What is the impact of neoliberalism on clinical psychology practice? A Foucauldian Genealogical Analysis

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ABSTRACT

There has been an increase in research looking into the impact of neoliberalism on mental health and healthcare over recent years, with studies particularly emphasising the harmful implications of neoliberalism on people's wellbeing. However, much of this research has been criticised for a lack of nuance and specificity, and only a few studies have looked at the impact of neoliberalism on clinical psychology practice. This is an important research area for a profession which aims to reduce psychological distress and to enhance and promote psychological wellbeing. This study analyses historical documents relating to the development of eight specific clinical psychology practices. A Foucauldian Genealogical Analysis is used to develop a critical interpretation of the mechanisms and power relations underlying the impact of neoliberal processes of governmentality and subjectification on these practices. The analysis suggests that in a neoliberal era, clinical psychology practices have predominantly supported and enabled a neoliberal hegemony. Documents published by the profession emphasise practices that can be used to change individuals' behaviour and 'ways of being' in line with neoliberal strategies. More recently, clinical psychology documents also show an increase in practices that offer resistance to a neoliberal hegemony. However, these practices exhibit a tendency of being marginalised or altered in service of neoliberal strategies. The analytical interpretation developed in this study offers tools to support the resistance of a neoliberal hegemony by providing critical questions that could be used to critique existing practices and policies and develop alternatives.

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1. INTRODUCTION

1.1 Introduction Chapter Overview

This chapter provides an overview of relevant academic literature which demonstrates why the profession of clinical psychology needs to develop its awareness of the impact of neoliberalism on its practices. Following an introduction to the theoretical and analytical approach of this study, this chapter presents an overview of research on neoliberalism and its consequences for people's wellbeing, focusing specifically on processes of neoliberal governmentality and subjectification. The literature regarding the relationship between neoliberalism and clinical psychology in England is then summarised, followed by a review of research on some of the key social and political contextual factors that have influenced the development of the profession. Finally, this chapter states the rationale, aims and intended implications of this study.

1.2 Guiding Theoretical and Analytical Principles

1.2.1 Section Overview

Much has been written about the impact of neoliberalism on mental health (e.g. Roberts, 2021; Moth, 2020; Cosgrove & Karter, 2018; Moth & McKeown, 2016; Sousa & Marshall, 2017; Esposito & Perez, 2014; Rizq, 2014; Teghtsoonian, 2009; Ramon, 2008; Carney, 2008) and healthcare more broadly (e.g. Schrecker, 2016; De Vogli, 2011; Unger et al., 2008; Navarro, 2008; 2007). However, neoliberalism is multi-faceted and academic literature has called for greater clarity regarding how the term is used and what aspects of neoliberalism are being examined (e.g. Bell & Green, 2016). This study focuses on neoliberalism as governmentality (Ward & England, 2007), which draws on a Foucauldian understanding of "specific mechanisms of government, and recognisable models of creating subjects" (Ferguson, 2010, p. 171). This also implies the process of neoliberal subjectification. This section will introduce Foucault's analytical concepts and the underlying epistemological approach, before presenting the aspects of neoliberalism that will be examined in this

study (section 1.3). The epistemological and methodological approach will be expanded upon in the methodology section (section 2).

1.2.2 Social Constructionism and Poststructuralism

This research adopts a social constructionist epistemological position, and draws on poststructuralist ideas, particularly those articulated by philosopher, Michel Foucault. Social constructionism is a theory of knowledge which proposes that knowledge does not correspond to an objective reality, but is actively constructed through social and cultural processes. Burr (2015) asserts that this stands in opposition to the positivist epistemology of 'mainstream psychology', which claims to possess objective, neutral, universal and real knowledge about the world. Social constructionism does not imply a rejection of all the practices, ideas and theories of mainstream psychology (Gergen, 2009), but does enable important critiques of the 'truth-claims' (Burr, 2015) of contemporary psychology knowledge and practices. Social constructionism is therefore a useful perspective for the current study, which aims to achieve a critical understanding of how clinical psychology practice has been influenced by the social context of neoliberalism.

Khan and MacEachen (2021) argue that social constructionism can neglect political and historical influences which produce bodies of knowledge and social activity. They advocate drawing on the poststructural ideas and analytical concepts advanced by Foucault. Poststructuralism challenges the universality of the truth-claims proposed by structuralism by emphasising the historical context within which social structures are produced (Raulet, 1983). Foucault's analytical concepts adhere to a social constructionist epistemology (Sharp & Richardson, 2001) and can be used to develop a 'history of the present' (Foucault, 1978), which provides an interpretation of how current social structures and practices have come about. This process involves an analysis of power relations, processes and 'conditions of possibility' that may have contributed to the '*emergence'* of some structures, practices or discourses and the '*descent'* of others. 'Emergence' and 'descent' are terms Foucault used to describe the processes by which some ideas and discourses arise and are privileged or become dominant 'truths' in society, while others become subjugated and discontinued (Rabinow, 1991). 'Conditions of possibility' refers to the conditions

and factors that may have contributed to or precipitated these processes. Foucault developed his analytical tools to provide critical interpretations of the power relations and processes underlying the historical development of contemporary ideas and practices used in mental illness (1965), sexuality (1978) and the penal system (1979).

1.2.3 Foucault's Analytical Concepts

To arrive at a 'history of the present' that accounts for why certain practices and social structures are the way that they are, Foucault focused his analysis on the power relations between governing bodies, systems and people. Foucault developed a range of analytical terms to describe these power relations and the processes through which they are effected, which are outlined below. Please refer to Appendix A for a small glossary of these terms.

Foucault argued that people or groups with influence in society use their '*disciplinary power*' to exercise forms of '*governmentality*' over people (Foucault, 2008; 2009). Governmentality refers to activity that is intended to influence and control people's behaviour. It is achieved through '*technologies of power*' which "determine the conduct of individuals and submit them to certain ends" (Foucault, 1988a, p. 18). These technologies of power act on human conduct 'from a distance' (Rose, 1998) by forcing people to obey certain rules (e.g. '*domination*'; Foucault 1988b) or, more subtly, by delimiting the boundaries of what is 'normal' or desirable and what is prohibited or excluded ('*normalisation*'; Foucault, 1979). These norms are justified using '*discourses*' (Foucault, 1981), which determine the limits of what is included or excluded as reasonable knowledge within different social disciplines and domains (Arribas-Ayllon & Walkerdine, 2008). Foucault (1978) argued that people are placed under systems of surveillance and judged along specific criteria (or '*specifications'*), using the technology of power of '*examination*'. People are then rewarded or punished depending on how much they adhere to, or deviate from, the norm (Hoffman, 2011).

Through the additional technologies of power of '*individualisation*' and '*responsibilisation*', individuals are encouraged to internalise the idea that they are individually responsible for what happens, or does not happen, to them

(Foucault, 1978). People therefore act to transform their conduct and identities in accordance with dominant discourses and desired norms, using '*technologies of the self*' (Foucault, 1988a). This process locates the responsibility for overcoming social difficulties within individual people, diverting attention away from the social conditions and power relations that produce them (Foucault, 1982). Through these complex power relations, discourses are therefore both created by, and ensure the reproduction of, social systems (Young, 1981). This is a dynamic and de-centralised process which ultimately aims to render citizens governable (Rose, 1999a). This entire process has been translated as 'subjectification' (Heyes, 2010). Subjectification refers to the process of changing people's identities or 'ways of being' (Willig, 2001) and has been described by Foucault (1982, p. 777) as "the different modes by which, in our culture, human beings are made subjects".

1.2.4 Section Summary

This section has described the underlying epistemological approach to this study. It has also introduced the Foucauldian analytical concepts which this study will use to critically examine the impact of neoliberalism on clinical psychology practice. Using this approach, neoliberalism can be understood as a dominant social and political ideology or discourse. By focusing on specific processes and power relations, neoliberalism can be seen to have emerged from certain conditions of possibility, with significant implications for society and social institutions. This theoretical approach will be useful in developing an understanding of the impact of neoliberalism on specific clinical psychology practices.

1.3 Neoliberalism

1.3.1 Section Overview

This section will begin by outlining different aspects of neoliberalism. It shall specify this study's focus on neoliberal governmentality and neoliberal subjectification. The significance of neoliberalism as a topic of research to the discipline of clinical psychology will then be examined through a review of some of the literature on the impact of neoliberalism on people and their physical and

psychological wellbeing. Finally, a review of the development of neoliberalism and neoliberal governmentality in England will be provided.

1.3.2 Neoliberalism Definition

Neoliberalism has been described as "the defining political economic paradigm of our time" (McChesney 1999, p. 40). However, defining neoliberalism is not an easy task (McCarthy & Prudham, 2004). Neoliberalism is multi-faceted and has been used to refer to a range of different phenomena across different social contexts (e.g. Bell & Green, 2016; Ferguson, 2010; Steger & Roy, 2010; Ward & England, 2007). The aspects of neoliberalism that will be discussed below include neoliberalism as an ideology, policy programme, form of state and governmentality.

As an 'ideology', neoliberalism emphasises individual freedom and self-interest (Harvey, 2005). Beattie (2019, p. 1) summarises neoliberal ideology as "collectively, human beings thrive under conditions of free competition". Coburn (2000) asserts that neoliberal ideology contains the following three core assumptions:

- Markets provide the best means to allocate resources.
- Societies are composed of autonomous individuals (producers and consumers) who are predominantly motivated by material concerns.
- Competition is the primary drive for innovation.

Neoliberalism has also been described as a programme of policy, which emphasises economic liberalisation through privatisation and deregulation (e.g. Ward & England, 2007) as well as lower taxes and protecting property rights (Winston, 2018). Neoliberal policies aim for the 'marketisation' of public services (Whitfield, 2012), which opens institutions up to market forces of competition, with the intention of increasing consumer choice and creating greater efficiency and productivity. Greater productivity is thought to lead to increased wealth and, therefore, improved collective wellbeing.

As a form of state, neoliberals privilege the role of the 'neutral' market over politicians for making decisions (Mirowski, 2014), and so advocate for a 'rolling back of the state' (e.g. Ward & England, 2007). This implies reduced state

intervention beyond its role in supporting the activity and growth of the market (Harvey, 2005).

Neoliberalism has also been defined as 'governmentality'. This refers to a specific way of controlling people's behaviour from a distance. By promoting certain values (such as efficiency or productivity) and subjectivities (such as autonomy), people are encouraged to take responsibility for their own wellbeing and opportunities in life (Ward & England, 2007). Neoliberal governmentality emphasises individualistic over collective solutions (Coburn, 2000) and utilises a process of subjectification to transform individuals' subjectivities (i.e. ways of being) and behaviour so that they can become self-governing.

This study will predominantly focus on neoliberalism as 'governmentality', as well as the accompanying process of neoliberal subjectification. These aspects of neoliberalism are especially relevant for a discipline concerned with people's identities (or ways of being), behaviour and wellbeing. A focus on governmentality extends the scope of political analysis 'beyond the state' (Rose & Miller, 1992) and into forms of power within professedly non-political settings, such as the school, family, or, indeed, clinical psychology practices.

1.3.3 Neoliberal Governmentality and Technologies of Power

Foucault proposed that the market is a "specific form of governmentality" which creates a new "regime of truth" and would become the "organising principle of society" (Foucault, 2008, p. 30). Neoliberal governmentality uses market principles to teach the "conduct of conduct" which directs human behaviour towards "human capital formation" (Foucault, 2009, p. 229). Human behaviour can be changed without force by those with disciplinary power, using informal governmental techniques (Lemke, 2012). These include the use of subtle technologies of power, such as: ideological manipulation; normalisation; examination; rational argumentation; moral advice; and economic exploitation (Lemke, 2000). Neoliberal governmentality is thought to be enforced through the creation of markets into all forms of life (Phillips et al., 2006; Treanor, 2005) and the examination of social norms and values in the form of targets, hierarchies, 'standards', 'quality control' (etc.). For example, neoliberal values such as productivity, success, virtue, and happiness are associated with wealth,

prestige and ‘coming out on top’ (Esposito & Perez, 2014). These norms are not only promoted and examined by the state but also by ‘global power elites’ who hold disciplinary power such as managers; corporate lobbyists; journalists; and celebrities (Steger & Roy, 2010).

