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Editorials
Clinical psychology in Europe and its relationships with psychiatry

The present and the future of clinical psychology in the UK

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In the UK clinical psychology is in demand. Training courses are being commissioned to provide more places each year. Currently (2001), 30 courses exist and train over 400 people per year, almost exclusively on 3 year doctoral degrees, which require supervised practice, academic ability and research skills.

"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" (Harvey, 2001). According to this document, the core skills of a clinical psychologist are 'assessment, formulation, intervention and evaluation' (p2).

It is the focus on formulation and intervention which has changed in the (almost) 30 years since I joined the profession as a trainee. At that time, in the early 70's, clinical psychologists were primarily seen as 'handmaidens' to psychiatry, asked primarily to provide technical data, such as IQ, personality and even psychiatric diagnostic testing, in order to inform the wardround in the old mental hospitals. It was a little like asking for a blood test, and about the same amount of time was allocated to listening to the results. Thus it is interesting to reflect on the changes in the UK over these years, and to consider possible future developments in this relatively new profession.

Clinical psychologists defined themselves comparatively early as 'scientist - practitioners' (e.g. Shapiro, 1969) and this emphasis remains. While initially this covered assessment and little else, increasingly this approach has also included both the development and evaluation of new psychological therapies, together with a tendency not to endorse less effective interventions. Examples of the former include new treatments for social phobia (Clark, 1986), for anorexia nervosa and bulimia (Fairburn et al., 1998), and psychosis (Garety et al., 2001). In this sense, clinical psychologists in the UK have been particularly interested in effective therapies, while not necessarily being wedded to one therapeutic approach (Roth & Fonagy, 1996). This emphasis means the majority of clinical psychologists in the UK espouse CBT as their primary therapeutic orientation. Other approaches would include systems therapy, IPT (Interpersonal Therapy), DBT (dialectical behavioural therapy) and CAT (Cognitive Analytic Therapy). A relatively small proportion, (perhaps 10%) would practice psychoanalytic approaches. These individuals would have had to organise their own training (it is not a national training requirement). Because the majority of practitioners work in the National Health Service, which currently emphasised both an effective and short intervention, psychoanalytic approaches are not seen as a priority.

Thus the 2001 BPS document discusses that 'clinical psychologists are more than psychological therapists', and goes on to point out that 'this is not a skill unique to clinical psychologists, nor should it be.' Instead it endorses that clinical psychology is 'one of the

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applications of psychological science to help solve human problems.'(p 4). Because of this breadth, clinical psychologists now work in many different areas, ranging from mental health teams, within General Practice surgeries, in General hospitals, dealing with a wide range of physical health problems, (e.g. diabetes, heart disease, cancer, pain, HIV and AIDS), with social service teams, forensic services, rehabilitation and resettlement teams. A minority work in higher education, involved both in training and in pure and applied research. Clinicians work with individuals, couples, families and groups, and also at the organisational level, such as with teams, wards or day centres. They may work with all age levels, from small children to older adults, across the life span, and across the range of disabilities, including both learning disability, people with severe mental health problems, with brain injury, with physical and sensory problems and with substance misusers.

Clinical Psychologists in the UK are now the largest single group of applied psychologists. There are estimated to be 4,200 currently practising (figures from the BPS). This compares to about 10,000 psychiatrists, 3,128 of whom were practising as consultants in 1998 (figures from the Royal College of Psychiatry). Thus they remain a relatively small professional group in mental health, and typically work within one or more multidisciplinary teams, where they may be on their own professionally. However, the days of justifying the role of a clinical psychologist in a mental health team, or most other settings, are receding. They are sought after in many teams, mainly for their expertise in psychological therapies, particularly in the evidence based ones, where they are often seen as the key practitioners. Frequently, they are also the profession who is turned to when complex cases need to be offered help, and when all else has failed. While they may not have unique skills for 'difficult to treat' patients, their background of evaluation, and interest in developing new approaches is usually seen as a particular advantage.

Until recently, clinical psychology was not only a relatively small profession, but also a scarce resource, so that vacancy rates of 25% were common, particularly in less popular specialities, and outside of the major conurbations. This is starting to ease, because of the increase in training places alluded to above. Given the age of the profession, which is around 50 years, (dated from when the first course was started at the Institute of Psychiatry, London, in 1947), it is now expanding at between 5 and 10% per year, and has not yet hit a peak of retirements and death.

A recent survey of current training courses using the Delphi technique (e.g. Linstone & Turoff, 1975; Jones & Hunter, 1995) confirms the centrality of the scientist -practitioner model to clinical psychologists in the UK (Kennedy & Llewelyn, 2001). They also found that clinicians felt they needed to be highly responsive to the 'cultural and institutional context' of their practice. As the authors point out, 'clinical psychology in the UK is almost synonymous with the National Health Service'. This means not only is the training now almost entirely funded by government, but also that the majority of clinicians work for the NHS, and more importantly perhaps, retain an acute sense of the needs of their employers. Thus in some ways, clinical psychology 'like other state funded enterprises, is not entirely in control of its own future'. While this may not sound ideal, it does ensure that the profession works hard both to 'define its unique identity, and to develop in accord with nationally and politically set priorities' (all quotes from p77).

