

British Clinical Psychology in Historical Perspective: The Genesis of a Profession.

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This article, written in 1982-3 was submitted to several journals at the time but despite 3 attempts we could not get it published. Nevertheless, it has continued to generate interest over the years and is therefore offered here as a resource.

Referees' criticisms at the time focussed on a number of points, of which the following are representative:

- The article focussed too much on the controversy over the BPS 'Medical Section' of the British Psychological Society.
- We omitted critical elements in the development of clinical psychology (Shapiro, behaviour therapy, child guidance, the Tavistock).
- We didn't discuss training of clinical psychologists.
- We were biased in our analysis.
- The referencing was not sufficient.

These points are all fair, but none of the referees questioned either our account or our analysis of the 'Medical Section controversy'. It was clear that at least some did not understand our approach, which was innovative at the time. Some of the 'elder statesmen' of British clinical psychology who would appear to have been some of the reviewers found our contextualist history at odds with their expectation of a ('Whig') history of human progress (one complained about 'jargon' - presumably vocabulary from other social and human sciences). Our intention was to analyse an episode that took place during the emergence of the profession of clinical psychology, in order to illuminate some of the reasons for its growth and development. The article was never intended to be a comprehensive history of clinical psychology, but perhaps we could have been clearer in explaining and justifying our illuminative case history approach. We believe that the Medical Section controversy does indeed tell us something about the emergence of clinical psychology, about what it is and is not, and about its place in the administration of mental distress - in terms of the management of people and the management of ideology.

We might rephrase our thesis now as follows:

Clinical psychology emerged as both a new actor and as a tool in the modernisation of the social administration of mental disorder/difference and the people affected by it. A dominant actor was the similarly modernising profession of psychiatry. But in order to achieve this modernisation of processes, ideologies and practices it was necessary to deal with a grouping that could claim a hegemonic (or at least confusing) definition of psycho-medical practice and theory. This tendency (dynamic psychotherapy, and its club the BPS medical section) had to be marginalised in order to establish a

modern, 'scientific' (read reductionist - empiricist) professional hegemony in the field.

For a broad based yet critical review of the emergence and consolidation of British clinical psychology we commend John Hall's series of articles (Hall, 2007a, 2007b) in *History and Philosophy of Psychology* (it was John's citation of this article that has prompted us to make it more widely available).

References to Foreword

- Hall, J. (2007a). The emergence of clinical psychology in Britain from 1943 to 1958 part 1: core tasks and the professionalisation process. *History and Philosophy of Psychology*, 9(1), 29-55.
- Hall, J. (2007b). The emergence of clinical psychology in Britain from 1943 to 1958 part 2: practice and research traditions. *History and Philosophy of Psychology*, 9(2), 1-33.

A B S T R A C T

With the formation of the National Health Service in Britain, the profession of clinical psychology was also established around a scientific model and psychometric practice. Some key events are described in the struggle for status of this new profession. It is argued that there were important common interests between clinical psychology and orthodox psychiatry, and these are discussed in relation to a conflict within the British Psychological Society between the new clinical psychology and a third force, psychodynamic "medical psychology". Finally, the discussion is brought up to date via a consideration of the wider social relations of the mental health services over the course of the last century.

Clinical Psychology in Britain, like any other profession, has evolved over time. From their beginnings as technical assistants to psychiatrists and working largely as mental testers, clinical psychologists have moved into other areas of the health and social services, taking on new roles in the process. Even at this stage of its evolution, there are some uncertainties about what work the profession should undertake and how it should be organised. (2) Clinical psychology may not actually be in a crisis, but it would perhaps take little to precipitate one.

In order to fully understand the current state of the profession, a historical analysis may be helpful: it will, perhaps, not only facilitate an appreciation of how certain features arose, but also provide greater insight than could a purely contemporary analysis. For example, the rise and fall of different interest groups, and their interplay can only be comprehended over a period of time; yet such an understanding is vitally relevant.

This paper has two major concerns. The first is a discussion of the period from the birth of the National Health Service (NHS) in 1948, to 1960, by which time it could be said that the profession although small, had become truly established. In addition to its central relevance to the genesis of the profession, this period is of interest insofar as those events that took place during this time illustrate the relationships of clinical psychology with the psychiatric profession. The second concern will be an attempt to situate these relationships within their broad societal context; specifically, it will emphasize the links between the origins of mental health services and the ways in which social deviancy more broadly has been administered within successive social systems. Whilst this emphasis is not new, it has only recently been stressed in historical research dealing with the mental health services. (3)

The background : early British Psychology

In order to understand the course of events from 1948-1960, it will be helpful to consider some earlier developments. "Psychology" has been self-defined by professional organizations on both sides of the Atlantic: in Britain, the British Psychological Society (BPS) was founded in 1901. It began as a learned, scientific society (its constitution was borrowed from the Physiological Society, (4), and, of course, the original members had not been trained as psychologists, there being no psychology degrees at that time.