Foucault (2000, p. 229) argued that neoliberal governmentality “penetrates more deeply into people’s psyches”. As it is inefficient to force people to change their behaviour against their will, neoliberalism focuses on an internal locus of social control (Goldberg, 2008), exploiting people’s minds, emotions and freedom to enforce its governmentality (Han, 2017). Neoliberal governmentality also utilises individualisation and responsibilisation as technologies of power. While messages such as “the unemployed are the authors of their own destiny and success” can appear empowering (Furlong, 2016, p. 232), it puts a disproportionate amount of responsibility on individuals, obscuring social and political factors. This creates a state of perpetual precarity and anxiety, which is itself a technology of power (Lorey, 2015). Butler (2015, p. vii) describes precarious feelings and insecurity as “a regime, a hegemonic mode of being governed, and governing ourselves”. Precarity reinforces competition as the only legitimate way to structure human activities (Metcalf, 2017) and undermines communal trust (Light, 2010). The promotion of social norms which must be performed by self-activating, disciplined and responsible subjects allows those in power to control people’s behaviour indirectly. This enables the ‘government at a distance’ that is characteristic of neoliberal governmentality (Kipnis, 2008).

1.3.4 Neoliberal Subjectification and Technologies of the Self:

In speaking about her policies, Margaret Thatcher famously said: “Economics are the method; the object is to change the heart and soul” (Margaret Thatcher Foundation, MTF, 1981). Neoliberal governmentality is effected through a process of subjectification, whereby neoliberal subjects use ‘technologies of the self’ to transform their behaviour and ways of being in accordance with neoliberal values and norms (e.g. Foucault, 2008; McNay, 2009; Brown, 2003; Gilbert, 2013). The subjectivities or identities promoted by neoliberalism are offered in market terms, such as ‘consumers’, ‘customers’ (Monbiot, 2016), ‘producers’ and the ‘entrepreneurial subject’ (Foucault, 2008; Brown, 2003;

Rose, 1992). These promote qualities of autonomy, competitiveness, adaptability, efficiency, responsibility, self-determination and self-reliance (e.g. Siromahov, 2017; Rose, 1992; McNay, 2009; Coombes & Morgan, 2015). Markets create competition, which seems to produce a 'natural hierarchy of winners and losers' (Monbiot, 2016). This means that anxiety about becoming a 'loser' is pervasive (Timimi, 2017) and dependent and vulnerable ways of being are experienced as shameful (Layton, 2009). Under neoliberalism, subjects are encouraged to perceive themselves as a commodity in a marketplace (Dardot & Laval, 2014; Inch et al., 2020; Monbiot, 2016). Subjects must continually examine and work upon themselves to 'keep up with the Joneses' and can never be satisfied with the outcome in order to keep markets productive (Furlong, 2016). As Hayward (2021, p. 17) describes, "In a neoliberal age, we are all encouraged to master ourselves and optimize our effectiveness". Han (2017) suggests that this leads to the judgement and exploitation of ourselves and others, as well as spiritual burn-out.

Although this summary of the process of neoliberal subjectification is based on theoretical research, Scharff's (2016) qualitative study lends some empirical support to these assertions. Scharff found that interview participants experienced themselves as analogous to a business, competing with themselves and others, staying positive, embracing risks, surviving difficulties, and hiding vulnerabilities, despite feeling anxious and insecure. Scharff's study is limited in its generalisability as it is based on a sample of all-female musicians talking about their careers. Further research is needed into how people are affected by neoliberal subjectification in different areas of life. This is especially pertinent to the discipline of clinical psychology and how it positions its service users[1]. Many see subjectivity and self-creation as an essential function of psychology (MacIntyre, 1985; Danziger, 2003; Smith, 2005; Hayward, 2021).

1.3.5 The Relevance of Neoliberal Governmentality to Clinical Psychology: The Impact of Neoliberalism on People's Wellbeing

[1] 'Client' is a prevalent term used by clinical psychologists to describe people who use their services, but has been critiqued for being consumerist (e.g. McGuire-Snieckus et al., 2003). This study will therefore use the term 'service users'.

Initially, neoliberal governmentality's emphasis on personal growth, self-actualisation and happiness (Adams et al., 2019) could be seen to support people's wellbeing. However, feelings of insecurity, depression, and anxiety are more commonly linked with neoliberalism (e.g. Sennett, 1998; Ehrenberg, 2010; Hall & O'Shea, 2013; Scharff, 2016). Neoliberalism has been associated with a decrease in global economic growth (Chang, 2002)[2], reduced worldwide gains in life expectancy (De Vogli, 2011) and a sharp increase in inequality, nationally and globally (Rothwell, 2016; Piketty, 2015; Ostry et al., 2016; World Inequality Database, n.d.). For example, Wilkinson and Pickett's (2009) epidemiological research found that in Britain, between 1975 and 2006, social mobility stalled and then reversed. During this period, inequality grew[3] and rates of mental 'illness' increased.

As inequality has risen over this period, so has mistrust and anxiety about social status (Buttrick & Oishi, 2017). Increased inequality has also been associated with increased rates of 'mental illness' (Wilkinson & Pickett, 2009; Verhaege, 2014). Wilkinson and Pickett (2017) demonstrate that people with lower income levels exhibit more 'status anxiety', depression, feelings of inferiority and shame, whereas those with higher levels of income present with higher levels of narcissism, psychopathy and self-enhancement. Neoliberal governmentality requires people to be constantly engaged in competition to instil an ethics of self-government (Furlong, 2016). Fear of losing one's place in the social hierarchy acts as a motivational force for self-examination, self-improvement and self-regulation in line with socially-desired norms, such as autonomy and productivity (Treanor, 2005). It is not possible to definitively determine the causational impact of neoliberalism on psychological and material problems from theoretical and correlational studies of inequality. However, Becker and colleagues (2021) conducted 3 quantitative research studies across 750 participants that showed that increased exposure to, and perception of, neoliberal ideology decreased wellbeing and increased loneliness by increasing people's perceptions of being in competition with others.

[2] Except for the economic elites (Monbiot, 2016).
[3] The UK now has one of the highest levels of income inequality among rich nations (Wilkinson & Pickett, 2009).

The impact of neoliberal governmentality on psychological wellbeing is compounded by the fact that structural barriers impinge on people's ability to change their circumstance (Hamilton & Strickland, 2020). To name just some examples, level of education (Naylor at al., 2002), gender (Leaker, 2008) and ethnicity (Blackaby et al., 2002) all affect market opportunities. Nonetheless, neoliberal governmentality recasts inequality as virtuous (Monbiot, 2016) and emphasises an autonomous subjectivity which obscures the fact that individuals are not able to act independently of their social and political environment. Current UK Prime Minister Boris Johnson declared that: "inequality is essential for the spirit of envy and keeping up with the Joneses… a valuable spur to economic activity" (Watt, 2013). Neoliberal technologies of power individualise these structural inequalities (McNay, 2009). This pathologises people for their lack of ability to act autonomously to improve their circumstances and increases their sense of hopelessness (Hagan & Smail, 1997). This has a disproportionately negative impact on members of marginalised social groups (Younis, 2021).

1.3.6 Neoliberalism in England

Neoliberalism became the dominant ideology across many parts of the world in the 1980's, proposed as a response to rising unemployment and inflation rates of the 1970's (Steger & Roy, 2010). Neoliberalism can be understood as a "complicated but coherent political project" involving a network of business executives, fundraisers, journalists, politicians, policy experts and academics who were ideologically opposed to regulation and redistribution (Schrecker, 2016, p. 478). The rising threat of socialist and communist political power have also been argued to be potential conditions of possibility for neoliberalism's emergence (Harvey, 2005). Neoliberalism re-asserts social conditions that allow for the continued accumulation of wealth and power for the economic and political elite (Harvey, 2005).

In England, the introduction of neoliberalism is closely tied to the rise of the Conservative government to political power under Margaret Thatcher in 1979. Thatcher was opposed to the political trend of the previous decades, which she called 'collectivism' (MTF, 1981). Her policies, which became known as 'Thatcherism', emphasised the reduction of trade union power; reduced taxation

and government spending; the privatisation of key public industries; and deregulating the economic market (Steger & Roy, 2010). In terms of neoliberal governmentality, greater control of public institutions from a distance was effected through Thatcher's 'New Public Management' policies, which centred on measuring and evaluating the performance of services. This has been termed a 'technology of performativity', which serves the strategy of shaping moral and political conduct for governmental purposes (Dean, 2010).

The 'New Labour' era is commonly seen as "a continuation and extension of neoliberalism" (Hindmoor, 2018, p. 26) with policies such as the creation of quasi-markets using 'partnerships' and managerially-driven targets, as well as increased policing (Smith & Morton, 2006). Peck and Tickell (2002) submit that the 'roll-out' neoliberalism of New Labour emerged to regulate and control those who had been marginalised by the 'roll-back' neoliberalism of Thatcherism. Similarly, Ling (2000) argues that New Labour's neoliberal reforms increased a neoliberal governmentality through tighter measures and controls intended to promote the self-regulation of welfare providers and recipients. Subsequent Coalition and Conservative governments have further extended discourses that promote self-governance and social inclusion through involvement with the labour market, so that neoliberalism has become more pervasive and subtle (Fuchs, 2016; Moth, 2020).

1.3.7 Section Summary

Neoliberal governmentality has been argued to be powerful and pervasive. As we have seen, it uses the process of subjectification to extend neoliberal values as models for selfhood in modern society and change people's conduct. These are particularly important aspects of neoliberalism for the discipline of clinical psychology, whose practices also intend to change people's behaviour and ways of being. Given the breadth of research on harms attributed neoliberalism, it is important that clinical psychology critically examines its practices to see how it engages with potentially deleterious processes. Following from critiques of research into neoliberalism (e.g. Kipnis, 2008; Kingfisher & Maskovsky, 2008; Bell & Green, 2016) it is important that research into this area is critical, reflexive and nuanced and looks at how neoliberalism is effected using specific examples.

In line with Foucault's emphasis on writing a 'history of the present', the next section will provide a summary of the academic literature on the present relationship between clinical psychology and neoliberalism. This will then be followed by an overview of the literature on the social and political conditions that may have contributed to the emergence of the current status quo of clinical psychology practice (section 1.5).

1.4 Academic Literature Review of the Relationship Between Clinical Psychology and Neoliberalism

1.4.1 Section Overview

An academic literature review was conducted in order to develop our understanding of the present relationship between clinical psychology practices and neoliberalism. A systematic approach was applied through the use of a scoping review, with the intention of reducing the possibility for biased source selection and developing a more balanced understanding. This approach defines the search terms which are to be used for identifying studies in different research databases. This section will define the search terms used for the scoping review and present a narrative summary of the literature identified by the review.

1.4.2 Defining the Academic Literature

An initial search was conducted on the following specialist research databases: APA PsycInfo, Academic Search Complete, CINAHL Plus, Science Direct and Scopus. Using the terms 'neoliberal governmentality' or 'neoliberal subjectification' and clinical psychology as search terms did not yield any results. However, using 'clinical psychology' and 'neoliberal*' or 'capital*' or 'consumer*' as search terms[4] (or subject terms where more appropriate) yielded 42 results. I supplemented this search with a Google scholar search, and looked at the first 100 results (out of 7,010 relevance-ranked results). Arksey

[4] Using the 'AND' function meant that both 'clinical psychology' and either 'neoliberalism' or 'capitalism' or 'consumerism' must appear within the academic journal to be included in the results. Using the * function (as in neoliberal*) denotes that as well as the term 'neoliberal', if additional suffixes, such as in 'neoliberalism', 'neoliberals' etc, appeared in the study, the study would be included.

and O'Malley (2005) advise specifying exclusion and inclusion criteria to decide which studies to report on. Appraising the article titles and abstracts, I included all articles that related to clinical psychology practices in England. I excluded articles that related to clinical psychology practice outside of England and any sources which did not examine the relationship between clinical psychology and neoliberalism (for example, a study on treatment for 'compulsive buying', which authors suggest happens more in neoliberal societies). After duplicates were removed, 18 articles remained. This number was reduced to 11 after the same inclusion/exclusion criteria was applied to a full text appraisal. These 11 research articles were added to using citation searching, which increased the total number of sources to 20 (see Appendix B for full list of sources).

