Chapter 1 Introduction

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This introductory chapter gives an outline of the development of psychology as a discipline from the mid-19th century, and the later interrelated concepts of clinical, medical and abnormal psychology. The professional practice of clinical psychology began in the United States, but under circumstances very different from the status of psychology in Britain at the same period. The chapter also describes the interacting roles of the British Psychological Society and the universities in contributing to the shape and size of psychology as a discipline. As the NHS is the dominant employer of clinical psychologists, its structures and conditions of employment have been a major influence in how the profession has developed.

What is psychology? …

Introductory text books on psychology usually refer to the long history of philosophical and medical thought that led to the modern concept of 'psychology', and then see the establishment of a psychological laboratory by Wilhelm Wundt (1832–1920) at the University of Leipzig in 1879 as a defining point in that history. While there is a long history of thinking about what are now seen as psychological topics, examining the second of these historical 'tropes', or conventional narratives, helps to understand how modern academic and scientific psychology achieved its current position.

Graham Richards (2010), in his critical account of the history of psychology, identifies the middle of the 19th century as the point when a discipline calling itself psychology can be considered to exist. He sees two developments as supplying both an integrative framework for the emerging discipline, and scientific procedures for pursuing them. These are evolutionary thought, associated with the work of Charles Darwin and Herbert Spencer, and the appearance in Germany of the methodologies identified with Gustav Fechner and Wilhelm Wundt. He also sees the statistical tradition of Galton and Pearson as influential, a tradition underpinning the whole field of psychometrics and psychological assessment (see chapter 10).

Leslie Hearnshaw's introduction to the history of psychology in Britain (Hearnshaw, 1964) similarly suggests that the work of Alexander Bain (1818–1903) marks a turning point in British psychology in four ways: he defines psychology more clearly than before; he lays an accurate physiological foundation for psychology; the requirements of scientific method are better understood; and his *The Senses and the Intellect* (1855) is considered 'the first text book of psychology written in the modern manner'.

For English-speaking psychologists, Wundt has 'unduly dominated our picture of late 19th-century psychological thought' (Richards, 2010, p.39) and is a controversial figure. Hearnshaw sees *three* figures – G.T. Fechner (1801–1887), Hermann von Helmholtz (1821–1894) and Wundt – as laying the foundations of modern psychology from their shared background in experimental physiology (Hearnshaw, 1987, chapter 9). The attention paid to Wundt is only partly because of the labora-

tory he founded, but also because he attracted numerous American postgraduate students from the 1880s. It is then possible to see Wundt as an early psychologist conferring status on the discipline through his good experimental credentials. The debate about Wundt is a salutary example of the tangle between the actual contribution of a psychologist as actor, and the contribution of audiences in revering teachers and leaders (Rieber, 2003).

Scientific psychology developed in German universities, and the modern research university developed from the model of the University of Berlin, founded by Wilhelm von Humboldt in 1810 (Rüegg, 2004, pp.3–31). The emphasis on research also led in turn to the creation of a new form of research degree, the Doctorate in Philosophy (PhD). The German model of universities was influential in the United States, and as the American psychologists who had studied in Germany returned to academic posts in the United States with their new knowledge and doctoral degrees, the United States proved highly receptive to the new discipline.

The era after the American Civil War saw the foundation of numerous secular universities, such as the postgraduate Johns Hopkins University, with a growing demand for postgraduate education. William James (1842–1910) became professor of psychology at Harvard in 1889, and in 1890 published *The Principles of Psychology*, a landmark in the history of psychology in the United States. He was a central figure in the developments from 1880, alongside G.S. Hall, who had completed a doctorate under Wundt, and was a driving force in the institutionalisation of psychology in America, founding not only the American Psychological Association (APA) in 1892 – the first national psychological society in the world – but also the *American Journal of Psychology* in 1887.

Alongside this academic and laboratory tradition, derived from a physiological background, are other clinical traditions, derived from both an organic and psychodynamic background. The long history of lunacy, based mostly in asylums, had generated a medical approach to diagnosis exemplified by the work of Emil Kraepelin (1856–1926). He had studied at Leipzig, and later worked at Heidelberg and Munich, and through successive editions of his Textbook (see Kraepelin, 1899) laid the foundation for a system of psychiatric diagnosis that underpins present-day practice (but see the historical account and critique of Kraepelin's work by Bentall, 2004). Sigmund Freud (1856–1939) was based in Vienna for most of his life. Following a fellowship in Paris in 1885 with the French neurologist Jean-Martin Charcot, he became interested in hypnosis, and from 1895 was publishing papers and books (such as his *Psychopathology of Everyday Life*, 1904/2003) on his ideas and therapeutic methods, which led to the development of psychoanalysis. Unlike Kraepelin, he formed a school of followers, early members of which included Carl Jung and Alfred Adler.