It was not until the 1914-18 war, however, that there was any significant focus by British psychologists on psychological disorder. Quite early in the war, it became clear that significant numbers of soldiers were succumbing to breakdowns during active service at the front. While traditional military thinking ascribed this to cowardice and malingering, it seems that medical officers recognized that the malady was usually genuine. An early theory attributed the breakdowns to the concussive effects of shells bursting near the victims, hence the term "shell-shock", but as everyone seems to have realised by the end of the war (5) this was an inadequate explanation.

Orthodox psychiatry offered little in the way of a theoretical framework to understand these cases of "war neurosis". Orthodox psychiatry had begun

in the asylums. The Medico-Psychological Association, the professional association for psychiatrists (now the Royal College of Psychiatrists), had started as the Association of Medical Officers of Asylums and Hospitals for the Insane and their Journal of Mental Science (now the British Journal of Psychiatry) had begun as the Asylum Journal. Orthodox psychiatry, like its charges, was segregated from the rest of society, both geographically and administratively; many asylums were remote from the cities; inpatient care could be given to uncertified patients only after 1923, and at only one hospital - the Maudsley - and generally not until 1930. Outpatient services were similarly underdeveloped in 1914. (6) It was orientated to the closed institution of the asylum, where its scope was classificatory and custodial. Not surprisingly, it could offer little insight into neurosis, whether war-induced or not.

A number of early BPS members, however, were involved in the army medical services. C S Myers, W H R Rivers, W McDougal, Henry Head and W Brown, for example, were directly involved, while T H Pear and Elliot Smith maintained an active interest and involvement from their University base at Manchester. Myers for example, was Consultant Psychologist to the British Armies in France, while Rivers worked at special hospitals set aside for war casualties, at Maghull outside Liverpool and Craiglockhart in Scotland. A measure of the involvement of these BPS members is the publication of at least three books on the subject, (7) and the fact that evidence from Brown, Myers and Rivers was drawn upon and quoted in the Report of the War Office Committee of Enquiry into "Shell-Shock", (8).

These people developed psychotherapeutic methods that drew upon the new Freudian ideas, especially the concepts of "instinct" and the "unconscious"

(which provide the title of Rivers' book), while retaining a highly pragmatic approach:

The guiding principles of psychotherapeutic treatment at the earliest stages should consist in the re-education of the patient so as to restore his memory, self confidence, and self control. For this restoration of his normal self, a judicious admixture of persuasion, suggestion, explanation and scolding is required.(9)

When the war was over, interest in both psychotherapy and psychodynamic ideas continued. The BPS was reorganized in 1919, the need for money prompting the broadening of membership from those engaged in psychological work to those interested in psychology. In addition, specialist sections were formed: Educational, Industrial and Medical. The Medical Section included people who had been active in treating war neurosis, and it became a forum for discussion of psychodynamic theory and psychotherapy. Many of the founder members of the Medical Section began to focus upon other areas of interest, but the broad psychodynamic orientation of the Medical Section remains to this day. It was just this orientation of the Medical Section that was to influence the developments within the Society from 1948.

In the interim a number of things had happened. Psychology had expanded, not greatly (it was still taught at only a handful of Universities), but sufficiently to provide a pool of people whose primary training was in psychology. The main growth in applied psychology had been in Industrial and Educational psychology. There was a handful of psychologists working in hospitals, largely in a research capacity, notably at the Crichton Royal Hospital in Scotland, and at the Maudsley hospital in London. The BPS had developed a certain professional self-consciousness: the issue of professional organization was first raised in BPS Council (the executive

body of the society) in 1934, when a register of members was set up as a first step towards the definition of the defining characteristics of one termed a "psychologist". The 1939-1945 war had seen the development of "man-machine studies" and the use of psychologists in various roles in selection and training. Academic psychology was still dominated by the London psychometric school, centred around Burt, and the Cambridge experimental school, centred on Bartlett.

Orthodox psychiatry had also developed; it had widened its scope beyond the asylum, and was seeking a fuller integration with the rest of medicine within the framework of the new National Health Service (NHS).

Clinical Psychology Enters the NHS

In his recent autobiography, Eysenck, (10), claims responsibility, at the behest of a leading psychiatrist, Sir Aubrey Lewis, for setting up the profession of clinical psychology in the NHS. Indeed, Eysenck and his colleagues were centrally involved in the development of British clinical psychology, and psychologists do appear to have entered psychiatric services at the invitation of the psychiatric establishment. We are here talking of the orthodox psychiatric establishment that had its origins in the asylum psychiatry of the last century. While eclectic, drawing on psycho-analytic as well as medical sources, it has been biased towards the organic, individualistic approach that gained ground in the area of severe mental disorder (its home base) since the 1930s, when the Mental Treatment Act as well as Electroconvulsive Therapy, Insulin Coma Therapy, and Leucotomy were introduced.