1.4.3 Narrative Summary of the Academic Literature Review

The number of articles returned is remarkably low. This reflects Sugarman's (2015) assertion that academic discussions about neoliberalism in psychology are rare. Almost all of the studies returned by the search were critical of the impact of neoliberalism. This could reflect the fact that the term neoliberalism is becoming a popular source of critique (Bell & Green, 2016).

1.4.3.1 *Clinical psychology research- defining the norm:*

Furlong (2016, p. 213) argues that it is "literally true that Psychology has generated, and then disseminated … a dominant story specifying what is normal and what is not". Clinical psychology's statistical modelling determines what is 'normal' in mathematical and also social terms. Roberts (2015, p. 87) contends that the emphasis on statistical analysis and "regulation of so-called abnormal behaviour has always been about the maintenance of the status quo". Miller and Crabtree (2008) assert that clinical psychology research usually works on behalf of global corporate capitalism by maintaining oppressive structural hierarchies.

1.4.3.2 *Clinical psychology discourse- supporting an individualistic neoliberal subjectivity:*

Gezgin (2019) argues that clinical psychology protects a neoliberal status quo through the separation and 'atomisation' of individuals from their social context and the 'psychologisation' of social and political phenomena. He asserts that the 'neoliberal cure' advanced by mainstream psychology is about changing yourself, not society. Gezgin suggests that this

diverts responsibility away from social and political conditions and implicitly blames the individual for their natural feelings of failure and inadequacy. Thomas (2019) echoes this view; he cites the work of Friedli and Stearn (2015), who argue that clinical psychology practices have been used in the enforced assessment and treatment of benefit claimants. This places the blame for the continued use of benefits on faulty attitudes and behaviours, which deflects attention away from social factors. Fisher (2017) proposes that people who experience the inevitable psychological impact of social marginalisation and discrimination are made responsible to manage this with medication, positive thinking and mindfulness practices. He suggests that consciousness raising can help people to direct attention to the power structures that produce the distress and take collective action. Fisher's (2017) article was published in 'Clinical Psychology Forum', a journal published by the British Psychological Society's (BPS) Division of Clinical Psychology (DCP). This appears to suggest an openness by the profession to explore these ideas. However, it appeared in a special issue on 'Power, interest and psychology', indicating that it is seen as specialist and marginal to the central issues of clinical psychology.

Clegg and Lansdall-Welfare's (2020) archival analysis demonstrates that between 1980-2008, while clinical psychology has presented itself as a discipline that can solve individuals' problems, the number of BPS members has grown fivefold. They argue that clinical psychology has increased its popularity by becoming a neoliberal institution that increasingly separates people from their social environment. They also contend that although clinical psychology publications have advocated for social justice, there is a lack of political analysis and reflexivity.

1.4.3.3 *Clinical psychology services- the factory model:* Neoliberal psychology services have been described by several academics as a 'factory model' combining restrictive discourses of business and science. Gezgin (2019) proposes that the use of performance-based targets resembles a manufacturing base and results in less time and resources available for each client. Rizq (2014) contends that the business focus created by 'New Public Management' has created an audit and clinical governance discourse which enforces regulation and adherence to service protocols, policies, guidelines and manuals

under the guise of transparency and accountability. Rizq argues that this undermines trust and relationships as individuals are turned into numbers whose treatment of suffering is transformed into a consumer activity. Loewenthal (2015) suggests that the dominant discourse of 'evidence-based practice' defines its own narrow boundaries, to the exclusion of alternatives. Loewenthal describes how this produces a culture of registration and regulation which extends to all areas of practice, controlled from a distance by the state with claims of 'quality assurance', efficiency and value-for-money. Pickersgill (2019) asserts that the collection and recording of clinical outcomes actually improves accountability and political legitimacy. However, as noted by Rizq (2014), it may be the erosion of trust produced by neoliberal ideology that necessitates accountability through quantifiable evaluations.

Dudley (2017) suggests that neoliberalism has created a marketplace environment which has compelled psychologists to engage with market ideologies. He argues that the profession has had to compete within and between services to fight for funding, to the detriment of engaging with the complexity of their work with service users and the social and political landscape. Dudley contends that as a consequence, technical knowledge that can be quantified, compared and marketed has been privileged over intuition, compassion and empathy, despite the fact that these qualities are repeatedly shown to be most important factors for therapeutic outcomes (e.g. Wampold, 2015). Schwarz (2018) asserts that the utilisation of scientific discourse ('scientism') has been used in a competitive market climate to confer authority and a greater market position for the profession.

1.4.3.4 Clinical psychology therapy- the neoliberal cookie-cutter?:

Rose (1999b, p. 43) states that psychological therapy embodies "a whole way of seeing and understanding ourselves in modern societies. The words of the psychotherapies, their explanations, their types of judgement, their categories of pathology and normality… have a proactive role in shaping the subjectivity of those who would be their consumers". Standardised therapies can therefore act as powerful tools to effect the process of subjectification, akin to a cookie-cutter in a factory. Lemke (2000) suggests that the recent emphasis on self-esteem teaches people to assess and modify themselves, in a process that Pupavec

(2004) terms ‘therapeutic governance’. Schwarz (2018) contends that individualistic neoliberal ideology is replicated in therapeutic discourse, which de-contextualises and ‘commodifies’ (Timimi, 2017) constructs, such as ‘resilience’, ‘disorders’ and ‘emotional intelligence’ and ‘self-esteem’. The focus is therefore on individual treatments, which teach and sell attributes that are judged to be ‘successful’ within a neoliberal culture, such as affect management, self-esteem and confidence (Adams et al., 2019). Ferraro (2016) asserts that therapeutic techniques, such as those used in Cognitive Behavioural Therapy (CBT), have proliferated because they act as an extension of neoliberal governmentality through the indoctrination of conformity with the status quo via self-government. Ferraro argues that ‘technocratic’ approaches are promoted in guidelines, policies and practice because they are cheaper and more standardised ways of indoctrinating a moral regimen by correcting ‘distorted cognition’. The success of these technologies can be examined and measured using “numerical evaluations rather like the key performance indicators (KPIs) of the corporate world” (Ferraro, 2016, p. 20).

Ferraro makes important points about how CBT may be applied. However, his assertion that psychological therapies cannot be used outside of providing “distraction, forced positivity and rationality… promotion of narcissism (“self-esteem”), enforcement of various “biopolitical” regimes (of sleep, medication, diet, exercise), and short-lived manipulations of affect” (p. 20) excludes many of the therapeutic encounters that I have witnessed in clinical psychology settings, which do encourage people to feel and express a range of emotions, not all of which are ‘positive’ or ‘rational’, and which acknowledge the injustice of their environment. Olivier (2020) argues that psychological therapy can play an important liberating role by encouraging a rejection of the psycho-political subjectification invoked by neoliberal governmentality. Olivier promotes consciousness-raising and ‘de-psychologisation’ within therapy to this end.

1.4.4 Section Summary

This section has reviewed the literature base on the relationship between clinical psychology and neoliberalism in England. The research reviewed suggests that present clinical psychology practices support and enable neoliberal processes of governmentality and subjectification. With some

exceptions (e.g. Thomas, 2019; Fisher, 2017) there was a notable lack of specificity regarding how neoliberalism impacts clinical psychology practice and what other factors have influenced the development of these practices. The next section develops a more nuanced understanding of the impact of neoliberalism on clinical psychology practice by providing an overview of the academic literature regarding the historical and contextual factors that have influenced clinical psychology practice.

1.5 A Critical Review of the Development of Clinical Psychology Practices

This section explores historical factors that could help to account for the present situation described in the preceding section. This section is not a genealogy, but in keeping with the aim and approach of the current study, will attempt to identify contextual factors that could be used to develop a nuanced 'history of the present' (Foucault, 1978). Foucault advised that this endeavour should focus on locating "the forms of power, the channels it takes, and the discourses it permeates" (1978, p. 11). This section aims to build an understanding of the impact of neoliberalism and other factors on present-day clinical psychology practice through a critical historical analysis focused on power relations. A Foucauldian approach emphasises developing an account that has political utility rather than one that is objectively true (Foucault, 1980; Dean, 1992). Continuing the focus on governmentality and subjectification, this section will explore the development of clinical psychology practices within wider governmental policies and strategies before and after 1979, as well as the subjectivities constructed by different clinical psychology practices across this period.

1.5.1 Defining Clinical Psychology Practices

Clinical psychology is not a unitary and unified profession (Richards, 1983), and so defining its practices is not straightforward. Roberts (2015, p. 33) contends that major disputes within the profession have meant that "psychologists seem unable to agree on what their subject is or even how to study it". Drawing on recent DCP publications, a contemporary definition of clinical psychological practices could be: those practices that are done by clinical psychologists to

"reduce psychological distress and to enhance and promote psychological wellbeing by the systematic application of knowledge derived from psychological theory and data" (DCP, 2001, p. 2; 2010, p. 2). The development and definition of clinical psychology practices has been influenced by a combination of professional, social and political processes over time. This section presents an overview of academic literature that has considered these contextual factors and how they have impacted on the development of clinical psychology practices.

1.5.2 The Development of Clinical Psychology Practices in Relation to Governmentality Strategies Before 1979:

The DCP was established as a section of the BPS in 1966. In the first DCP meeting, the chair, Mahesh Desai, affirmed the main practices of clinical psychologists as: assessments (including a formulation of the condition); involvement in treatment; research; and teaching (Hall et al., 2015). According to the academic literature, there are a diverse range of potential conditions of possibility for the emergence of clinical psychology in this particular form. The literature emphasises the impact of the scientific discourse privileged by the BPS; clinical psychology's relationship with psychiatry; social and political factors (e.g. World Wars) and the growth of the profession within the National Health Service (NHS). These areas will be critically examined, with a focus on their role in shaping clinical psychology practices in ways that relate to strategies of control over people's behaviour, i.e. governmentality.

Clinical psychology developed out of the broader field of psychology, which emerged as a profession at the turn of the 20th century (Richards, 1983). In 1901, the BPS was founded in a meeting at Mind and Logic at University College, London (Hearnshaw, 1964). Their aim was to 'advance scientific psychological research, and to further the cooperation of investigators in the different branches of psychology' (Hall, Pilgrim & Turpin, 2015, p. 8). An emphasis on scientific discourse subjugated the philosophical discourse that psychology had previously endorsed (Hearnshaw, 1964). This was in line with the Enlightenment values privileged by Western societies (Porter, 2001) and appeared to offer potential solutions to the problems faced by modern society. For example, the statistical methods developed in 19th century Britain by Galton,

and later by Pearson, led to the study of individual differences and psychometric tests (Hall et al., 2015). Academics assert that these methods gave governing bodies the potential for greater control over society by using technical solutions to solve social problems (Rose, 1985). These problems ranged from classifying and regulating parts of the population such as criminals, races and the mad (Burt, 1927); to personnel selection and industry efficiency in World War 1 (Pilgrim & Treacher, 1992) and justifying eugenicist and colonial practices (Pilgrim & Patel, 2015). Clinical psychology originally emphasised only practices of research and psychometric tests (e.g. Eysenck, 1949), which arguably served political strategies of control over people, but were portrayed as neutral and scientific (Pilgrim & Treacher, 1992).