The 'psychological' foundations for clinical psychology are thus primarily German and American, and include the academic and laboratory traditions of Wundt, Fechner and von Helmholtz, the clinical traditions of Kraepelin and Freud, the American influence of James and Hall, and the British statistical traditions of Galton and Pearson. The First International Congress of Psychology was held at Paris 1889, and the following Congresses, all growing in size, confirmed an international consensus around the nature of the new discipline of psychology.

…and what is clinical, medical or abnormal psychology?

In 1945 the Council of the British Psychological Society (BPS) said that the term 'clinical psychologist' was 'not necessarily meaningless, but…liable to too much ambiguity and misunderstanding to be used by the Society' (BPS, 1945, p.50). How could this be?

The first use of the adjective 'clinical' in connection with psychology has conventionally been seen as referring to the practice of the psychological clinic set up in 1896 by Lightner Witmer of the University of Pennsylvania. This clinic was mainly for 'retarded children' and for children with physical defects associated with delayed development, and would probably now be called a child development clinic. William Healey also set up a clinic in a court setting in Chicago in 1909 to study antisocial behaviour. Misiak and Sexton (1966) explicitly contrast the two models, describing Witmer's model as essentially psychoeducational, following the Wundt and Kraepelin tradition, and as being 'static and segmented', and Healey's clinic as following the tradition of Freud and the French School, and as a 'dynamic total approach'.

There is at least one other earlier use of the term clinical psychology, in a pamphlet published in Edinburgh in 1861 entitled *The Clinical Teaching of Psychology* by James Crichton-Browne, a leading Scottish doctor. He wrote that the medical authorities 'will be compelled at length to incorporate clinical psychology with the other departments of professional education, and to require a study of it in every aspirant to medical education'. He was writing at a period before the emergence of scientific psychology and Freudian psychology, and it is apparent in the text that what he means by psychology is what would now be termed psychopathology or psychiatry, but he uses the terms 'clinical', 'medical', and 'practical' psychology with equal meaning.

A number of other terms have been used to describe the range of activities now undertaken by present-day clinical psychologists. The term 'medical psychology' has been widely used. Confusingly, the professional organisation for British psychiatrists, formed in 1841 as the Association of Medical Officers of Asylums and Hospitals for the Insane, was later known as the Medico-Psychological Association, and from 1926 until 1970 as the Royal Medico-Psychological Association (RMPA). The Medical Section of the British Psychological Society (BPS) published the *British Journal of Medical Psychology*, which was in practice an outlet for mainly psychodynamic papers. During the First World War the medically qualified doctors W.H.R. Rivers, C.S. Myers and W. McDougall were termed psychologists in the British Army (see Shephard, 2014). Abnormal psychology has been taken to refer to the psychology of 'abnormal' mental states and behaviour, most frequently those associated with psychological distress, and some early books with this title are in fact descriptions of psychopathology written by psychiatrists. H.J. Eysenck's monumental *Handbook of Abnormal Psychology* (1960) is an important example of a British text in this field, and was followed by a number of textbooks directed at the medical student market, such as that by Miller and Morley (1986).

Early American and British usage of the terms 'clinical', 'medical', and 'abnormal' psychology thus became confounded. Any of these terms and definitions not only claimed intellectual and scientific territory, but positioned that knowledge professionally. Another approach to understanding the term is to see

how it has been used by British clinical psychologists. The academic Oliver Zangwill thought in 1965 that 'clinical psychology involves people as well as problems, flair as well as training, art as well as science…above all the clinical psychologist has to learn to be useful, to doctors, their patients and to his own discipline' (Zangwill, 1965, p.18). The practitioner Mahesh Desai (1967), in his chair's address to the first scientific meeting of the newly established Division of Clinical Psychology, talked of the main functions of clinical psychologists as clinical assessment of patients in relation to their problems (which he also saw as formulation of opinions on the nature of the patient's condition), participation in treatment, guidance and rehabilitation, research, and teaching. The Division of Clinical Psychology of the BPS (Toogood, 2010) defines it as follows: 'Clinical psychology aims to reduce psychological distress and to enhance and promote psychological well-being by the systematic application of knowledge derived from psychological theory and data'.

In Britain the term 'clinical psychology' is now used widely, sometimes when strictly speaking an individual psychologist should be described as a health or forensic psychologist, or clinical neuropsychologist (see chapters 19, 21 and 22). In this book we have not sought to define the boundaries between these closely related branches of applied psychology. The term medical psychology continues to be used to describe the applications of psychology in general medical settings, but it would be archaic for psychiatrists now to describe themselves in that way. Abnormal psychology continues to be used to describe the psychological theories and processes used to explain both the problems presented by patients and some of the psychological variation within the 'normal' population.

An American legacy?

A number of accounts of the early history of clinical psychology as a profession in Britain have been published, claiming for example that 'clinical psychologists in Great Britain were from the start greatly influenced by their American counterparts' (Liddell, 1983). Was this true?