The psychologists were employed largely as testers. We can identify three main reasons why psychology and testing might have been attractive to psychiatry at this time.

1. The diagnostic process

Sir Aubrey Lewis, a leading psychiatrist of the time, provided a discussion of the distinction between "mental illness" and simple deviance. (11) His model was the same as the organ-based disease model in general medicine. Here, a general malaise in the patient could result from the failure of one of the various parts of the body. Similarly, to diagnose the presence of mental illness, in addition to there being a disturbance of general efficiency, there would need to be a disturbance of one (or more) of the various mental part functions.

A problem with this type of medical modeling is that the definition of mental part functions is rather difficult (witness the complexity of modern mental philosophy or the variety in cognitive psychology). It seems likely then, that the technology of mental testing promised something more definite to the psychiatrist: mental part functions could be objectively tested through psychometry, to divine just which bits of the psyche were faulty. The factorial structure of the popular Wechsler Intelligence tests and the various personality tests could be seen to offer such a possibility. Eysenck, writing in 1950, in what was the journal of the psychiatric establishment, put it as follows:

It is usually far more important clinically to know that a patient has a high verbal ability, low visuo-spatial ability, very low manipulative ability, but comparatively good rote-memory and excellent associative fluency, than to be told that his IQ is around the 100 mark. The concept of the mental profile, rather than the mental index number, is to the fore in modern clinical testing.(12)

The self-perception of clinical psychologists as revealed in documents of

the time was consistent with their main role as diagnostic testers.(13)

2. Respectability within medicine

As a marginal branch of medicine with a dubious status, particularly in 1948 before the "pharmacological revolution", psychiatry stood to gain respectability from the employment of psychologist-testers.

Firstly, other medical specialities could draw upon supplementary scientific workers, such as radiographers, pathology technicians, biochemists, etc.

If "real doctors" had such resources, then analogously, why should psychiatrists not draw upon psychologists?

Secondly, psychologists were actually well qualified academically, with training in scientific methods, statistics, research design, measurement techniques etc. This would lend scientific plausibility to psychiatry, perhaps through association, but also through advice and collaboration on research. A significant amount of such collaboration did take place, as may be ascertained from skimming jointly authored papers in the Journal of Mental Science in the early 1950s and onwards.

Psychology, then, would in various ways lend weight to psychiatric opinion.

3. Common ideological roots

In addition to the above motivations for employing psychologists, it is worth pointing out a similarity between (a) orthodox psychiatry, best exemplified in the emphasis on classification, custody and therapeutic nihilism of the asylum, codified in the work of writers such as Kräpelin, and (b) psychometry, as it developed from Galton through Terman and Burt, again as a classificatory, administrative approach to social problems. Both approaches were essentially "social Darwinist", making scientific, biological, and inevitable, the divisions between social groups.(14)

Eysenck summed up the mutual interests of psychology and psychiatry as follows:

That a strong, respected and highly competent profession of psychiatry is essential for the growth and flourishing of clinical psychology appears obvious; it is perhaps no less true to say that the existence of well trained, competent, and friendly clinical psychologists can be of the utmost value to psychiatry. (15)

Subsequent events were to illustrate this mutuality of interest.

Problems for Clinical Psychologists

In the early 1950s clinical psychology was a new profession; it had no clear professional organization or status. There were three bodies which might potentially represent their interests, two within the BPS, and one outside it, the Association of Scientific Workers (AScW).

The AScW had represented clinical psychologists since the negotiations for setting up the NHS in 1947. While this trade union originated in the radical scientists' movement prior to the war (Haldane, Bernal, Needham, Hogben, etc (16)), by the 1950s it was seen as restricted to negotiation over wages and conditions of service, at least insofar as its psychologist membership was concerned.

Within the BPS there was the Committee of Professional Psychologists (Mental Health) (CPP(MH)), and the Medical Section. The CPP(MH) was founded in 1943 by educational psychologists to deal with all matters affecting the professional status of its members: in 1951 an adult (ie clinical) section

was formed, and also in that year representation was gained on the Council of the BPS. However, by this time there was pressure on Council from the CPP(MH) to allow a new name that did not contain the misleading term "committee". The issue of sectional status was raised, but this might have created problems with the Medical Section. Since the constitution of the BPS was under review (a Royal Charter was being sought) the matter was shelved at this point.

The Medical Section of the BPS has already been discussed. By the early 1950s it had become a kind of psychodynamic interest group, with many medically qualified members. The CPP(MH) thought that the Medical Section was unable to provide the relevant function for psychologists in the NHS.

Conflict in the BPS: the Crisis of the Medical Section

The situation just outlined was soon to be shattered by six years of dispute. In March 1952, Eysenck wrote to the BPS Quarterly Bulletin, complaining about the editorial policy of the British Journal of Medical Psychology (BJMP):

. . . It has become disturbingly clear to many of its readers that the number of papers devoted to scientific (experimental and statistical) studies in abnormal psychology was dwindling, while the proportion of papers dealing with idiographic, psycho-analytic, and other 'dynamic' topics was approaching unity . . .