The growth of clinical psychology after the war has been attributed to the applied use of psychometric testing to assist in psychiatric diagnoses (Hearnshaw, 1964; Richards, 1983; Harper & Townsend, 2021). Psychiatry had already established "medical hegemony over mental disorder" during the 19th century (Pilgrim & Treacher, 1992, p. 5). Clinical psychology was therefore obliged to accept a medical-organic explanation of mental disorder (Albee, 1998). This can be understood using Abbott's (1988) theory that professions compete for 'jurisdictional legitimacy', meaning the right to claim professional authority over areas of human problems. In order to claim jurisdictional legitimacy over 'mental disorder', the emerging profession of clinical psychology had to develop its practices in line with the dominant discourses of the time (i.e. medicine and science) but also demonstrate a unique contribution to society. The problem of 'shellshock' in both World Wars has been seen as an important catalyst for the development of psychological formulations and early treatments (Stone, 1985). The development of behavioural therapy in the 1960's (Richards, 1983) offered an alternative treatment approach to the lengthy psychoanalytic treatments favoured by psychiatrists. This approach was more scientific and time-limited and has been seen as offering an economically efficient alternative to psychiatry as a method for governing people who deviate from the employee-employer relations constructed by capitalism and industrialisation (Scull, 1979; Richards, 1983; Pilgrim & Treacher, 1992).

Clinical psychology practices have developed in response to pressures faced by its main employer, the NHS (Hall et al., 2015). Clinical psychology have progressively moved from hospital-based settings to community settings since Enoch Powell's 1961 'water tower' speech emphasised the importance of de-hospitalisation and community care (Richardson, 2015). Working within the NHS meant that clinical psychology practices have had to focus on individual problems as the NHS delivers support to individuals (Richards, 1983). The 1977 (Department of Health & Social Services) Trethowan report supported the independence and growth of the profession in the NHS, which was to expand the population it provided services to (e.g. to include primary health care) and could now receive referrals from GPs, not just psychiatrists (Hall & Wang, 2015).

1.5.3 The Development of Clinical Psychology Practices in Relation to Neoliberal Governmentality (Post-1979):

Thatcher's premiership introduced greater privatisation, marketisation, consumerism and managerialism into the NHS (Rogers & Pilgrim, 1996; Pilgrim & Patel, 2015). Thus, the NHS was increasingly managed like a private business, but controlled by central government. This led to government publications that privileged discourses of efficiency and cost-effectiveness (Pilgrim & Treacher, 1992). For example, the landmark Management Advisory Service (MAS, 1989) review of the profession focused on the efficiency of 'specialist' clinical psychology 'skills' and clinical psychologists' managerial and organisational roles. Furthermore, the 1990 National Health and Community Care Act introduced internal markets into the NHS through the purchaser-provider split, which promoted service marketisation and commodification (e.g. Harris, 2003). It also emphasised discourses of consumer choice and empowerment (e.g. Rummery, 2007; Coppock & Dunn, 2010). Clinical psychology practices responded by emphasising practices that gave it greater jurisdictional legitimacy in this climate. This included individual therapy, 'formulations' (Crellin, 1998) and more indirect and 'efficient' practices, such as training and consultation as well as service user involvement (Parry, 2015; Pilgrim & Treacher, 1992). In contrast, practices that aimed at social justice were subjugated (Pilgrim & Treacher, 1992). This reflects the view that

managerialism created a ‘regulatory state’ and a culture of control and compliance for professionals (Klein, 2001).

The New Labour government’s publication of ‘The New NHS: Modern, Dependable’ (DoH, 1997) set out new standards and targets for NHS services, including the increased provision of talking therapies. Bodies such as the National Institute for Clinical Excellence (NICE), National Institute for Mental Health in England (NIMHE) and Centre for Outcomes and Research Effectiveness (CORE) emerged to operationalise the ‘Evidence-Based Practice’ (EBP) discourse and deliver services and practices in line with the new standards. The ‘modernisation’ agenda was supported by further publications, including ‘National Service Frameworks’ and ‘New Ways of Working’ papers, which further embedded market norms (Worrall et al., 2010). It has been argued that standardised psychology practices that align more easily with the EBP discourse (e.g. CBT interventions) were taken on more eagerly by policy makers and the profession (Newnes, 2014). These are likely conditions of possibility for the 2006 development of Improving Access to Psychological Therapies (Peacock-Brennan, 2016). Furthermore, the ‘New Ways of Working in Applied Psychology’ document stressed the need for service delivery practices and emphasised that “leaders in service delivery need to be business-minded, politically aware, and demonstrate alignment to the organisation’s strategic objectives” (Hall & Wang, 2015, p. 74). Service delivery and leadership practices have since been increasingly emphasised by the profession (Kat, 2015).

Since 2010, the resurgence of Conservative government leadership has significantly influenced clinical psychology practice. Most notably, policy discourses have tended to endorse individualised conceptions of wellbeing through concepts of ‘self-care’, resilience and the promotion of employment (Sugarman, 2015; Taylor, 2015; Moth, 2020). These have arguably enabled a neoliberal governmentality from a distance. For example, the (2012) Health and Social Care Act stipulated that the ‘Clinical Commissioning Groups’ led by General Practitioners were to be managed by the NHS Commissioning Board, who are accountable to the Secretary of State for Health through the Quality and Outcomes Framework and Commissioning Outcomes Framework (Speed &

Gabe, 2013). The profession has responded by impressing that it can "contribute not only by improving the health and well-being of individuals but also the health of the nation through employability, productivity and social inclusion" (DCP, 2014a, p. 2). In this light, the clinical psychology practice of therapy can be seen to have changed from a 'cottage industry of artisan practitioners' to a technical enterprise serving a pre-specified machinery of delivery (Parry, 2015). Depending on the subjectivities (i.e. ways of being) that are promoted by therapy practices, this could be argued to enable neoliberal governmentality. Psychological therapies and health education practices that emphasise individualistic ways of being are posited as enabling a "moral regulation favoured by both government and public" (Pilgrim & Treacher, 1992, p. 190) by teaching citizens to become 'self-governing' (Hawksley, 2013; Rose, 1996a). The welfare state has thus been seen as a condition of possibility for government at a distance (Miller & Rose, 1990).

1.5.4 The Different Subjectivities Privileged by Clinical Psychology Practices:

Academics have argued that the history of psychology is a history of self-creation (e.g. Hayward, 2021; Smith, 2005). Clinical psychology practices provide discourses and technologies that can be used to construct different subjectivities, or ways of being, for people, depending on the theoretical approach underlying the practice. A predominant emphasis on a positivist and scientific theoretical understanding of psychological experiences was endorsed in the first 50 years of British psychology (Pilgrim & Treacher, 1992). This approach privileges a discourse of objectivity, which separates individuals from their environment and positions psychological problems as abnormal reactions to the environment (e.g. Meyer, 1933) and subjectivities for service users as 'unwell' (Richards, 1983). Scientific practices, such as behavioural interventions, have been criticised for a reductive and mechanistic view of individuals (e.g. Bannister & Fransella, 1970). By contrast, a more 'humanistic' theoretical perspective privileges a discourse of subjectivity, and positions psychological problems as adaptive responses to human problems in relationships or meaning-making (Richards, 1983). The tension between these two approaches was partially resolved through the inclusive but contradictory construction of 'scientific humanism' (Richards, 1983).

During the 1960's, the growth of the profession led to an increase in different theoretical approaches and diverse clinical practices, such that a new collective noun emerged: 'a disagreement of psychologists' (Pilgrim & Patel, 2015). Different approaches included feminist, cognitive, critical, experiential, systemic and constructivist understandings of individuals and their psychological experiences (Parry, 2015). These approaches increased the range of subjectivities available to service users, including more 'holistic' ways of being that present "the individual as a functioning unity and in relation to the social environment" (Richards, 1983, p. 8). However, the eclectic spirit of the 1970's changed with the introduction of neoliberalism and the renewed focus on more individualised and positivist practices that could demonstrate effectiveness (Newnes, 2014). Nonetheless, clinical psychology has always contained conflicting factions (and subjectivities) and critical psychology, liberation psychology, community psychology and social constructionist perspectives have continued to challenge the dominance of an individualistic discourse (Smail, 2005; Kat, 2015; Bowden et al., 2015). Clinical psychology has also attempted to adapt its practices to work with oppressed groups in society by challenging perspectives which construct disempowering subjectivities for people who have been marginalised (e.g. Bowden et al., 2015; Pilgrim & Patel, 2015).

1.5.5 Section Summary

This section has provided a historical overview of some of the factors and conditions of possibility that may have led to the present situation described in section 1.4. A focus on governmentality and subjectification has been used to explore how clinical psychology practices have developed in response to social and political factors. Before the 1960's the profession emphasised scientific and technical practices (e.g. research, psychometrics, behaviour therapy). In the 1960's and 1970's clinical psychology practices expanded, incorporating a greater range of theoretical approaches. However, since the advent of neoliberalism, the profession has privileged technical practices aimed at individuals, thereby subjugating alternatives. It is also evident that the profession contains a diverse range of theories and practices, which serve different professional, social and political strategies and construct different

subjectivities for people. This demonstrates the need for a more nuanced analysis of the mechanisms by which specific practices relate to neoliberal processes of governmentality and subjectification.

1.6 Rationale For The Current Research And Research Aims

The review of the literature provided in this chapter has suggested that neoliberalism has a significant impact on clinical psychology practice. However, the extent to which neoliberalism impacts on specific practices and the specific mechanisms by which this happens remains unclear. This section will provide an overview of the rationale and aims of the current study, followed by the study implications and the core research questions.

1.6.1 Rationale for this Study

The review of the literature suggests that neoliberalism has a powerful, pervasive and negative impact on people's wellbeing (section 1.3) and on clinical psychology (section 1.4). It is important for a discipline that intends to "reduce psychological distress and to enhance and promote psychological well-being" (DCP, 2001, p. 2; DCP, 2010a, p. 2) to conduct research into the impact of neoliberalism on clinical psychology practice. The historical review of literature regarding the influence of contextual factors suggests a range of social, political and professional factors impacted on the development of clinical psychology practices. Governmentality, and neoliberal governmentality in particular, appear to have had a significant impact on clinical psychology practices.

However, there is a lack of literature that has directly looked at the relationship between clinical psychology and neoliberalism in England (11 articles found through a scoping review) and the vast majority of the research cited in this chapter has been theoretical and has lacked nuance, reflexivity and specificity. This accords with research that has highlighted these issues and the need for critical research to provide accounts of the mechanisms by which neoliberalism impacts on specific areas of healthcare (e.g. Bell & Green, 2016; Kingfisher & Maskovsky, 2008). This study also meets appeals for more historical research

(e.g. Hall et al., 2003; Pilgrim, 2010; Bunn, 2001) and greater reflexivity within the profession of clinical psychology (e.g. Schwarz, 2018; Walsh et al., 2014).

By using historical documents, this study attempts to contribute to the literature base with a more empirical examination of the impact of specific aspects of neoliberalism on clinical psychology practice. A Foucauldian methodological approach will be used to develop a rich and detailed analysis of the power relations and processes that are implicated in this relationship. Previous research has used Foucauldian and critical approaches to build an understanding of the development of clinical psychology practices (e.g. Richards, 1983; Rose, 1985; Pilgrim & Treacher, 1992). However, these studies have predominantly focused on the time period before the advent of neoliberalism. Further research is needed to update and extend a critical understanding of the development of clinical psychology and its practices.

1.6.2 Aims of this Study

The current study aims to provide a critical and reflexive historical analysis that directly and empirically examines the impact of neoliberalism on clinical psychology practices. This study intends to look specifically at the impact of neoliberal governmentality and subjectification using an analysis of historical power relations and processes. By focusing on the period following Thatcher's election in 1979, now known as 'neoliberalism', this study aspires to update and extend previous critical historical analyses by focusing on the neoliberal era. This study aims to provide a nuanced account by examining the mechanisms by which neoliberalism impacts on specific clinical psychology practices, while also considering the impact of other contextual factors. By providing an analysis of the specific mechanisms and power relations underlying neoliberalism's impact on clinical psychology practice, this study aims to provide specific implications for professional practice, as well as research, training and policy implications.