A detailed history of the development of clinical psychology in the United States has been written by Reisman (1991). There were at least three influences on early American 'clinical psychology'. One was psychometrics: Alfred Binet (1857–1911) had founded the first laboratory of physiological psychology at the Sorbonne in Paris in 1889, and collaborated with Theodore Simon, a psychiatrist, to produce the ground-breaking 30-item Binet–Simon scale, which Henry Goddard, a former student of G.S. Hall, revised to make the scale more suitable for general use in America. Second, the mental hygiene movement was initiated by Clifford Beers: from his own experiences at a psychiatric hospital he wrote an autobiography, *A Mind That Found Itself* (1908/1950), and with the support of William James and the leading psychiatrist Adolf Meyer, the National Committee for Mental Hygiene was formed in 1909. Third, Freud's early work was becoming known in America and G.S. Hall, impressed by his work, invited Freud, along with Jung and others, to Clark University in 1909 and as part of this visit a number of lectures were given promoting psychoanalysis.

During the First World War American psychologists were developing their clinical work. At the 1917 APA convention a group of concerned clinicians met and formed the American Association of Clinical Psychologists (AACP). An under-

acknowledged figure in this initiative was Leta Hollingworth, who was the first secretary of the AACP, and the first woman to have a leading role in American clinical psychology (Routh, 1994). The AACP was absorbed into the APA, so is the direct ancestor of the APA Division of Clinical Psychology. A number of American clinical journals were well established by the 1930s, including the *Journal of Clinical Psychology* and the *Journal of Abnormal and Social Psychology*; a wide range of formal psychometric tests had been developed; and by 1937 the eminent R.S. Woodworth could write an article drawing on the history of clinical psychology (Woodworth, 1937). The massive support for clinical psychology training by the US Veterans Administration from the 1940s was primarily to assist in the rehabilitation of US servicemen engaged in the Second World War, driven by ideas of social utility, reflecting the prewar existence of an identifiable group of clinical psychologists.

What then was the legacy of this as far as the UK was concerned? Two other new professions contributing significantly to mental health care had been developed in Britain before the Second World War, both of which were directly influenced by American practice. Psychiatric social work had been introduced in a carefully planned way, with the first training course in London in 1930 and the establishment of a professional organisation paid for by the anglophile American Commonwealth Fund (Stewart, 2013). Occupational therapy had developed at the same time, with the first trained occupational therapist appointed in Britain, at a hospital at Aberdeen, having trained in the United States. The first training course in Britain was set up at Dorset House in Bristol in 1930, with the first principal of the training course also having trained in the United States (Wilcock, 2002).

It is difficult to establish any similar direct funding or training links with America for clinical psychologists. The psychological clinic set up by Witmer was not the primary inspiration for the child guidance clinics set up in Britain and Scotland in the 1920s (Stewart, 2013). While H.J. Eysenck from the Maudsley Hospital was funded by the Rockefeller Foundation in 1947 to visit training courses in America, his mind was made up before he went and there is little evidence he learned from his trip (Buchanan, 2010), while the person responsible for training at the Maudsley, M.B. Shapiro, did not visit the United States early in his career. Considerable attention was paid in the United States to effective training, as shown by the APA's Shakow Report of September 1947, and by the Boulder conference of 1949 that put forward the scientist-practitioner model of training, but references to American training precedents are not prominent in early post-war British psychological publications (see chapter 24). There are no known early examples of an American-trained clinical psychologist occupying a senior post in Britain, although from the 1970s there were a few senior psychologists, such as Roger Squier in Kent.

Although the professionalisation of clinical psychology in Britain was conducted some decades after American developments, the extent to which it was directly informed by American practice is unclear, although American journals, other publications and test materials were used widely in Britain from the Second World War. In America there was massive federal funding and established university departments. In Britain there were no home-grown clinical psychology journals, no public budget for training and few home-produced psychological tests. There could hardly have been a worse period to start a new healthcare profession in Britain than in the 1940s.

Psychology in Britain

Psychology was far slower to become established as an academic discipline in Britain compared to both Germany and the United States. The period of most relevance to this book is around the Second World War: there were only five professors of psychology in Britain in 1939, the first being at Kings College London, with C.S. Myers as the first professor (but only part-time) in 1906. Three other noteworthy appointments were at University College London, where Cyril Burt followed C.E. Spearman in 1931; at Cambridge, where Frederic Bartlett was appointed in 1931; and at Edinburgh, where James Drever (primus) was also appointed in 1931 (Hearnshaw, 1964).

Before the Second World War there were at least three ways in which the term 'psychology' would have been understood by the general public in Britain. First, there was the tradition of scientific psychology already outlined, taught in universities and teacher training colleges and still emerging from the disciplines of philosophy, physiology and education. Second, there was the 'New Psychology', deriving from the tradition of psychoanalysis. Third, there was a strong tradition of popular or folk psychology, supported by a number of magazines and by organisations such as the British Federation of Psychologists (Thomson, 2006). It would not have been self-evident to even a reasonably educated person what the term 'psychology' meant on its own, or what knowledge or skills to expect of someone who called themselves simply 'a psychologist', let alone a clinical psychologist.