This disparity between factual and speculative papers might have been thought to be accidental, but it would appear that it represents editorial policy. In a letter to an intending contributor, which has been shown to me, the Editor writes as follows: 'The editorial group has now considered

your paper and we feel that it does not fit in with the policy we are trying to adopt for the Journal. Although we have, in fact, published one or two articles of what is usually referred to as the statistical kind, we wish instead to develop along the lines of giving priority to articles concerned with the dynamic interactions of the forces in the individual personality and its development. As you will understand, your paper does not fit well into this scheme.'

This decision raises quite a number of important problems. To what extent is it simply a reflection of the Editor's personal feelings? Is it based on a decision by the Council of the BPS? Is it in the best interests of psychology as a unified science that such arbitrary restrictions should be enforced?

. . .

The position would be bad enough if there were many psychological journals in this country to which material dealing with abnormal and clinical psychology could be sent. But the sad fact is that there is no other psychological journal in this country catering for this particular kind of material, and while we

may be grateful for the broadmindedness of the Editor of the Journal of Mental Science, who has generously opened his pages to psychologists working in the fields of abnormality, and while occasional papers of this type appear in the General Section of the BJ (17), nevertheless

the growth of research into these problems requires a purely psychological journal of its own. 18

The ensuing six years of dispute between the BPS Council and the Medical Section, were characterized by, (i) a clear opposition between experimentalist and idiographic approaches; and (ii) the alleged problem of the lack of an outlet for experimental or statistical work by the new scientific psychologists. Yet, as Eysenck pointed out in the above quotation, papers of this sort were published in the Journal of Mental Science (the organ of the psychiatric establishment). This may be verified by looking at issues of that journal for the early 1950s: there was indeed a fairly prolific output of this sort by psychologists. In addition, as Main 19, on behalf of the Medical Section, claimed, between 1949 and 1955, 30% of papers in the BJMP were in clinical/experimental psychology.

Nevertheless, Eysenck and his allies in the CPP(MH), were successful in starting a debate throughout the BPS, parts of which surfaced in correspondence in the Bulletin, and in persuading the BPS Council to take "legislative" action (internal to the Society) against the Medical Section.

In 1953 a Publications Committee was set up to administer policy on the Society's journals. In addition, the General Secretary of the BPS wrote to the Secretary of the Medical Section asking them to widen the scope of the BJMP, to include papers from psychologists other than "medical psychologists" (the term used to describe medically qualified people working on psychological disorder, from a generally dynamic standpoint). The Publications Committee, in its 1954 report to the BPS ACM suggested that the BJMP should cover psychotherapy, neuropsychiatry, clinical/experimental research, child guidance and remedial education. The Medical Section, however, was uncompromising, resisting such interference in its affairs.

At this time it was disclosed in Council that the Royal Medico-Psychological Association (20) was "alarmed" by the number of psychological papers submitted to them, and interestingly, W Mayer-Gross, a well known organically orientated psychiatrist protested that the BJMP was produced for a clique. Meanwhile, within the Medical Section, two factions had appeared, asking for time in meetings and space in the journal for discussion of (a) testing and statistics, and (b) pharmacology and physiology.

A joint committee between Council and the Medical Section was convened to consider relations between the Medical Section and the Society. Not surprisingly it quickly reached an impasse. Council representatives thought that in the interests of the Medical Section and the scientific prestige of the BPS, the Medical Section should broaden its scope to include all applications of psychology to medical problems (biochemistry, neurology, endocrinology, and experimental psychology). The Medical Section representatives, however, while agreeing that these areas were valid areas of enquiry, did not feel that the scope of the Section's activities could be widened so as to include them.

Council was becoming somewhat peeved by the intransigence of the Medical Section and began using the following constitutional methods.

- 1) They changed the method of election for the Medical Section committee (1955) from a show of hands to a postal vote, thus enabling people other than those actively involved (the "psychodynamic clique") to vote.
- 2) The appointment of the Society's journal editors was taken over by the Council in 1957.
- 3) Also in 1957, a BPS Committee of Inquiry on the Medical Section reported. It suggested the following aim for the Medical Section:

. . . to consider and discuss any aspect of
medical psychology whether from a 'dynamic'
clinical, experimental, or other point of view .

Rules for the section should be reformulated in accordance with principles approved by Council, and the Medical Section should report to Council, within one year, of the steps taken to implement the above. Finally, the BJMP should be conducted in accordance with principles formulated by the Publications Committee, and approved by the Council, and should be open to articles in those areas covered by the above aims.