1.6.3 Implications of this Study

This study aims to generate greater awareness of some of the socio-political contextual factors, power relations and processes underlying clinical psychology practices. This would empower clinical psychologists and service users with more awareness and information with which to make informed choices about

the practices they engage with. Research has highlighted the professional obligation to engage with reflexivity and critical thought in order to avoid replicating harmful aspects of dominant discourses (e.g. Sugarman, 2015; Davies, 2008; Schwarz, 2018). Similarly, Walsh and colleagues (2014, p. 402) have cautioned that "If psychologists' faith in scientific expertise is not tempered by critical and ethical reflection, professional applications of psychology might contribute to exploitation and oppression rather than emancipation".

The findings of this research may also have implications for how clinical psychologists position themselves in relation to wider social, economic and political factors. There have been consistent and growing calls for professionals working within the mental health field to attend to and challenge the 'upstream' social and political determinants of individuals' mental health problems 'downstream' (e.g. Burns, 2015; Roberts, 2021; Smail,1993; 1996). These research findings could empower clinical psychologists with information regarding how these 'upstream' factors influence specific practices that are within their influence and control. This has implications not only for individual clinical psychologists, and services, but for the profession of clinical psychology. As noted by Burr (2015), knowledge and social action go together. The implications of the knowledge gleaned from the findings of this research could contribute to critical 'upstream' activities by representatives of clinical psychology (e.g. BPS, DCP) who have greater power to advocate and lobby for political change.

1.6.4 Research Question

The current study aims to address the following questions:

- What is the impact of neoliberalism on clinical psychology practice?
- How have neoliberal processes of governmentality and subjectification impacted on specific clinical psychology practices?
- What are some of the other relevant contextual factors that have influenced the development of clinical psychology practices?

1.7 Summary of Introduction Chapter

This chapter has provided an overview of the academic literature relating to the impact of neoliberalism, particularly neoliberal governmentality and subjectification, on clinical psychology practices. This has demonstrated the need for the profession to develop greater awareness of the specific mechanisms by which neoliberalism impacts its practices. The next chapter will outline the methodology that will be used in this study to analyse key historical documents and develop a critical interpretation of the mechanisms and processes underlying the impact of neoliberalism on specific clinical psychology practices.

2. METHODOLOGY

2.1 Methodology Chapter Overview

This chapter will outline how the methodological approach and analytical tools derived from a Foucauldian Genealogical Analysis (FGA) can be used to analyse the impact of neoliberalism on clinical psychology practice. This chapter will begin by explaining the epistemological underpinnings of the current research. A think tank that was conducted with clinical psychologists and 'Experts by Experience' to shape the focus of the analysis will then be described. Subsequently, this chapter will explain FGA as a methodological approach, as well as the analytical tools derived from this approach that were used in the current study. The data collection strategy and documents used as the basis of the analysis will then be outlined, followed by a discussion of the ethical considerations and reflexivity which informed the study's analysis.

2.2 Epistemology

As stated previously (section 1.2) this study is written from a social constructionist epistemological perspective. This perspective asserts that human activity is determined by culturally-specific knowledge, beliefs, values and assumptions (Weinberg, 2014). Knowledge and action in the world is therefore understood to be relative to its social and historical context. This

stands in contrast to a positivist epistemology, the dominant epistemology of mainstream psychology, which asserts that knowledge reflects absolute truths about the world (Burr, 2015; Arribas-Ayllon & Walkerdine, 2008). A social constructionist perspective asserts that in order to understand social phenomena (such as clinical psychology practices) we need to critically examine the context from which they emerged. This study also uses ideas derived from poststructuralism and Foucault, which directs the study's methodology towards an analysis of historical power relations. Arribas-Ayllon and Walkerdine (2008, p. 111) submit that Foucault's methods of genealogical investigation can be used to explore how psychology's emergence and development has been connected to "specific sites and problems concerned with the administration of social life". As discussed earlier (section 1.3) neoliberalism emerged and became a dominant discourse and form of governmentality in a specific historical context, which has coincided with the development of clinical psychology practices. A genealogical approach nested in a social constructionist epistemology is therefore well suited to critically examine the influence of socio-cultural historical contexts, such as neoliberalism, on the development of clinical psychology practice. This study emphasises social constructionism rather than poststructuralism because it represents a more established epistemological framework within the discipline of clinical psychology (e.g. Burr, 2015).

Hook (2005) argues that a Foucauldian genealogical approach is an epistemology of critique. This perspective identifies knowledge-production as primarily a critical and political act, including the 'making of critique'. A genealogical approach does not intend to replace one truth with another, but does intend to critique taken-for-granted knowledge in order to produce an awareness of the complexity and contingency of social phenomena (Smart, 1983) and so disturb apparently secure 'regimes' of truth (Foucault, 1980). This 'counter-ontology' therefore functions to enable different views for how the world could have been or could be (Hook, 2005). Social constructionism has been critiqued for denying the reality of anything outside of discourse (e.g. Bradley, 1998; Pilgrim & Bentall, 1999; Nightingale & Cromby, 1999). However, social constructionism does not contain a unitary ontological view and most social constructionists do not negate the external reality of phenomena

(Edwards, 1997). Instead, social constructionism aims to deconstruct the processes by which external phenomena are experienced and brought into being through social relationships (Edley, 2001). As Rose (1999a, p. xv) submits: “This approach does not seek to deny as such the ‘objectivity’ of knowledge, but to describe the ways in which objectivity is produced, and the consequences of the production of objectivity”.

2.3 Think Tank

A think tank was conducted to incorporate the perspectives of people who had provided and used clinical psychology services and ground the study in the subjectivity of those it impacts and intends to serve. The aim of the think tank was to elicit participants’ views about the focus of the study and what data should be collected, over what time period, to be most relevant and meaningful.

Six participants were sought: three clinical psychologists and three ‘Experts by Experience’ (a term used to foreground the expertise of people with experience of mental health services), through a method of convenience sampling. Clinical psychologists were recruited using contacts of the researcher, through previous clinical experiences and placements. Experts by Experience were recruited from the Experts by Experience panel of the Group of Trainers in Clinical Psychology, a group which was co-facilitated by the researcher’s supervisor. Participants who had experience of clinical psychology practices over a time period of 40-plus years were sought, as they could give greater insight into changes within psychological practices since the introduction and development of neoliberalism in England.

Five participants attended the think tank online (three clinical psychologists and two experts by experience). The think tank was organised using a ‘fishbowl’ method (Kane, 1995). This allowed the clinical psychologists and experts by experience to hear each other’s thoughts and reflect before coming together to discuss as a larger group. After an explanation of the research and the fishbowl method, participants were given simple prompts for discussion:

- What is the impact of neoliberalism on clinical psychology practice in the NHS?

- Who is affected by this? How?
- What are the areas and issues that feel most relevant and important for research in this area to focus on?
- What texts or other sources do you think it would be good to analyse?

The main themes elicited:

- Neoliberalism as an 'invisible ideology'.
- Neoliberalism about protecting the wealth of the rich.
- [Despite neoliberal discourse suggesting otherwise] the government is always intervening.
- Neoliberalism values productivity (IAPT given as an example).
- Neoliberalism about 'getting rid of' unproductive members of society.
- Neoliberalism and social context are not discussed in psychological services.
- Social problems are turned into individual pathology e.g. "need to broaden out and anchor problems in social terms".
- Neoliberalism focus on comparison and evidence constrains creativity and innovation.
- Neoliberal focus on individuals means a lack of emphasis/energy on social action.
- Clinical psychology practices as a professionalisation, commodification and even exploitation of help.
- Suggested focus on books and BPS and DCP documents from the last 20-40 years of clinical psychology practice, especially since the election of Margaret Thatcher.

One other theme discussed was the complicity of the clinical psychology profession. One of the clinical psychologists asked whether clinical psychologists were a 'victim' of neoliberal ideology or a willing and proactive participant, and discussed the competitive, ambitious and successful nature of the profession. The discussion that followed influenced the direction of the current study. Whereas initially, the focus had been on the influence of neoliberalism on clinical psychology practices, more space has been given to the bi-directional nature of the relationship.

2.4 Methodological Approach: Foucauldian Genealogical Analysis

Foucault's genealogical analysis provides a framework for understanding how we come to know who to be and how to act, by examining how prevailing social discourses in society have been constructed over time and how they influence social structures. Foucault's genealogy begins with a critical examination of the discourses that dominate an area or discipline in society. This process deconstructs and 'problematises' the dominant knowledge and implications of the discourse, by exposing its origins, influences and consequences (Rose, 1996b). A genealogical analysis looks at the connection between knowledge and power by examining the social conditions and political motivations that might have led to the emergence and dominance of certain discourses and the subjugation of others (Foucault, 1977, 1978). Discourses exercise power by constructing subjectivities for people that make them governable through conformity to the social norms imposed by the discourse (Arribas-Ayllon & Walkerdine, 2008). A genealogical investigation therefore proposes "an analysis which can account for the constitution of the subject within a historical framework" (Foucault, 1980, p. 117). A FGA investigates how power relations have served political motivations by looking at what discourses and technologies are being used by bodies who hold disciplinary power to shape subjectivities, such as politicians, professionals and public institutions (e.g. clinical psychology).

Foucault (1980, p. 83) defined genealogy as "the union of erudite knowledge and local memories which allows us to establish a historical knowledge of struggles and to make use of this knowledge tactically today". Historical documents are used selectively in order to develop an interpretation of why and how certain discourses have become dominant ('erudite knowledge'), and what alternative possibilities have consequently been marginalised (Kearins & Hooper, 2002). This analysis can be used 'tactically' in the present, to develop awareness of the political motives and strategies underlying dominant discourses and challenge the power they hold over people and social institutions. The interpretation produced by a genealogical analysis is not intended to provide a better discourse or 'more true truth' (Hook, 2007).

Interpretations are used to produce a critique capable of destabilising the dominant discourse, opening up possibilities for alternative behaviours and ways of being for people. The intention is therefore more political than epistemic (Hook, 2005).

Arribas-Ayllon and Walkerdine (2008) argue that Foucauldian genealogical investigations can be used in psychological research to expose "the historical conditions through which psychological knowledge has played a part in shaping the conduct of individuals in Western societies" (p. 110-111). For the current research, a FGA will be used to critically examine the power relations underlying clinical psychology practices during the period of neoliberal governance. A critical analysis of historical documents will be used to reveal the power relations underlying dominant discourses and practices, and to search for alternative, marginalised knowledges. The outcome of this analysis could be used to challenge the hegemony of dominant clinical psychology knowledge and develop an awareness of the political motivations and power processes underlying contemporary practices.

2.5 Analytical Tools: Perspectival Dimensions

Foucault was careful to avoid specifying a prescribed method for a genealogical analysis (Rose, 1999a; Tamboukou, 1999; Arribas-Ayllon & Walkerdine, 2008). Nonetheless, some broad suggestions have been described by Kearins and Hooper (2002). They draw on Dreyfus and Rabinow's (1982, p. 119) advice to begin with a "diagnosis of the current situation". This diagnosis should take into account the power relations and discursive practices that "can account for the constitution of the subject within a historical framework" (Foucault, 1980, p. 117). Thereafter, data in the form of historical texts are sought, in order to ground the genealogy "in documents, not on abstract formal codes or unwarranted interpretations" (Lemert & Gillian, 1982, p. 135). The analysis should then proceed with a pragmatic historical interpretation of what has happened within the social body to account for the present situation. In order to aid this process, some suggestions for the analysis have been provided in the literature.

Tamboukou (1999, p. 215) proposes that the genealogical researcher should create a "methodological rhythm of their own and pose questions which invite us to interrogate what we know". Questions underlie the FGA approach and guide the analysis of documents. However, there are no pre-determined questions. Foucault intended his work to be used as a "kind of tool box which others can rummage through to find a tool which they can use however they wish in their own area… I don't write for an audience, I write for users, not readers" (Foucault, 1994, p. 523-524). Foucault's tools and analytical concepts suggest the areas to be investigated and questions to be asked of historical documents in order to develop an analysis and interpretation of the social phenomenon being researched. For example, Foucault (1982) established a range of areas which could be investigated within a genealogical study: systems of differentiations (how individuals are differentiated); objectives pursued; the means of bringing power relations into being (by force, coercion, surveillance etc.); forms of institutionalisation of power; and the rationalisations for the exercise of power.