The role of the British Psychological Society

By the end of the 19th century, more universities had been founded in Britain, and 'science' had become institutionalised. In 1876 the Physiological Society was established, building on the expansion of both physiological research and the teaching of physiology to medical students, with meetings centred on the presentation of scientific papers for discussion. What would seem more natural when psychologists in Britain, many with research interests in physiological psychology, wanted to establish a psychological society, than that they should look to the Physiological Society for a model?

The present British Psychological Society (BPS) was formed at a meeting at University College, London, in 1901 – an earlier attempt to set up a 'Psychological Society of Great Britain' had failed after just four years, probably through an emphasis on spiritualism, and a failure to engage with the metropolitan intellectual elite (Richards, 2001). The 10 people who met in 1901 were an assorted group of academics and educationalists, including the physiologist Frederic Mott, already an FRS; W.H.R. Rivers, later famous for his anthropological work and therapeutic work in the First World War; and one woman, Sophie Bryant, headmistress of the North London Collegiate School. Their aim was 'to advance scientific psychological research, and to further the cooperation of investigators in the different branches of psychology'. The membership criteria were limited to those who were 'recognised teachers in some branch of psychology, or who have published work of recognisable value', so the BPS was formed in the mould of a select learned society.

In 1910 the Society had a membership of less than one hundred, and this had risen to 717 in 1927 (Hearnshaw, 1964). The major reason for this increase was the decision taken in 1919, led by C.S. Myers, to open the doors to those who were

'interested' in psychology, mostly people who were interested in the applications of psychology in the educational, industrial and 'medical' fields. The possibility that these three groups might form organisations of their own was one stimulus to change the membership criteria, but the accompanying substantial increase in membership subscriptions placed the Society for the first time in a reasonably stable financial position (Edgell, 1947).

Three 'Sections' were formed within the Society, one for each of these three fields of interest. The field of education was the first in which an applied psychologist was employed, by the half-time appointment of Cyril (later Sir Cyril) Burt to London County Council in 1913. The industrial field was boosted by the creation in 1921, again by Myers, of the National Institute of Industrial Psychology (NIIP), the largest employer of psychologists before the Second World War. Most of the members of the Medical Section were engaged in some form of psychotherapy in private practice; many of them were doctors who did not see the Medico Psychological Association (MPA), dominated by the asylum superintendents, as their natural institutional home.

At the beginning of the Second World War the BPS was both a learned society and an open-membership association, which was legally incorporated as a limited company in 1941, giving it a number of new powers. The governing body was the Council, made up of the elected officers, directly elected members, and representatives of the different subsections of the Society, crucially the three Sections (Education, Industrial, and Medical), and the editors of the associated journals. The Council reserved to itself all major decisions regarding communication with outside bodies, but there were no structures for professional psychologists. There were a number of ramifications of this structure. A number of the officers of the Society were also medically qualified, so as professional issues began to arise the position of the BPS on an issue could be put forward by representatives who were medically qualified, creating a potential conflict of interest. Quite apart from professional psychologists, a group of young experimental psychologists felt that the BPS did not meet their needs, and in 1946 the Experimental Psychology Group was formed, following an initiative by Oliver Zangwill, in intent and method remarkably similar to the initial meeting of the BPS in 1901 (Mollon, 2006).

The next major step for the BPS was the closure of membership in 1958, restricting full membership to those who possessed a formal qualification in psychology, normally an honours degree with psychology as the main content of the degree. The BPS laid down criteria for the acceptability of such degrees for membership, and by requiring entrants to a range of postgraduate courses, including clinical psychology, to meet those criteria it effectively controlled – and continues to control – entry to all fields of applied psychology in Britain: in 2014 the BPS approved 800 different psychology courses.

A Royal Charter was granted in 1965, conferring the right to be consulted on a range of government issues, and also to set up a chartering procedure, protecting the title of members. Following the grant of the Royal Charter, British educational psychologists formed a separate organisation as both a trade union and a professional body, the Association of Educational Psychologists (AEP), whose objectives were to 'raise the profile of educational psychologists', the implication being that they considered this was not achievable within the BPS (Martin, 2013, p.53). It was

not therefore axiomatic that the BPS would remain the umbrella organisation for all British psychologists. In the United States a split has occurred, with the American Psychological Society being formed in 1988 (now renamed as the Association for Psychological Science) to represent experimental psychologists, who were concerned that the APA (continuing as the larger organisation) was more concerned with practitioner issues.