Just before their deadline in early 1958, the Committee of the Medical Section reported back to Council. The Council's instructions (substantially those of the Committee of Inquiry) had caused deep concern, and they urged the Council to reconsider. They suggested a statement of aims for the Section:

To further the understanding of disturbances of human thought, feeling and behaviour, their psychopathology and treatment, and discuss these in terms of the psychological processes involved .

The Committee was not drawing up rules at this point. It seems that Council was somewhat surprised and affronted by this. At its February 1958 meeting, various suggestions were made, such as the formation of a new section, a section with two subsections, or the expansion of the Social Section to accommodate the "scientific" psychologists. Council resolved that the Medical Section committee be reminded that Council had asked them to prepare rules. This reminder appears to have worked, since by the next Council meeting, a month later (March 1958), draft rules had been provided by the Medical Section. Criticisms of these rules were fairly minor, so the matter was referred to the "Committee of Past Presidents" (a frequent way of dealing with important non-routine matters at this time). Also at the March 1958 Council meeting, a decision was taken to

exclude the holding of a medical degree as a sufficient qualification for BPS membership, although discretion might still be applied. This measure would obviously limit membership of the BPS and the sections to "real psychologists". It would, of course, have excluded Myers, Rivers and McDougall!

Finally, in October 1958, Council accepted the Medical Section's aims and rules, with some minor amendments. In effect, the six year dispute had fizzled out, without greatly changing the orientation of the Medical Section or its journal (witness the typical contents of the BJMP today).

It would seem that the crisis came to an end largely because the clinical psychologists found other solutions to their grievances. Journal policy was in the hands of the Council's Publications Committee, but more important, the negotiations that had commenced in 1956, to set up the British Journal of Social and Clinical Psychology (which appeared in 1962) were well under way. Perhaps of greater relevance to their professional status, the English Division of Professional Psychologists (Educational and Clinical) was formed in 1958 (a Scottish Division followed soon afterwards). This was a division of the BPS for clinical psychologists, and was the forerunner of the current Division of Clinical Psychology. Clinical Psychology now had a definite professional body, with a clear status within organized psychology. Any need to squeeze out psychodynamic medical psychologists was thus diminished (as we shall see, there were other forces also acting to marginalize them), although some people had an interest in developing "scientific" behavior therapy and in discrediting psychodynamic approaches, as therapy and as theory.

Understanding the Dispute: the Context of Clinical Psychology (1948-1960)

We have dwelt upon the crisis over the BPS Medical Section because it illustrates some of the interests of those groups that influenced the early development of British clinical psychology. These interests were introduced

in an earlier section, and will be explored here before finally attempting to place them in the context of certain developments in British society and so develop a perspective with which to understand current clinical psychology.

The three interests involved were:

- 1) The new clinical psychologists, trained in scientific psychology, but in practice working largely as mental test technicians;
- 2) The orthodox psychiatrists, with a basically organic and empiricist approach to mental disorder, still not fully integrated into the medical profession, yet working among a wider clientele than did their forerunners either in the latter half of the last century, or during the 1920s and 1930s;
- 3) The anomalous and small group of medical psychologists, medically qualified but using psychodynamic concepts in "therapy" with a selected group of outpatients. In spite of its small size, this group was (and perhaps still is) considerably identified with popular notions of what psychology entails. We may regard the medical psychologists as a "confusion factor" from the point of view of the other two groups vis a vis the public and other groups.

For both clinical psychology and orthodox psychiatry, professional status was a major issue. We have seen how clinical psychologists were a small group, present in the NHS by virtue of the patronage of the psychiatrists and with no clear professional organization within organized psychology. Furthermore, they complained of having no outlet for their research papers, which was potentially restrictive for their individual careers and their corporate image within psychology, especially since the "non-scientific" ideas of medical psychology did have an authorized BPS organ, the BJMP. There might well have been confusion, in the eyes of the public, the medical profession, and other psychologists, about which group could claim to authentically or legitimately practise the applied psychology of mental disorder.

For orthodox psychiatry, status problems arose from their history of segregation from the rest of the medical profession, as we have seen above. Baruch and Treacher (21) argue that it was not until the 1959 Mental Health Act, and the later establishment of psychiatric units in general hospitals, that psychiatry achieved a status that was other than marginal to the rest of medicine. Clearly this process took time, from the nineteenth century when asylum physicians had to live at the asylums and give up private practice, up to the current integration of psychiatry in medicine, with its own Royal College, its media personalities, University chairs, and units in general hospitals. The physical treatments of the 1930s, the new drugs of the 1950s, the selective incorporation of Freudian esotericism, the development of outpatient clinics, and the introduction and expansion of treatment on a voluntary basis, together with other developments, can be seen as landmarks along this road, as can the setting up of the NHS and the creation of clinical psychology as a supplementary profession in the late 1940s and 1950s.