Based on Foucault's tools and theories, Rose (1999a) developed six 'perspectival dimensions' to be used as tools for selecting historical documents and constructing questions for the analysis of documents, in order to arrive at a critical interpretation of the 'history of the present'. These perspectival dimensions are listed below, alongside questions derived from each dimension that were used to guide the analysis of documents in the current study:

2.5.1 Problematizations:

Akin to Foucault's 'differentiations': The phenomena that are constituted as problems within society and the criteria by which things or people are rendered problematic.

Research questions:

- What problems do psychological practices intend to solve?
- What criteria determine whether someone receives psychological practices?

2.5.2 Explanations:

Akin to Foucault's 'rationalisations': The justifications of practices and the discourse employed to justify practices. This includes what criteria is used for what is deemed acceptable or not, and what is included as evidence for or against explanations.

Research questions:

- What justifications are given for the use of psychological practices?
- By what criteria are psychological practices deemed necessary?

2.5.3 Technologies

Akin to Foucault's 'means of bringing power relations into being' (and 'technologies of power'): The techniques used to assess, reform and cure, and the apparatuses within which intervention is to take place.

Research questions:

- What technologies are used in psychological practices to assess, reform and cure problems?
- What are the intended outcomes of psychological practices?
- How do psychological practices intend to achieve their outcomes?

2.5.4 Authorities

Akin to Foucault's forms of 'institutionalisation of power': The people/groups of people and knowledge that lays claim to authority, and the procedures by which authority is maintained.

Research questions:

- What is included as authoritative knowledge within psychological discourse and practices?
- How do clinical psychologists protect and further the authority of their discourse and practices?

2.5.5 Subjectivities

Akin to Foucault's 'technologies of the self': What ways of being are promoted for people as desirable, and what must people do to reform or improve themselves.

Research questions:

- How are people constructed by psychological discourse and practices?
- What ways of being do psychological practices make available to people?
- What personal qualities and characteristics are emphasised as desirable or undesirable by psychological discourse and practices?

2.5.6 Strategies

Akin to Foucault's 'objectives pursued' and 'governmentality': the ideological and strategic aspirations underlying the practices and roles of those in positions of power.

Research questions:

- What social and political strategies do clinical psychology practices serve?
- What professional strategies do clinical psychology practices serve?

Each document was analysed with these questions by coding documents using different codes for each perspectival dimension. A table of relevant material from each of the documents was made, along with codes for each of the perspectival dimensions and a short written note of the answer to the research question alongside each code (e.g. "people constructed as consumers" for a subjectivity code; "professional strategy of expansion" for a strategy code). Notes were also made of where the codes relate to neoliberal governmentally and subjectification, as well as other contextual factors. This table of codes and notes helped to identify the common themes across documents and develop the analytical interpretation (see Appendix C for an extract from the table).

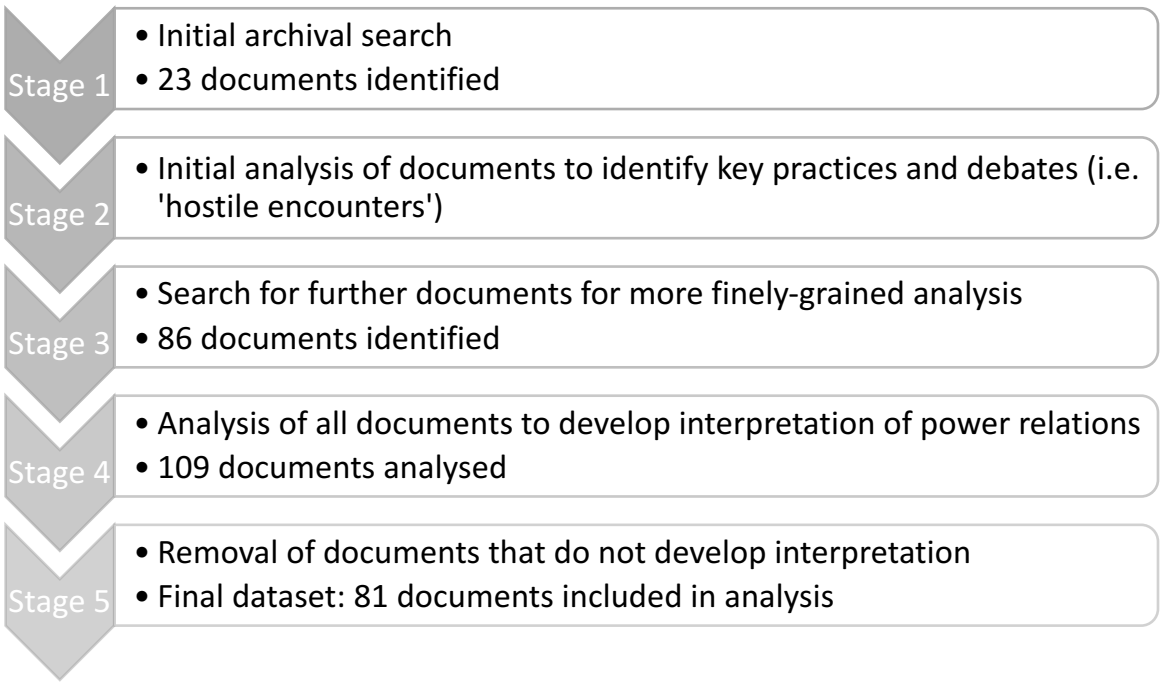
2.6 Data Selection

Kearins and Hooper (2002) suggest using research questions to conduct an initial search and analysis of archival documents, in order to see if the questions provoke new perspectives on the present situation. They also draw on Foucault's (1980, p. 83) injunction that documents should identify "hostile

encounters” between “specialised areas of erudition” and areas that have been “confined to the margins of knowledge”. During this initial stage of data collection, I used the research questions to search for documents that would give an indication of the main practices used by clinical psychologists between 1979 and the present date (2022). From an initial analysis of these 23 documents, some of the main practices and debates or ‘hostile encounters’ were identified. Once these areas have been identified, Kearins and Hooper propose selecting further documents based on their potential to lead to a more finely-grained analysis of particular situations and power relations. At this second stage of data collection, further documents were sought on the basis that they could provide more depth and clarity on the power relations and processes underlying the development of the practices identified in the initial stage. From this stage, a further 86 documents were identified. A more in-depth analysis using the approach and questions derived from a FGA (outlined above) on all 109 documents was then used as the basis for the critical interpretation of the impact of neoliberalism on clinical psychology practices. Kearins and Hooper (2002) suggest setting aside incidents that neither confirm nor disconfirm the emerging interpretation. Once these documents were set aside, the final dataset of documents included in the analysis consisted of 81 documents (see Appendix D). This process is reflected in Figure 1, below, and then expanded upon.

Figure 1

Flow chart representing the process of selecting and collecting historical documents for analysis



2.6.1 Initial Data Selection

The initial search focused on documents by bodies with disciplinary power who have the authority to define clinical psychology practices and influence the formation of subjectivities. Due to the focus on governmentality and subjectification, documents were searched for and selected from the archives of the BPS and DCP, Government policies (e.g. Department of Health) and the NHS. The inclusion criteria was whether the document focused on the core professional practices of clinical psychologists in England, since 1979. Specifying this time frame and geographical area was done to allow for greater depth in a more specific context. Genealogy requires “a knowledge of details and it depends on a vast accumulation of source materials” (Foucault, 1977, p. 140). Within the time constraints of a doctoral thesis, specifying a more concise timeframe and a geographical area aims to meet these criteria. 1979 was selected because it is the year Thatcher came to power and introduced her policies and was suggested by the think tank participants. However, many of the ideas associated with neoliberalism, such as individualism, monetarism and free trade long pre-dated this date and were present in English culture already. The focus on England was selected because it is a more precise area, and one

which I have a greater knowledge of details as I have lived and practiced clinical psychology here. Studying clinical psychology practices in the UK was considered, but would have necessitated the inclusion of a greater range and number of source materials and therefore less knowledge of details due to the different policy bodies and practices used by devolved nations.

23 documents were identified which met these criteria. From the initial analysis of these documents, eight core clinical psychology practices were identified: assessment; formulation; intervention; evaluation; consultation and leadership; reflective practice; social awareness; and service user involvement. The former four practices comprise the core practices used by clinical psychologists in direct work with clients, and can be seen in documents since 1979, although the nature of these practices have changed. The latter four practices have developed more in recent times. These were selected because they showed evidence of change since 1979, and appeared to reflect debates or 'hostile encounters' between dominant and marginalised discourses, practices and subjectivities. For example, a tension between humanistic and scientific/mechanistic subjectivities can be observed in different formulation and intervention practices from the documents. Practices included under 'social awareness' represent a debate between individualistic practices (e.g. 'cultural competency') and practices that target social context (e.g. 'social action'). An awareness of some of the significant contextual factors in the development of clinical psychology practices (discussed in section 1.5) was also helpful in identifying these practices. Furthermore, my experience of clinical psychology practice from training also informed the selection of what the key practices are.

2.6.2 Selection of Further Documents

Based on the findings of the initial search, further documents were sought to develop a more finely-grained analysis of the practices identified in the initial stage of data collection. Documents were searched for on the basis that they might be able to shed light on the practices and debates or 'hostile encounters' that were evident in the initial documents. The BPS and DCP archives were searched again for documents relating to leadership. Measures of service evaluation were searched for from NHS England service commissioning targets. Intervention guidance and protocols were searched for from University College

London's Centre for Outcomes and Research Effectiveness [CORE] competency frameworks and NICE guidance. Service user websites were searched for documents relating to service user involvement and service user experiences with interventions. Books referenced in the BPS Diploma in Clinical Psychology Reading Lists were also included. From this stage of data collection, a further 86 documents were identified, creating a total dataset of 109 documents.

Kearins and Hooper (2002) advise analysing documents guided by the emergent set of research questions and setting aside documents that do not help to develop the emerging analytic interpretation. 28 documents were set aside, leaving a final dataset of 81 documents. The final stage is to organise the information from the analysis into a radical critique (Kearins & Hooper, 2002).

2.7 Ethics

This research did not require formal ethical approval as the research dataset consisted of documents that are in the public domain. The think tank participants helped to shape the research aims and focus, but did not provide data for the analysis and so were not classified as research participants. However, the think tank participants were given an information sheet prior to the think tank (see Appendix E) and compensated for their time with £15 online shopping vouchers, in keeping with general ethical principles.

Additional ethical considerations include the risk that critical research has in being used to denigrate a profession, which could lead to reduced funding in a climate of financial precarity. This research does not intend to degrade clinical psychology as a profession, but does intend to provoke important questions about the historical construction and implications of its professional practices. Indeed, it is proposed that this could generate a greater awareness of the origins, influences and consequences of clinical psychology practices. This could lead professionals to practice more ethically by making more informed choices about the practices they use.

Studies that use documents as data for analysis necessarily requires a subjective interpretation (Suzuki et al., 2007), which places the researcher in a position of power to make decisions about the content and procedure they choose for the analysis (Willig, 2017). It is therefore important to be reflexive and transparent about the researcher's own prejudices and motivation for conducting the research.

2.8 Reflexivity

From a Foucauldian perspective, research itself is a form of knowledge production and represents a political act existing within a particular discourse and framework. This perspective emphasises the need to examine the social context of the research process and the researcher's reflexivity i.e. the researcher's "own intrinsic involvement in the research process" (Burr, 2015, p. 172). In the absence of assumptions of objectivity and neutrality, all research claims and practices are argued to be subjective, context-dependent and political, attempting to "validate some representations of the world and to invalidate others" (Burr, 2015, p. 173). Reflexivity is therefore seen as a critical research task, as it intends to demonstrate how the research has been shaped by social and political factors acting on the researcher (Burr, 2015).