The role of the universities

The supply of candidates for clinical psychology postgraduate training is crucially dependent on the capacity of university psychology departments. Indeed, the health and vitality of a discipline is often assessed by the number of its university departments, the numbers of its faculty and the overall numbers of students enrolled on its courses, as reviewed by the International Benchmarking Review of UK Psychology (ESRC, 2011, pp.1–37). Psychology within the UK was a late developer compared to its counterparts in Germany and the United States. During the first half of the 20th century, psychology as a discipline was expanding quickly in these countries and this was due to the accompanying expansion in numbers of universities and colleges. The UK, by contrast, had a much more conservative higher education establishment (Hearnshaw, 1969) and university expansion did not come about until the 1960s, both by the establishment of completely new campus-based universities and by former 'colleges of advanced technology' (CATS) being awarded university status, both preceding and after the Robbins Report on higher education (Committee on Higher Education, 1963). University education became more available to both older students and those without the conventional school background, to an increasing proportion of whom psychology was an attractive subject (see Anderson, 2006).

From 1960 to 1969 the number of chairs established in psychology had increased from 13 to 21, together with a doubling of the BPS membership from 1595 to 3356 (Hearnshaw, 1969). Up to the late 1980s the numbers of single honours psychology programmes accredited by the BPS were approximately doubling every 10 years, until there were 109 programmes accredited during 1985–1989, resulting in just over 2000 new graduates per year in 1989 for UK universities. From the 1990s onwards there was a massive step change in the expansion of both courses and student numbers, and in the next five years 310 programmes were accredited, rising to just under 500 programmes in 2014 (L. Horder, BPS Partnership and Accreditation Manager, personal communication, January, 2015). The increase in programmes was associated with a large increase in students, so there were 5645 psychology graduates in 1996.

There may be several factors behind this growth. A-level psychology was becoming increasingly popular, reflected in an annual growth rate of 14 per cent between 1985 and 1997, the third fastest growth rate for any GCE A-level subject. By 1997 there were over 27,000 A-level candidates within psychology (Holdstock & Radford, 1998). As psychology as a discipline was adopted by polytechnics and 'new universities' (post-1992) they typically had larger intakes of students than their more conventional counterparts, with a shift in their teaching philosophy from the traditional university laboratory approach, reliant on small practical classes, to larger lecture-based modes of delivery. More recent figures for the number of applicants

demonstrate continuing growth. For example, in 2009 there were 17,761 UCAS applicants and 15,385 accepted onto courses. As a subject area psychology is now one of the top three most popular subjects for study at UK universities, only outmatched in absolute terms by the numbers of medical students, or in growth rates by student numbers within economics (ESRC, 2011). Current estimates are 91,000 students, including 18,000 postgraduates (Hulme, 2014).

What is the impact of the discipline's popularity on the profession of clinical psychology? As discussed in chapter 7, even in the 1970s the Trethowan Report (DHSS, 1977) commented on the ready availability of psychology graduates. Clearly supply far outstrips demand for clinical psychology training, but there are both challenges and opportunities in this situation. If the profession is to serve minorities within the population, then one requirement is that the psychology workforce matches that diversity. The sheer numbers of psychology graduates ought to ensure that minority groups (e.g. members of ethnic minorities, and gay and lesbian people) have better opportunities for recruitment into the profession (Turpin & Coleman, 2010; Turpin & Fensom, 2004). The profession needs to actively encourage and welcome these graduates into its fold, and ensure that its values and practices are relevant to minority groups and cultures (Williams et al., 2006). The second opportunity is to encourage more psychology graduates into careers in other health professions, including support roles for applied psychologists.

How many clinical psychologists were there?

It is difficult to answer the question 'What is the size of the profession?' with precision, for a number of reasons. Statistics for England and Wales were the ones usually quoted in official reports, but these figures of course omitted Scotland and Northern Ireland. Figures could be quoted as either numbers of psychologists, or as full-time equivalents (FTE). Figures could be based on NHS employees, or on BPS membership lists. So the following data are only as good as contemporary methods of collection and aggregation: it is impossible to present whole-time equivalents for the whole of Britain on a consistent basis across the period. One of the most careful recent calculations (Turner et al., in press) gives numbers for clinical psychologists employed by the NHS in England and Wales only (see Table 1.1). Figures for the BPS and BPS subsystems are derived from annual reports of the Committee of Professional Psychologists (Mental Health) (CPP(MH)) and the BPS membership lists (see Table 1.2).

Figures for the subgroups within the CPP(MH) show those who were members of the child and adult subsections separately. In 1951 there were 211 and 17 members of the two sections respectively. The figures for 1966 show that at that point there were fewer clinical psychologists than educational psychologists, while in 2010 there were over three times more clinical psychologists than educational psychologists in the respective Divisions of the BPS.