We can situate the BPS crisis within the context of the long march towards the medical respectability of psychiatry. Orthodox psychiatry supported clinical psychology in at least three ways:

- 1) Through the establishment of clinical psychology;
- 2) Through the support of individual psychiatrists (such as Mayer-Gross) for clinical psychology against medical psychology, and in collaborative research work;
- 3) Through the publications policy of the Royal Medical-Psychological Association, a) by publishing the work of the scientific clinical psychologists, and b) by expressing concern about the volume of such work once the dispute over the BJMP had begun. There are two aspects to such support. Firstly, it established and consolidated clinical psychology,

which as we have argued, was one way of legitimating the scientific and medical status of orthodox psychiatry. Secondly, it tended to diminish the credibility of medical psychology. If psychiatry was to acquire the respect of the medical profession, unscientific and non-medical psychodynamic notions would have to be, if not discarded, then consigned to an ancillary position in an organically orientated eclecticism.

Furthermore, dynamic psychotherapy,

. . . stemming, in this country, largely from the psychoanalytic school, could only be practised by people (most usually doctors) who had undergone a lengthy and expensive initiation ceremony . (22)

Psychologists of course, only rarely had access to this but the average psychiatrist, perhaps working in a provincial mental hospital, was also unlikely to have had the opportunity for the necessary initiation. If that exclusion united clinical psychology and psychiatry, then so did a common empiricism and an individualistic, intrapersonal approach to mental disorder. Even once clinical psychologists began to extend their role to therapy (via Pavlovian/neo-Hullian behaviour therapy) the general structure of their practice vis a vis their clients was strikingly similar to the dominant treatment method of psychiatry (ie drugs). Whatever their virtues (and that is not at issue in this paper), both treatment approaches were acontextual, taking a person out of her/his natural setting to a clinic where treatment was prescribed and often carried out. Both approaches were based on mechanistic biological conceptions of essentially passive "patients".(23)(The common assumptions underlying the interest in mental testing have already been explored.)

We therefore suggest that the crisis over the medical section may be seen

in terms of an alliance between psychiatry and clinical psychology, based upon (a) the needs of each profession to improve its status, and (b) a common outlook with roots in empiricism and social Darwinism. Medical psychology was a "confusion factor" for both groups, having a considerable purchase on popular notions of psychiatry/psychology which embarrassed both clinical-scientific allies, and in addition holding an anomalous position in post-war psychology in having its own BPS section and control of the relevant BPS journal, the BJMP.

We would suggest that British clinical psychology still bears marks from the 1950s. The dominance of biological-mechanical conceptualizations, the survival of mental testing rather than the convincing development of context-relevant and intervention-relevant assessment strategies and the continued split between trade union and professional organizations, are obvious examples of traditions from the 1950s. An anti-intellectualism or extreme pragmatism in clinical psychology, reproduced through a socialization process steeped in atheoretical empiricism (rather than empirical research within a heuristic framework of theory), whether manifest in ignorance about psychoanalysis, behaviorism or the structure and functioning of the welfare state, is still with us and it continues to impoverish clinical practice at every level by its failure to critically examine the readily available categories imposed by both "psychology" and the immediate workplaces of psychologist. It is still the case that the majority of psychologists work within a one to one framework with clients, and even where they have moved into the realm of "systems", their methods are either inevitably drawn from individual orientated practices, or else are hardly distinctive. These phenomena are not directly attributable to the 1950s crisis, but it is possible that the polarization in organized psychology then had the effect of strengthening these acritical tendencies. A final tradition that remains is a remarkable concern with status (eg psychologists using the term "consultant", PhD clinical psychologists misleading clients

and other workers with the title "Doctor", or colleagues introducing themselves by their rank, and the demand for legal registration when clinical psychologists are in fact regulated by Whitley Council(24); however the recent interest in democratic departmental organization perhaps heralds a challenge to such unconvincing elitism (25). What has perhaps changed since the days of mental testing is the new professional skill of carving out new fields of expertise, with no real justification by virtue of being psychologists.

It remains, however, to try and locate the development of clinical psychology, as outlined here, within its societal context.

The Wider Context: Clinical Psychology in Society

So far we have considered psychiatry as a context for clinical psychology, especially in relation to its struggle for status. One way that psychiatry improved its status was the acquisition of ancillary psychologist technicians, but as we have seen, the emergence of a credible psychiatric profession has a history extending from the last century to the present. If psychiatry provides an immediate context for clinical psychology, then the broader context will be the relationship of psychiatry itself to certain aspects of the social system. Of particular importance is the more general form of administration of social deviancy (ie deviation from the social norm), which by definition includes mental disability and disorder.

Deviancy is constructed and perceived differently from within different social systems, and those forms of deviancy that are currently taken to be the legitimate concern of the mental health services are no exception. Scull (26) has demonstrated that while the most severe forms of mental disorder and mental handicap were recognized early on (27) it was not until the late eighteenth and early nineteenth centuries that these conditions were seen to be the legitimate concern of the authorities

and were given an administrative status similar to that of today. Not until an institution - based system of poor relief began to replace the early decentralized system stemming from the Elizabethan Poor Law, did the separation of "lunatics" from such groups as the chronic sick, the physically disabled, or the old and feeble really begin.