While this all seems positive, there are of course various negatives. Although expanding, the profession still lacks legally enforceable registration. It currently operates a voluntary system of 'Chartering' which means in fact that most employed clinicians have to be qualified via a BPS accredited course, or equivalent, and are subject to the ethical code and disciplinary procedures of the BPS. This has the power to remove you from the register of chartered clinical psychologists, and otherwise discipline you. Any such result is reported publicly in 'The Psychologist'. However these sanctions only apply to members of the BPS, and anyone can currently call themselves a psychologist and offer therapies in a private capacity, without any legal challenge. This is due to change when registration becomes a legal requirement, but depends on political will. Although it is due to happen in the near future, unless it does, the possibility of future unethical and other unregulated behaviour by psychologists, and the potential for being discredited in the eyes of the public remains a worrying scenario.

Secondly, because it is a small profession, and because 'there will always be more demand than psychologists can fulfil' (Harvey, 2001), there is continuing worry about the ability of clinicians to work in a self sustaining and justifiable way, without risking 'burn out' (Reid et al., 1999) or the charge of elitism. Allowing access to psychological expertise without either 'diluting' it, or restricting it to those who either

demand it most vocally, or those who have more 'popular' conditions, has been problematic. Some services have battled with waiting lists a year long and growing longer. Others have tried to train other professionals to deliver treatments, but in some areas this has been limited to successful training but almost no implementation, for example in family work for schizophrenia (Fadden, 1997).

Another problem may be one of overdiversity. The fact that the range of conditions that can be offered clinical psychology services is now so large, and expanding, together with the shortages of personnel identified earlier, has meant both that other professions have moved to fill the gaps, and that the quality of services offered in so many different areas may be harder to monitor. Thus there has been a growth in Counselling Psychology, which has a slightly narrower focus on adult mental health problems, but a similar 3 year training to doctoral level as Clinical Psychologists. There has also been a growth in the numbers of 'psychology assistants', who are supervised but untrained psychology graduates, often, but not always, waiting to be accepted on to Clinical or Counselling psychology training courses. New professional specialities are also being created, ranging from Health Psychologists, Forensic Psychologists, Neuropsychologists to Child Psychologists. While the profession remains essentially unregulated, the potential for public confusion and perhaps exploitation by the unscrupulous, cannot be ruled out.

A final feature of the profession, which does not have clear positives or negatives, but is an ongoing trend, is the fact that it is becoming increasingly female. The ratio of male to female trainees has moved from around 50:50 to nearer 20:80 or lower, and this has been consistent for at least the last decade. Psychiatry has also become more female during this time, as has General Practice. As ever the tendency for the higher profile positions to remain male does not change as quickly and does not yet reflect the female preponderance in more junior positions. It remains to be seen whether these trends, which mirror other demographic and population changes in the numbers of women accessing higher education, in the UK and elsewhere, will have noticeable or noteworthy effects on the profession in the future.

As for the future, this is notoriously difficult to predict, and all we ever have is past behaviour. I think we have reached a more optimistic phase in the UK, in the sense that in the past the profession of clinical psychology felt under threat of marginalisation, of annexation or of atrophy. These threats do not seem to be current.

Future expansion at least in the short to medium term seems assured. The role and purpose of clinical psychology has been defined, and there are relatively few detractors. Users of mental health and other health services reportedly would like more talking therapies, and the future problem remains one of access and availability.

Because evidence based therapies are current government policy for the NHS, clinical psychology seems very likely to continue to have a key role, both as developer of these via clinical and theoretical research, and as deliverer of them, as practitioners. There is a view that the scientist-practitioner model of clinical psychology depends more on attitudes than behaviour, as most clinicians do not actually carry out published or publishable research, and trainees shed this part of the training as soon as possible after qualifying (Pilgrim, 1997). There is also the view that there may be a future split between these clinicians and between 'academic' psychologists, and a future lack of credibility for clinical practice that may be less research based, (reported in Kennedy & Llewelyn, 2001). However, this threat has been voiced before, rather regularly, and so far, the requirement of practitioners to use efficacious and effective clinical interventions has helped to counter it.

At present clinical psychology in the UK is looking and feeling more coherent, more respected, more grounded in both theory and its application to practice, and therefore more relevant, than I can ever remember. Psychology itself appears to have more complex and better tested theories of human behaviour than previously, and this can only improve clinical practice. While one can never predict the unexpected or control current or future government policy, it looks possible that clinical psychology in the UK can continue its relatively cautious climb towards becoming the sensible, needed and innovative profession that many of us wish it to be.

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