Precisely because of doubts about the reliability of official figures, the DCP periodically organised workforce surveys. One of the most careful surveys (Scrivens & Charlton, 1985), commissioned by the Steering Group on Health Services Information, gave 1486 clinical psychologists in post in England in 1985, with 1734 established posts. This report also showed that 70 per cent of NHS districts had fewer than nine psychologists in post, and that 30 per cent of districts had fewer than four

Table 1.1 NHS clinical psychologists in England and Wales 1950–2010/11 (Turner et al., in press)

Year	*psychologists*
1950	<121
1960	179
1970	399
1980	1078
1990/91	2200
2000/01	5316
2010/11	8837

Table 1.2 Members of the BPS, and members of relevant BPS subsystems 1945–2010

Year	*BPS members*	*CPP(MH) members up to 1965 DCP members from 1966*
1945	1164	77
1950	1897	208
1955	2345	350
1960	2655	425
1965	3587	479
1966	3300	163*
1970	3811	362
1980	7655	966
1990	14,105	1574
2000	26,809	4210
2010	48,195	9554

*The CPP(MH) became the DCP in 1966; the fall in membership is due to educational psychologists moving to their own Division.

posts. Sample figures for Northern Ireland are 10 individuals in 1967, 68 in 1998, and 257 (230 FTE) in 2013. Sample figures for Scotland are 10 FTE in 1948, 94 FTE by 1976; in 2000 there were 428 individuals (360 FTE) and in 2014 795 individuals (668 FTE) (see chapter 23). What all of these figures show is that during the first decade of the NHS only a minority of mental illness or mental handicap hospitals employed even one psychologist.

The statistics from the current statutory registration body, the Health and Care Professions Council, are more reliable. Disentangling the numbers for August 2014 for all categories of practitioner psychologists shows that 8854 psychologists were registered as only clinical psychologists (7242 women and 1603 men, so 82 per cent female). Another 470 psychologists are registered with various combinations of clinical with forensic, health, counselling and educational psychology (one person is registered as clinical, counselling, forensic and health), giving 9324 individuals currently registered as a clinical psychologist (HCPC, 2015).

The British National Health Service

The creation of the NHS

The origins of the profession of clinical psychology are interlinked with the creation and subsequent development of the British National Health Service (NHS). The two-volume official history of the NHS by Charles Webster (1988, 1996) gives detailed information on many of the points made in this section. Developments within the profession have been in response to demands placed on it by the NHS as its major employer, and the great majority of funding for training has been from the NHS. This symbiotic relationship between the development of a state healthcare system and the profession of clinical psychology is unique to the UK (see chapter 24).

Before the Second World War economic depression, and a failure to reform health, education and social services, meant that there was no overall coordination in Britain of the patchwork of state-funded, locally funded, voluntary and privately funded services. Hospitals for people with mental disorders and mental handicap were provided and managed by county and borough councils, and poor law institutions were locally managed. Provision by the most prestigious teaching hospitals, managed by Boards of Governors, was however uncoordinated, and the charitable 'registered' English mental hospitals – including the Bethlem Hospital and the Retreat at York – were administered on the same pattern and similarly were located because of historical patterns of local philanthropy. The consequences of the lack of any planning of hospitals were most apparent in London, and over a period of 50 years the twin principles slowly emerged of regionalised hospital planning, and of hospital planning centred around major teaching (then voluntary) hospitals, with a clearer functional relationship between these hospitals and other general hospitals. As the possibility of war loomed from 1938, the government created the Emergency Medical Service (EMS), which created groups of hospitals on the basis of a number of 'regions' throughout the country.

During the Second World War national priority was given to every activity directed at survival of the state through military action, yet during the war major social welfare and educational policies were being prepared. In 1941 Sir William Beveridge, a 61-year-old civil servant, was asked by Britain's wartime coalition government to chair a committee on the coordination of social insurance as part of the process of post-war reconstruction. The Beveridge Report was finally published in December 1942, and laid the foundations of a comprehensive health and welfare system. The Report provided 'the vital kick to the "five giants" programme that formed the core of the post-war welfare state: social security, health, education, housing and a policy of full employment' (Timmins, 1995). In Beveridge's terms these meant tackling poverty, disease, ignorance, squalor and unemployment.

The landslide victory of the Labour Party at the 1945 General Election followed six years of great loss of life, social upheaval and economic and financial hardship. The new government nationalised a number of industries (such as the rail system), and there was an expectation of political and organisational reform of welfare services. Aneurin 'Nye' Bevan was appointed Minister of Health with a seat in the Cabinet, and in 1946 the National Health Service Act was passed. It promoted 'the establishment in England and Wales of a comprehensive health service designed to

secure improvement in the physical and mental health of people of England and Wales and the prevention, diagnosis and treatment of illness'. On the 'appointed day' of 5 July 1948, the National Health Service had arrived.

> [The NHS] was the first health system in any Western society to offer free medical care to the entire population. It was, furthermore, the first comprehensive system to be based not on the insurance principle, with entitlement following contributions, but on the national provision of services available to everyone. It thus offered free and universal entitlement to State-provided medical care. At the time of its creation, it was a unique example of the collectivist provision of health care in a market society. (Klein, 1983, p.1)

NHS structures

The 1946 NHS Act divided England into 14 Regional Hospital Boards (RHBs), related to the Regions established for the EMS, and there were five RHBs in Scotland. The Act created three types of healthcare management (the tripartite system). General medical and other practitioner services were managed by 'Executive Councils' and local health authority clinics, all of which were the responsibility of the new RHBs. Public health services, and usually child guidance clinics, continued to be managed by local education authorities. All hospitals (other than teaching hospitals), were organised into 'groups', managed by 700 separate Hospital Management Committees (HMCs). For general hospitals these typically centred around one or more larger non-teaching hospitals, while mental illness and mental handicap hospitals were typically managed by their own dedicated HMCs. Teaching hospitals were directly responsible to the Ministry of Health, and were managed by Boards of Governors. This hierarchical RHB and HMC structure was to remain fundamentally unchanged until 1974.