It has been argued (28) that the institutional response to insanity, the building of public asylums, may be attributed to the development of a national free-market economy at this stage. The mentally deviant had to be segregated from the able-bodied poor, since to give relief to the latter group would have undermined labour mobility and the labour market, forcing wages up. Hence the distinction between workhouses and asylums. The latter took on curative pretensions, and their physicians, with the help of the asylum reform movement, staged what amounted to a coup, albeit within a framework of (often ineffective) legal requirements and safeguards. (29) Resulting from, yet serving this custodial and medically defined system, the essentially custodial and classification ideology of inherent defects grew up (termed "Psychiatric Darwinism" by Skultans, (30)

This then formed the external context for the psychiatric profession, a context that while allowing its development in the nineteenth century, also had the cost of segregating psychiatry from the development of the medical profession more generally. While as Wolfensberger (31) has noted, the rationales for mental hospitals had become untenable by the 1920s, the re-integration of both psychiatric patients and psychiatry itself did not gather momentum until the post 1945 period, which was when clinical psychology emerged.

During the post 1945 period, we have seen a change in the role of the asylum. This has been a complex process, characterized on one side by the need to reduce costs while now being able to support clients by means of welfare cheques in the community 32, and at the other by expansion of

mental health professionals into the community which has included the annexation of new client groups, new behaviors, new technologies and new settings.(33)

"Medical psychology", it will be remembered, emerged in the second and third decades of this century as an approach to those mild forms of deviancy, often termed neurosis, that then fell outside the scope of psychiatry. By 1960, through a dual process of selective co-option and squeezing out of medical psychology, together with legislation in 1930 and 1959, British psychiatry had become firmly entrenched in this area.

Clinical psychology, then can be seen as emerging as part of the process by which psychiatry moved out of its ghetto with the help of new ideologies, new technologies, and changes in the economic imperatives for segregation that had led to the asylums being built in the previous century but which now called for their closure or at least a drop in the numbers of inmates as the asylums/relocated within a more comprehensive system of mental health services.

The curious thing about clinical psychology was that it got landed with a technology (mental testing) that had the character of an "applied ideology" from the period of segregation (classification but little more). This sat rather uneasily with both a more managerial ideology (of experimentation and eventually of therapy) that was accessible to the psychologists and became more relevant as the modernization of the mental health services got under way. However, given the importance of changes in the economic underpinnings of the services throughout their development, we can only be wary of forces that will shape the development of clinical psychology in the future. The redesign of work and the associated structural unemployment (34) that is so apparent today (even if it does not provide more than a contributory explanation for the current crisis) will surely be of utmost relevance. A huge unskilled "leisure class" is forming, and the

form that its accommodation will take with existing societal structures is not yet clear. We would not be surprised if, whatever their actual expertise, clinical psychologists' next major role will be in some way as advisors in the management of this population, perhaps initially through contact with those who are mentally disabled. Even if this scenario is too extreme, it is certain that the restructuring of the economy whether via planning or via "market forces" will have a profound effect on the health and social services(35), and this in itself will be sufficient to greatly influence the mode of working of clinical psychologists.

NOTES

1. The account presented here is based chiefly on research in the archives of the British Psychology Society, and on publications of the period. In the interests of readability, bibliographic references to the archive material will be omitted, but interested readers are welcome to contact the authors for further information. We are grateful to the BPS archivist, Dr Sandy Lovie and the Dept of Psychology, University of Liverpool, for making the materials freely available to us. Irene Taylor assisted in the task of sifting through the archives. An earlier version of the paper was presented to the Yorkshire branch of the BPS division of Clinical Psychology. We are grateful to Chris Cullen, John ~~Mason~~ and Andrew Sutton for comments on an earlier draft.
2. See for example, Bender M P Community psychology - when? Bull Br Psychol Soc, 1979, 32, 6-9; Davis H Clinical Psychology - a profession or a guild? Bull Br Psychol Soc, 1978, 31, 290-291; Dickens P The defective psychologists - clinical psychology and mental handicap, Bull Br Psychol Soc, 1978, 31, 40-41; Hetherington R The changing role of the clinical psychologist, Bull Br Psychol Soc, 1981, 34, 12-14; Humphreys A Has general practitioner - psychologist liaison any relevance for community psychology?, Bull Br Psychol Soc, 1981, 34, 235-237; McPherson I and Sutton A (Eds) Reconstructing Psychological Practice, 1981, London : Croom Helm; Michie S The clinical psychologist as an agent of social change, Bull Br Psychol Soc, 1981, 34, 355-356; and Treacher A Anti-psychiatry or anti-clinical psychology - that is the question, Bull Br Psychol Soc, 1979, 32, 346-349.

