is that clinical psychologists are often paid more than other providers of psychological therapy; for instance, within the NHS Talking Therapies initiative (although, as we will see in Chapter 3, this also has corollaries for clinical psychology). Still, the provision of CBT by people who are not clinical psychologists has occasionally raised concerns.

These tensions have collectively contributed to the launch of a professional society specifically for clinical psychologists: the Association of Clinical Psychologists UK (ACP-UK). Incorporated as a Community Interest Company in 2018 following an initial launch in the summer of 2017, in some ways the ACP-UK was a long time coming. Since at least the 1980s, some DCP members were dissatisfied with their relationships with the wider BPS, with various plans bubbling at different points to develop a professional society dedicated to the needs of clinical psychologists (Hall and Wang, 2015). The ACP-UK has expanded rapidly in size and has various member networks within it to support practitioners. Some of these have resonances with the DCP Faculties, such as the Clinical Health and Neuropsychology Psychology Network. It has also swiftly grown in influence, undertaking meetings with stakeholder organisations like the HCPC and the Royal College of Psychiatrists and putting out joint statements with other professional societies – including the BPS.

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Nonetheless, the relationship between the ACP-UK and BPS is not always easy. Peter Kinderman (2017), for instance, felt that he had to resign as a Trustee of the BPS given his support of the ACP-UK and what he described as a contrasting view on the part of other Trustees that the BPS 'needed to press forwards with one message; that the Society (and only the Society) was the natural home for psychology and psychologists'. Later, in 2020, the BPS Practice Board declined to approve a Memorandum of Understanding to shape collaborative working between the DCP and the ACP-UK, noting among other factors in the decision that the latter was 'a competitor organisation' (BPS Practice Board, 2020, p. 9). Relations seem to have improved, with the websites of both organisations proudly displaying news items relating to co-working on different campaigns. However, the very existence of the ACP-UK as is a reminder that the psychological complex is a matrix of many shifting facets, and that the actions of clinical psychologists themselves are key to many of those shifts.

Persistence through Reconfiguration

As sociologist Andrew Abbott (1995, p. 876) has noted, 'no social entity ever takes shape in a vacuum'. The social entity that is clinical psychology operates within a wider complex of psy disciplines, discourses, and practices (Rose, 1985) which inform what it has been and what it could become. In this chapter, I have reflected on how recent and ongoing shifts in clinical psychology are both powered through and have impacted claims-making and boundary work in relation to other professions, configuring the discipline in particular ways. Boundaries shift both iteratively and dynamically in response to changing contexts and professional evolution (Lindberg et al., 2017) while also helping to maintain a professional whole (Abbott, 1995). Practitioners labour to sketch out or even remake modalities of distinction within clinical psychology, such that the whole might retain its uniqueness and so help it to endure. Boundary work ensures that clinical psychology persists, rather than fracturing into further emergent professional realms or collapsing completely into the domain of applied psychology. At the same time, the reification of certain visions of clinical psychology provides a fleetingly stable referent in relation to which other fields might configure themselves.

Debates, discussions, and proclamations about diagnosis and the 'medical model' comprise one form of boundary work in which clinical psychology is presented as being distinct in orientation and approach to (a certain style of) psychiatry. This particular working of boundaries is

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significant by virtue of the prominence and influence of many claims-makers. When senior figures within the BPS advance assertions about what clinical psychology is like and what it *should* be more (or less) like, these do not float unacknowledged into the ether. While the transport of these proclamations through the circuits of discourse constituting the profession cannot necessarily be taken for granted, my encounters with clinical psychologists (and psychiatrists) working at the coalface of practice nevertheless indicate their traction. Not everyone agrees with every statement made by the DCP or senior clinical psychologists in relation to diagnosis, yet their quantity and prominence are often noted by Division members. Demarcations from psychiatry help to refine how the praxis of clinical psychology can be recognised as distinct, and so contribute to shaping practitioners' understandings of themselves and others (Hacking, 1995, 2002).

Clinical psychology is not, however, configured solely through professional, epistemic, and ontological politics with an 'external' competitor for resource and prestige. It is also shaped through more 'internal' negotiations with other kinds of explicitly psychological practitioners. As professions like health psychology place increasing emphasis on their skills as therapists, and as lower-paid professionals such as nurses with CBT training become ever more visible within the NHS, the need for clinical psychology to assert its novelty and significance increases. Clinical psychologists are well paid compared to the average UK wage and often to others who deliver psychological care, are highly qualified by anyone's standards, and enjoy associated social prestige. However, changes to the overall landscape of healthcare have left some within clinical psychology concerned that the value of their expertise is being diminished and the uniqueness of their training and skill-set downplayed. Organisations like the ACP-UK consequently today represent a compelling alternative to the BPS, which also continues to support professionals like counselling psychologists who can be direct competitors to clinical psychologists (e.g. for NHS jobs).

Clinical psychology, then, is at once a prestigious and influential profession while also being increasingly called upon to justify itself within a healthcare system ever more subject to an economic calculus of value. In these circumstances, the unique skillset of clinical psychologists vis-à-vis other therapeutic practitioners is not always apparent to healthcare commissioners and policymakers. This striving for singularity, and the role of boundary work within that, has a long history; as Derksen (2000) has argued, the boundaries between clinical psychology and psychiatry in the 1940s and 1950s were productive for the former profession in terms of helping to configure what exactly it offered in relation to its competitor/

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patron – stimulating innovation as a result. We can see similar dynamics operating over the 21st century, as discursive and institutional manoeuvring help to configure clinical psychology not only with respect to psychiatry but also in relation to other psychological specialities. The tensions that result are themselves propellants for sociotechnical reconfiguration within the profession.

Given what we know about the interpellations between psychology, society, and the self, we can reasonably assume that the ontological and epistemic machinations of clinical psychology have material and subjective effects. The ways in which this field seeks to (re)position itself and is positioned by – and positions – other fields have professional and economic ramifications in terms of what clinical psychologists are enjoined or permitted to do within the NHS, and (relatedly) how many are employed. These outcomes in turn affect investments in staffing and the nature of job roles for other experts in the psychological. Ultimately, the "success" (or lack thereof) of clinical psychology undergirds what kinds of professionals and forms of care people seeking support are able to access, and how they are configured through these (e.g. truncated forms of CBT as opposed to longer-term integrative therapies, or diagnostic versus formulation-based ontologies of distress). As wide-ranging psychological expertise continues to flourish and proliferate, the meaning and nature of therapy – and its subjects – likewise continue to change.

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