My interest in this research area and approach towards the research has been informed by my social context and personal experiences learning about and using clinical psychology practices. Growing up in England, the discipline of clinical psychology appeared to be the dominant model for understanding distress and healing, and provided a vocation which matched my interest in these areas. As a young, white, British, agnostic man growing up in a socially and economically privileged area in England, the beliefs and discourses I have been exposed to largely corresponded with the dominant social and political discourses used in mainstream clinical psychology (e.g. science, rationality, realism, positivism, individualism, liberty). The privileges afforded by my social context may have contributed to an initially uncritical acceptance of these dominant ideologies and discourses. However, I became increasingly uncertain about some of the underlying assumptions of mainstream clinical psychology practices when I was exposed to alternative and conflicting ideologies and

discourses (e.g. Buddhism, Hinduism, Taoism, non-dualism, critical psychology). I began to question the impact of dominant discourses and ideologies from my social context on the wellbeing of myself and others. In addition, my pre-training experiences of using practices drawn from clinical psychology led me to feel uncomfortable about practices that appeared to promote relatively restricted ways of thinking, feeling, behaving or being. Neoliberalism is a dominant social ideology and discourse that has attracted much criticism (see section 1.3), for reasons that have resonated with me on a personal and professional level (e.g. feeling an unwanted pressure to work to improve myself). This motivated my interest in studying the impact of neoliberalism and exploring alternatives to the ways of being and behaving promoted by neoliberalism.

My prejudices against neoliberalism could have a negative impact on this study's credibility and contribution. For example, I could over-emphasise the role of neoliberalism in the development of clinical psychology practices and under-emphasise other contextual factors. I have used supervision and the literature review of clinical psychology practices (section 1.5) in order to attempt to minimise this risk. I have also attempted to remain aware of the impact of my social context and upbringing, for example on my ability to think outside of dominant discourses. I have attempted to reduce the impact of this by including perspectives of people who have used clinical psychology services from different demographic backgrounds, for example in the think tank and by documents from service user groups. These steps were also intended to minimise the likelihood of interpreting the past in the context of the present. I was especially aware of this potential tendency as I was born in 1992 and have not had direct experience of some of the time period in this study.

This research has been produced within the context of a three-year doctorate in clinical psychology at the University of East London (UEL) and written within the requirements and criteria of examined academic work. The dominant discourse used by the governing bodies of clinical psychology (e.g. the BPS who gives accreditation to the University doctorate) privileges a positivist scientific framework, which is evident, for example, in the recommended structure for theses (Introduction, Method, Analysis, Discussion). However, the dominant

approach of UEL training programme actively promotes a critical stance to the 'psy' professions (Harper et al., 2007) drawing on social constructionist and critical realist discourses. These discourses have provided me with some alternatives to positivist perspectives and methods. The emphasis on critique has also engendered a sense of confusion and uncertainty about the practices and methods I am being trained to apply. This study therefore contains a personal and professional vested interest in understanding the impact of neoliberalism on clinical psychology. I have used supervision, Personal and Professional Development (PPD) groups and a research journal to try to remain aware of the potential impact of these factors on the research. For example, I discussed in PPD groups the emphasis on critique from UEL teaching and the tendency towards critique in the face of uncertainty. I have attempted to counteract an over-emphasis on critique in this study by noting objections to critical perspectives in my research journal and acknowledging the usefulness and benefits of clinical psychology practices from personal experiences and academic research.

2.9 Summary of Methodology Chapter

This chapter has outlined the epistemological and methodological approach that were used for this study. The approach and tools derived from a FGA were used to analyse documents relating to eight core clinical psychology practices. The research questions drawn from the perspectival dimensions enabled an investigation of power relations and processes underlying these practices, with a focus on how these practices relate to neoliberal governmentally and subjectification, and other contextual factors. The methodology and analysis were also informed by a think tank, ethical considerations and reflexivity, which have been described in this chapter. The next chapter will detail the results of this analysis.

3. ANALYSIS

3.1 Analysis Chapter Overview

Following a brief summary of the literature on the current impact of neoliberalism on clinical psychology practice (section 1.4), a "diagnosis of the current situation" (Dreyfus & Rabinow, 1982, p. 119) will be presented, drawing on the main themes of the FGA across the different practices. A more finely grained analysis of each of the eight specific clinical psychology practices and the power relations underlying their development will then be provided. Each practice will be presented with a description of how it has changed over time, the technologies of power it draws on (i.e. methods for directing human behaviour towards certain objectives) and an interpretation of the strategies that these appear to be connected to. In particular, the analysis will examine how these practices appear to relate to neoliberal strategies of governmentality (i.e. control of people's behaviour from a distance using market principles) and subjectification (i.e. the construction of self-governing citizens who work on themselves to be autonomous, self-reliant, productive etc.). The analysis will also examine how these practices serve professional strategies, such as increasing the profession's 'jurisdictional legitimacy' (i.e. the right to claim professional authority over areas of human problems). A FGA draws on historical knowledge in order to contextualise the interpretation emerging from the documents. Some historical and theoretical references will therefore be provided throughout the analysis to support the critical interpretation.

3.2 Diagnosis of the Current Situation

The scoping review has suggested that in a neoliberal socio-political context, mainstream clinical psychology practices have developed into a 'factory model', providing practices that function to change individuals in line with social and political norms. The documents analysed here show that this situation has developed over time, using particular technologies in response to professional and socio-political problems, and in service of professional and neoliberal strategies. However, the documents also show evidence of alternative and marginalised practices.

The analysis of the documents suggests that despite the 'eclecticism' of the 1970's (Richards, 1983), scientific and technical practices that can demonstrate

their effectiveness using outcomes have been favoured in the neoliberal era. These practices align with clinical psychology's scientific-practitioner discourse and have also been able to demonstrate utility to their employers (NHS managers and the state). The context of increased marketisation and competition engenders professional compliance with governmental strategies using technologies of power of increased insecurity (i.e. 'precarity', Lorey, 2015) and scrutiny (i.e. 'examination', Foucault, 1978). Clinical psychology has therefore privileged standardised practices which can efficiently produce outcomes in line with targets and standards set by governing bodies, such as increased autonomy and productivity.

These practices have employed technologies of power to define healthy and normal ways of being and behaviour (i.e. 'normalisation', Foucault, 1979) and scrutinise people using these definitions (i.e. 'examination'), converting human experience into psychological terms (i.e. 'ideological manipulation', Lemke, 2012). This 'psychologisation' (Rose, 1999a) of human experience emphasises individuals' responsibility for changing their identities and behaviour, using additional technologies of power of 'individualisation' and 'responsibilisation' (Foucault, 1978). An individualistic psychologisation divides human experience into individual traits or behaviours that can be changed (Hayward, 2021). Individuals learn to change their ways of being and behaviour using technologies of the self drawn from psychological discourse and practices (e.g. self-examination, self-help and self-improvement techniques). Neoliberal subjectification is effected by the promotion of self-governing citizens who aim to change their behaviour and ways of being to become more autonomous and productive. This enables the 'government at a distance' characteristic of neoliberal governmentality.

There is also evidence of the development of practices that offer resistance to neoliberal strategies throughout this time, but especially in more recent years (the later 2000's). In particular, reflective practice, social awareness practices and service user involvement all have the potential to offer critical perspectives and construct alternative ways of being for people. It may be that the increased number and status of clinical psychologists has increased the profession's confidence to challenge the dominance of neoliberal ideology more

vociferously. Nonetheless, there is also evidence that the subversive elements of these practices often become diluted and the practices are transformed into commodities in service of neoliberal strategies.

3.3 Assessment

Clinical psychology assessments are a 'core competency' of clinical psychologists (BPS, 2006a). The profession asserts that assessments comprise a range of practices and procedures for "assessing individual change and stability and comparing the individual with others" (DCP, 2010a, pp. 4-5). The assessment and comparison of individuals with others can be seen to utilise technologies of power of normalisation and examination. From this perspective, certain areas of human life are made problematic and undesirable by comparison to a defined norm. Assessment practices have expanded in terms of their scope, procedures and populations. This expansion may be connected to their success in serving neoliberal strategies of governmentality and subjectification. However, professional strategies and other contextual factors have also impacted on this growth. Moreover, there is evidence of more cautious and critical perspectives towards assessments within the profession.

Since the introduction of neoliberalism, the scope of normalisation and examination across populations and areas of human life has increased. In the early 1980's, professional texts emphasised the assessment of 'abnormalities' of personality, cognition, intellectual functioning, motivation and emotion in populations of adult and child psychiatry and 'mental subnormality' (BPS, 1979/80). This soon expanded to include problems associated with age and ageing, life events, socialisation and education, friendship formation, intimacy, loneliness, courtship, marriage, pregnancy, childbirth, parenting, work and leisure, unemployment and retirement, death and dying (BPS, 1983a). By the end of the 1980's, the target population for assessments changed from those with 'psychiatric disorders' to 'psychological disorders' (BPS, 1987/88) and then to include the 'worried well' (MAS, 1989). In the 2000's, assessments broadened their scope further to include "tests of intelligence and ability, mood, personality, neuropsychological function" (DCP, 2001, p. 3). They also expanded to include "assessment strategies for individual clients, teams and

organisations" (DCP, 2010a, p. 5) and the "assessment of social context" (BPS, 2010, p. 18). At the same time, individual assessments started to privilege a 'needs-based' discourse (e.g. BPS, 2012), which emphasised assessments of people's (potentially limitless) needs over the identification of 'disorders'.

The expansion of human experience that can be normalised and examined using psychological assessments potentially leads to an increased "psychologisation of the mundane" (Rose, 1999a, p. 248). Rose argued that this causes individuals to perceive their ordinary human experiences as potentially problematic and in need of examination and reform, enabling a "government at a distance" (p. xxii) by extending control over a wider range of human activity. The growth of potential areas that require clinical psychology assessments could therefore be seen to advance neoliberal governmentality. However, this growth can also be seen to serve professional strategies by furthering the profession's jurisdictional legitimacy, especially in relation to their psychiatric colleagues. The profession also advises that psychological tests should only be used in the best interest of the 'patient' and with an acknowledgement of their limitations (DCP, 1983), evidencing a more cautious and critical perspective. The profession's move to community care settings (see section 1.5.2) may also have made assessments accessible to a wider range of people and experiences, although this change was advanced by governmental bodies and may also be connected to neoliberal governmentality.

The increase in populations and their behaviour and ways of being that are potentially problematic could be connected to neoliberal subjectification, although how 'abnormality' is defined depends on the theoretical approach. For example, Pope (1979, referenced in BPS, 1983b) contrasts the focus of a behavioural assessment on 'objective' attributes such as 'troublesome symptoms' to a psychoanalytically oriented interview's focus on 'subjective' experiences such as fantasies. Nonetheless, in line with a neoliberal subjectivity, both of these approaches define problems in individualistic terms, emphasising the internal divisions of individuals into different areas (e.g. symptoms or fantasies). Hayward (2021, p. 9) asserts that the psychologisation of human experiences under neoliberalism has led to the "fracturing of human identity into individual traits or behaviours that can be remodelled". Miles (1981,

referenced in BPS, 1983b) proposes that the norms which assessments of mental illness are based on reflect what is culturally or socially undesirable. Miles suggests that the threshold at which experiences become problems has been progressively lowered, reflecting the demand in contemporary Western society for 'indefinite progress' and expectations of a problem-free, happy and satisfied life. This may explain why a discourse of changing 'abnormality' has changed to one of 'maximising wellbeing' (e.g. DCP, 2001). The emphasis on indefinite progress and individual problems and vulnerabilities (e.g. DCP, 2001; 2011a) supports the idea that assessments enable a neoliberal subjectification. However, the presence of critical perspectives and the more recent inclusion of assessments of social context (e.g. BPS, 2010) demonstrates alternative perspectives and subjectivities.