This apparently neat structure concealed a number of significant differences between regions and within regions. While some were highly urbanised and compact, such as the Birmingham RHB, others were both more rural and extended, such as the South Western RHB, going all the way west from Gloucester. There were significant differences in funding, so that while the London Metropolitan Regions were relatively overfunded for their population, the Northern and East Anglia Regions were underfunded. For example, in 1955/56 the South West Metropolitan RHB, with 10.5 per cent of the population, had 13.1 per cent of the revenue allocation (Webster, 1988, section vii, chapter VIII).

What this meant in practice for the psychologists beginning to work in the NHS was that they were employed to work in specific hospitals, which had no tradition of cooperating with similar types of hospital within the same region. However, the coordination of funding for training for the various professional groups was carried out at regional level. Regional funding was central to the establishment of new clinical psychology training courses developed in the 1960s, so as the demand for psychologists grew, the key targets in lobbying for training funds were both the regional psychiatric advisory committee and the regional medical officer.

This original structure had a number of disadvantages, most obviously that the full range of health services for any one locality were provided by a number of individual HMCs, whose catchment areas did not match local government boundaries,

so that social care was difficult to coordinate with health care. The Local Government Act of 1972 reorganised the structure of local authorities to match the expected areas of the proposed health authorities, and the linked NHS Reorganisation Act was passed in July 1973, the exact 25th anniversary of the introduction of the NHS. In the implementation of the new scheme from 1974, a regional structure was retained, but with the 14 RHBs now renamed as Regional Health Authorities (RHAs). The Boards of Governors and HMCs were replaced by 90 Area Health Authorities (AHAs) run by an area team of officers, and 200 District Management Teams, each with a community health council and an elaborate parallel professional advisory machinery. The new AHAs essentially matched the new local authority areas, subdivided into Districts in large counties and cities; in Scotland the regional tier was abolished, with Health Boards being comparable to the English AHAs. The new Health Authorities and Boards brought together all hospital, community and practitioner services (organised through Family Practitioner Committees), and included the previously separate teaching hospitals. This enabled for the first time comprehensive planning of both clinical services and medical training, as well as social care, for the total population. This ethos of coordination of all area services also led to the creation of lead area posts for all clinical professions, including Area Psychologists.

In 1979 the Royal Commission on the NHS published a report which was critical of the 1974 NHS reorganisation on the basis of too many managerial tiers and administrators, leading to wasted money and a failure to make quick decisions, so in 1982 Area Health Authorities were abolished, leaving Districts and Regions to run the hospital units and GPs. Also in 1982 Roy Griffiths published his influential 1983 letter that recommended the introduction of General Managers (rather than administrators operating through consensus management) to Regions, Districts and Hospital Community Units, and establishing an NHS Executive at the centre.

From the later 1980s the increasing cost of the NHS became a political battlefield, with the escalating cost of acute hospital care being the driver. The consultative White Paper *Working for Patients* (Griffiths, 1989) led to 10 working papers. These introduced the concept of the 'purchaser–provider split' to create an 'internal market' within the NHS, in which Health Authorities would be purchasers, and hospitals would become self-governing Trusts, and along with other private hospitals would become providers. GPs were a second set of purchasers, with practices with over 1000 patients becoming fundholders. The new NHS Trusts were introduced in 'waves', the first wave of Trusts dominated by larger acute hospitals. These changes were also associated with the abolition of the former RHAs, their place taken by a tier of eight regional offices of the Department of Health and the new NHS Executive.

Further reforms to the NHS were introduced by the Labour Government in 1997, when 'The New NHS: Modern, Dependable' was published, laying out their vision, with key organisational structures being Strategic Health Authorities, Trusts and Primary Care Groups. In July 1998 'A First Class Service' was published, which set out how the vision was to be operationalised through the introduction of quality assurance systems. This led to the establishment of the National Institute for Clinical Excellence (NICE) to evaluate the evidence of the effectiveness of treatments, and National Service Frameworks for each health field to guide how the

services should be delivered. In 2002 the Primary Care Groups became Primary Care NHS Trusts, with a major role in commissioning non-specialist health services, accompanied by the creation of 28 Strategic Health Authorities, which replaced the previous more numerous DHAs.