3. See Doerner K Madmen and the Bourgeoisie, 1981, Oxford : Blackwell; Scull A T Decarceration : Community Treatment and the Deviant - A Radical View, 1977, Englewood Cliffs, N J : Prentice-Hall; Scull A T Museums of Madness : The Social Organisation of Insanity in 19th Century England, 1979, London, Allen Lane; and Burton M Understanding mental health services : theory and practice Critical Social Policy 1983, Issue 7, 54-74.
4. Hearnshaw L S A Short History of British Psychology, 1966, London : Methuen.
5. War Office Report of the War Office Committee of Enquiry into "Shell-Shock", Chair : Lord Southborough, 1922, London, CMND 1734.
6. Baruch G & Treacher A Psychiatry Observed, 1978, London, Routledge & Kegan Paul.
7. Myers C S Shell Shock in France 1914-1918, 1940, Cambridge : Cambridge University Press; Rivers W H R Instinct and the Unconscious, 1920, Cambridge University Press, and Smith G E & Pear T R Shell Shock and its Lessons, 1917, Manchester University Press.

8. Op.cit. Note 5.
River's evidence, incidentally, appears to anticipate some current ideas on helplessness and the controllability of stress.
9. Myers' evidence to War Office (see note 5).
10. Eysenck H J Hans Jurgen Eysenck, In G Lindzey (Ed) A History of Psychology in Autobiography, 1980, Vol VII, San Francisco : W H Freeman.
11. Lewis A L Health as a Social concept, Br J Sociol, 1953, 4, 109-124; see Wootton B Social Science and Social Pathology, 1959, London, George Allen & Unwin, 237-9, for a discussion of Lewis's criterion.
12. Eysenck H J Function and training of the clinical psychologist, J Mental Science, 1950, 96, 710-725, quotation appears on P.717.
13. e.g. Committee of Professional Psychologists (Mental Health) Postgraduate training in educational and clinical psychology. Bull Br Psychol. Soc, 1955, No.25, 1-18.
14. Compare the analyses of Kamin L J The Science and Politics of I Q, NY, Lawrence Erlbaum Associates, and Rose N The psychological complex : mental measurement and social administration, 1979, Ideology and Consciousness, No. 5, 5-68, for psychometry, with that of Gluse H E & Schmacke N Psychiatry and the origins of Nazism, Int J of Hlth Serv, 1980, 10, 177-196, for psychiatry.
15. Eysenck, 1950 (op.cit. note 12) p.714.
16. See Werskey G Making socialists of scientists : whose side is history on?, Radical Science Journal, 1975, No. 2/3, 13-50.
17. i.e. the British Journal of Psychology
18. Eysenck H J Letter to the Editor Bull Br Psychol Soc, 1952, 3, 97-98.

24. Whitley Councils are the joint staff-management bodies at a national level in the NHS. They govern wages and conditions of service including deciding on the appropriate qualifications and experience for admission to the various professions in the NHS. Proposals from the Thatcher government to replace them have recently appeared, but they followed rather than preceded the clamour for registration among British Clinical Psychologists. It should be noted that the survival of many concerns from the 1950s, especially that of status, can be related to the power structures within the NHS. For a discussion, see Navarro V Class Struggle, the State and Medicine : an Historical and Contemporary Analysis of the Medical Sector in Great Britain, 1977, London, Martin Robertson.
25. Bexley psychologists, The evolution of democracy in an NHS psychology department : Bexley Hospital Psychology Department, British Psychological Society Division of Clinical Psychology Newsletter, May 1980, (28), 24-30. There have been a number of similar experiments elsewhere.
26. Scull, 1979, op.cit. note 3.
27. Foucault M Madness and Civilisation, 1965, NY : Random House.
28. e.g. Scull, 1977, 1979, op.cit. note 3.
29. See Scull, 1979, op.cit. note 3.
30. Skultans V Madness and Morals, 1975, London : Routledge & Kegan Paul.
31. Wolfensberger W The Origin and Nature of Our Institutional Models in President's Committee on Mental Retardation. Changing Patterns in Residential services for the Mentally Retarded, 1969, reprinted by Human Policy Press, NY, 1975.

32. See Scull, 1977, *op.cit.* note 3.
33. See Miller P *Psychiatry - the renegotiation of a territory* (review of F Castel et al. *La Societe Psychiatrique Avancee*) *Ideology and Consciousness*, 1981, No. 8, 97-121, and see Burton, 1983, *op.cit.* note 3, for a general review of the changes in mental health and handicap services.
34. Braverman H *Labor and Monopoly Capital : the Degradation of Work in the Twentieth Century*, 1974, Monthly Review Press; Jenkins C & Sherman B *The Collapse of Work*, 1979, London : Byre Methuen.
35. See for example, Navarro V *The crisis of the international capitalist order and its implications for the welfare state*, *Critical Social Policy*, 1982, 2, (1), 43-62.