The period between 1948 and 1974 can now be seen as one of atypical organisational stability in the NHS, and the period between 1977 and around 1990 as providing a structure which enabled clinical psychology services to develop within a framework where psychologists had a significant degree of control over their working practices. An enduring feature of the changes of the past 20 years has been a stronger voice for GPs, and a shift towards more provision of services at the primary care level. The bewildering rate of organisational change constitutes a real challenge to clinical staff, where services to patients and communities are disrupted by the continuing reorganisation of local teams and changes in managers and budgets, and the flood of complex documents and practice guidance requires constant vigilance by national leaders and senior local psychologists.

Conditions of employment for psychologists in the NHS – the Whitley system

Before and during the Second World War, there were no national agreements about salaries or other conditions of employment for psychologists. With the creation of the new NHS, it became clear that a common framework needed to be created to formalise the roles and employment of educational and clinical psychologists within the health and education services. Before the war a national collective bargaining mechanism had been created for both the civil service and local government, involving separate management sides and staff sides, known as the Whitley system. It offered a relevant precedent for the new NHS, and in the early parliamentary debates on pay arrangements in the new health scheme the Minister gave assurances that a Whitley scheme would be an essential feature of the new service (Ross, 1952). In the spirit of this assurance, the Minister of Health, Aneurin Bevan, met with organisations in their perceived order of importance 'ending for the sake of prudence or completeness with minor groups such as medical auxiliaries, and with cognoscenti from alternative medicine, such as herbalists and homeopaths' (Webster, 1988, p.89). The Whitley framework was thus simply taken over for the NHS, although it did not include doctors.

The full Whitley Council system comprised a general council for matters of common interest, and nine functional councils, each dealing with a specific profession or group of workers. 'Professional and Technical Group A' (PTA) dealt with all graduate non-medical staff (who originally were almost entirely biochemists and physicists), and early negotiations were successful in placing clinical psychologists, as a graduate group, in PTA (see chapter 6). Each council had a 'management side', made up of representative senior managers from RHBs and the Ministry of Health, and a 'staff side' made up of representatives of staff organisations (and indirectly the professional bodies) acting as trade unions. The trade union for psychologists was originally the Association of Scientific Workers (AScW), which became through successive mergers ASTMS in 1969, MSF in 1988, Amicus in 2002, and since 2007 Unite (now the largest trade union in the UK).

The first Whitley circular relating to clinical psychologists (PTA Circular No.10) was issued on 7 February 1952, nearly four years after the NHS had come into

being (only significant PTA circulars are reviewed here: others simply gave revised rates of pay). It laid down the qualifications for appointment as a clinical psychologist, requiring the possession of an honours degree in psychology of a British or Irish University (or equivalent). Appointment could be to one of four grades. Assistants (starting salary £380) had to have at least one year's training before they could become Psychologists (who had to be at least 25 years old) – earning £530 a year at the bottom of the scale. They in turn could become Seniors if they held a 'post of greater responsibility'. Top Grade psychologists in 1952 had to occupy a post of 'exceptional responsibility', when they were paid a minimum salary of £1300 and a maximum of £1600. There was no requirement for any specified form of postgraduate training before entry to the psychologist grade. Subsequent circulars, apart from announcing new pay scales, successively refined the grading structure and criteria for different grades (Hall & Lavender, 2012).

The 1957 set of Whitley circulars (HM (57) 81 and Part II of PTA circular 52) for the first time formally recognised 'approved training courses'. Three courses in clinical psychology were approved: at the University of London Institute of Psychiatry; at the Crichton Royal, Dumfries (a leading Scottish mental hospital); and at the Adult Department of the Tavistock Clinic in London. Significantly four courses in educational psychology – all in London – were approved, only for work with children, although in practice once in an NHS post psychologists could and did move to other fields of work. Entry to the profession was also possible through what was called the 'probationer' system – essentially a supervised apprenticeship, with at first no requirement for any form of formal examination – which ended in 1983.

AL (PTA) 2/82, published in 1982, introduced a completely new approach to grading Principal and Top Grade posts, setting out explicit criteria for posts, including a stipulation of the number of psychologists accountable to a post to meet the grading criteria. The next major revision of the grading system was announced in AL (SP) 3/90, which introduced a new four-grade system, and the introduction of a common pay spine, in a radical restructuring requiring the assessment of every post against a number of factors, in practice difficult to interpret. This guidance was issued against the background of the linked reviews of psychology staffing and function by the independent Management Advisory Service (MAS, 1989), and the NHS Manpower Planning Advisory Group (MPAG, 1990). Agenda for Change (Department of Health, 2004) signalled a totally new approach to the grading of posts, by introducing a system of grading for individual posts that was common to all health professions other than doctors, marking the end of the preferential salary scales available to psychologists by virtue of their postgraduate training.

For over 50 years Whitley Regulations controlled the conditions of employment of most NHS employees, including psychologists. The Whitley circulars in the early years offered guidance to NHS employers who would have had no previous experience in recruiting and appointing clinical psychologists, and they created a degree of national consistency in how psychologists were employed. Mechanistic they may have been, but they controlled conditions of employment, influenced how psychologists made career choices and of course told psychologists how much they would be paid.

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