The procedures for the assessment of problems have also expanded from predominantly objective procedures such as the use of standardised tests, experimental design and statistical analysis (e.g. BPS, 1979/80) to more subjective procedures such as telephone calls and case notes (BPS, 1993/94). In the early 2000's, the number of procedures expands further to include measurements of behaviour and self-monitoring strategies for individuals in order to assess "individual change and stability and comparing the individual with others" (DCP, 2001, p. 3). Procedures that individuals can use on themselves indicates the promotion of technologies of the self, where individuals are encouraged to examine and reform themselves in line with norms (Lemke, 2012). This process is obscured by the increasing discourse of 'empowerment' (e.g. DCP, 2012; BPS, 2017). However, the discourse of 'clinical judgement' also increased over this time (e.g. DCP, 1983; MAS, 1989; BPS, 2006b; Roth & Pilling, 2007; HPC, 2008; BPS, 2019), which suggests that professionals feel they should retain the ultimate power to define abnormality. Pilgrim and Treacher (1992) argue that clinical psychology's claim to specialist and 'indeterminate' knowledge protects the profession's jurisdictional legitimacy in an era when its knowledge and practices are increasingly standardised and available for others to use at a reduced cost.

In the neoliberal era, clinical psychology assessments have increased in terms of scope, procedures and populations, increasing the extent of normalisation

and examination of human experience. Assessments have increasingly emphasised problems in individualistic terms, suggesting an affinity with neoliberal processes of governmentality and subjectification. Although evidence of more cautious and critical discourse suggests that the dominance of individualistic assessments have been contested, their privileged status by the profession indicates their professional and socio-political utility.

3.4 Formulation

Clinical psychology formulations are a 'core competency' of clinical psychology practice (BPS, 2006a). The profession has recently stated that formulations "provide a framework for describing a client's problem or needs, how it developed and is being maintained" (DCP, 2010a, p. 5). Although the practice of formulation has been used in clinical psychology since the 1950's (Crellin, 1998), Harper and Moss (2003) assert that it has only more recently become a central practice for the profession. The centrality of this practice appears to be connected to various professional and socio-political problems and strategies, including neoliberal strategies of governmentality and subjectification. The focus of formulations has shifted over time from almost exclusively individualistic models to include models that position problems in their socio-political context. However, the tendency towards psychological explanations of experiences that privilege individualistic, autonomous and responsible ways of being still appears to be dominant.

Formulations of problems (e.g. BPS, 1979/80) and therapeutic aims (e.g. BPS, 1982) are mentioned in documents relating to clinical psychology practice. However, formulations are not clearly defined or emphasised as a core practice until later. The 1989 MAS review established the 'unique role' of clinical psychologists as their ability to draw flexibly from a broad knowledge-base for the application of various psychological theories to complex problems. The ability to draw on a broad theoretical knowledge base and deal with complex problems became a "unique selling point" of the profession (DCP, 2007a, p. 10) and formulations were seen as the "lynchpin that holds theory and practice together" (Butler, 1998, p. 2). Formulations therefore served to strengthen the authority and jurisdictional legitimacy of the profession in a competitive

professional context (Crellin, 1998). The (1989) MAS review also highlighted that the unique role of clinical psychologists provides a cost-effective and efficient service through the prevention or management of health problems. The practice of formulations therefore also proliferated in the context of this wider socio-political strategy.

The 1990 Guidelines for the Professional Practice of Clinical Psychology (DCP, 1990a) suggests that clinical psychologists should define problems in such a way that "the client recognises as an adequate description and which the clinical psychologist recognises as one in which he or she can claim useful knowledge or experience" (p. 4). Formulations therefore provide the means for converting problems into psychological explanations, enabling the psychologisation of human experience. The precise explanation depends on the theoretical approach. For example, Beck and colleagues' (1979) 'Cognitive Therapy of Depression' emphasises 'collaborative empiricism' whereby the therapist and 'patient' create hypotheses and test them out in order to modify 'dysfunctional' cognitive processes. This approach privileges a scientific and technological approach (Crellin, 1998) and constructs ways of being for people that emphasise their autonomy in changing and improving problematic parts of themselves. More recently, professional publications have emphasised 'biopsychosocial' formulations, which focus on the personal meaning of experiences for individuals (e.g. DCP, 2000). The emphasis on phenomenology offers a more humanistic subjectivity, which contrasts with a purely 'technological' approach. The co-existence of multiple models under such a 'biopsychosocial' framework addresses the professional problem of maintaining a sense of coherence despite a diverse theoretical basis. This stands in contrast to predecessors of the formulation that emphasised single models, such as behavioural 'functional analysis' (e.g. Owens & Ashcroft, 1982). Furthermore, formulations further the profession's jurisdictional legitimacy by offering an alternative framework to psychiatric diagnoses.

Psychological explanations contained in these models of formulation predominantly describe experiences and problems in individualistic terms. This draws on technologies of power by converting human experiences into psychological explanations (ideological manipulation) which emphasises an

individualistic understanding of experiences (individualisation) as problems (normalisation). An individualistic psychologisation enables a neoliberal subjectification by framing the responsibility to change problematic behaviour or ways of being on individuals (responsibilisation). The emphasis on collaboration and 'facilitating clients' understanding' (e.g. BPS, 2005) teaches individuals to internalise individualistic explanations and subjectivities, and learn technologies of the self to change their behaviour and ways of being.

However, in the later 2000's, there is an increased emphasis on formulations which emphasise social and political factors. The 'Good Practice Guidelines on the use of psychological formulation' (DCP, 2011a) emphasises the need to balance the scientist-practitioner model with a reflective-practitioner model in order to go beyond a 'technical-rational' practical approach and incorporate intuition. The document also notes that formulations tend to focus at the individual level, privileging ideas of independence and autonomy, which neglects the wider causal social and political factors. However, the stated aims of formulations include increasing service users' sense of meaning, hope and agency, which nevertheless privileges the individual level. Johnstone and Dallos' (2014) book on formulation raises similar concerns about the effect of a positivist scientific approach to formulation on mystifying the social reality of people's distress. The 2017 DCP revised document 'Understanding Psychosis and Schizophrenia' also emphasises the bio-psycho-social model, but advocates for formulating people's experiences as understandable reactions to trauma, abuse, deprivation and oppression. This appears to offer alternative, more 'holistic' ways of being which frames individual experiences as inter-connected with their social and political context. The DCP publication of the Power Threat Meaning Framework (PTMF; Johnstone & Boyle, 2018) can be seen as an extension of the trend to formulate problems in their socio-political context, with an emphasis on co-constructing personal meaning. However, an article by Scheherazade (2018) on a critical Service User website, called 'Recovery In The Bin' (RITB) critiques the PTMF for being a 'somewhat contrived psychologisation' where concepts such as 'learned helplessness' and 'apathy' replace psychiatric language of symptoms but with the same individualising and disempowering effect.

The development of formulations in the neoliberal era appear to have largely focused on individualistic psychological explanations, which appear to use technologies of power to enable a neoliberal subjectification. However, key professional strategies have also been served by this practice, and alternative frameworks for formulations focusing on social and political factors have been promoted within the profession, particularly in more recent years. Nonetheless, individualistic frameworks and explanations appear to have maintained their privileged status in formulations.

3.5 Intervention

Clinical psychology interventions[5] are a 'core competency' of clinical psychology practice (BPS, 2006a). Contemporary professional discourse asserts that interventions "involve the use of psychological models to facilitate the solution of a problem or to improve the quality of relationships" (DCP, 2010a, p. 6). Despite the 'eclecticism' of therapeutic approaches in the 1970's (Richards, 1983), individual therapies that aim to promote independence and autonomy have dominated the clinical psychological practice of interventions in the neoliberal era. However, a greater emphasis on interventions that target social action is evident from the later 2000's.

The 1980 document DCP document titled 'The Psychological Therapies' proposes that all therapies aim to foster the capacity for self-help and self-responsibility. This document draws on Meltzoff and Korneich's (1970, p. 6) assertion of the intention of psychological therapies as "assisting individuals to modify such personal characteristics as feelings, values, attitudes and behaviours which are judged by the therapist to be maladaptive or maladjustive". The Psychological Therapies document states that newer behavioural and client-centred approaches have secured clinical psychologists' right to practice therapy within the NHS, indicating how these approaches provide reciprocal benefits for the profession and NHS. The newer approaches include Beck and colleagues' (1979, referenced in BPS, 1983b) Cognitive Therapy of Depression and Turner and colleagues' (1981, referenced in BPS,

[5] This section is based on the analysis of documents relating to psychological therapies, with 'indirect' interventions discussed later (section 3.7)

1983b) handbook of Clinical behaviour therapy. These texts emphasise time-limited techniques for changing maladaptive or dysfunctional aspects of people and increasing their self-determination. Similarly, the 1989 MAS review stresses the need for brief, cost-effective and efficient interventions to promote patient wellbeing and independence by teaching skills of self-management, thereby reducing the need for more costly physical health interventions.

Despite the "commercialisation of the NHS" and "effects of market force ideology on healthcare provision" stated as a 'concern' (DCP, 1994, p. 6), professional documents in the wake of the MAS review assert that interventions are cost-effective and good value for money (e.g. DCP, 1990b). They emphasise that clinical psychology interventions can empower "the person or organisation to be more competent and self-directed" (DCP, 1994, p. 2); enhance "self-efficacy, self-worth and personal dignity" (DCP, 1995a, p. 18); and enable "individual service users to have the necessary skills and abilities to cope with their emotional needs and daily lives in order to maximise psychological and physical well-being… to enhance and maximise independence and autonomy; to have a sense of self-understanding, self-respect and self-worth" (DCP, 2001, p. 2). In line with neoliberal subjectification, the dominant aim of psychological interventions from these documents is to increase individuals' ability to autonomously change parts of themselves using technologies of the self (e.g. 'self-management' skills). The profession also states that psychological interventions aim to help people develop psychologically-informed ways of thinking and to change behaviour (e.g. DCP, 2001), which supports neoliberal governmentality strategies of effecting behaviour change from a distance. This reflects McPherson and Sutton's (1981, referenced in BPS, 1983b) assertion that psychologists work on behalf of the state and so their practices will inevitably act to support the state's strategies.

In the 2000's, the climate of EBP led to the development of these interventions into standardised and manualised 'packages of care', which could prove their effectiveness via 'outcomes' in research trials. Clinical psychologists combined with the CORE programme[6] to develop therapy manuals for CBT (Roth &

[6] CORE is a partnership with the Royal College of Psychiatrists and is funded by the WHO, the World Bank, professional bodies and national governments (University College London, n.d.)

Pilling, 2007); Interpersonal Psychotherapy (Lemma et al., 2008a); Psychoanalytic/Psychodynamic Psychotherapy (Lemma et al., 2008b); Humanistic Psychological Therapies (Roth et al., 2009) and Systemic Therapies (Pilling et al., 2010). These manuals privilege discrete and replicable skills, transforming interventions into commodities, which can then be evaluated using the technology of examination in order to assess their compliance with governmental standards and criteria. The commodification of these interventions enables the neoliberal 'factory model' discussed earlier (section 1.4.3.3), whereby individual subjectivities and behavioural changes can be produced and examined with greater efficiency. Despite the range of manualised interventions mentioned above, CBT exhibits a privileged status. From 2008, training accreditation criteria stipulated that qualified clinical psychologists must be able to implement at least two evidence-based therapies, which "must include cognitive-behaviour therapy" (BPS, 2008, p. 16). CBT may also have achieved its privileged status in a neoliberal age because it supports an individualistic subjectivity, and it promotes technologies of self. For example, NICE guidelines promote the use of individual guided self-help based on the principles of CBT (e.g. NICE, 2009; 2020).

Towards the later 2000's, there is evidence of a growing resistance to the dominance of individualistic interventions aimed at promoting autonomous subjectivities. The BPS (2008) stipulates "understanding social approaches to intervention; for example, those informed by community, critical, and social constructionist perspectives" (p. 12) as a required outcome of training. The 2018 BPS Code of Ethics and Conduct differs from earlier editions by removing the emphasis on self-determination; deleting the suggestion that people can act as "free moral agents" (e.g. BPS, 2006b, p. 13); and adding the importance of recognising issues related to environmental context and power. The profession contends that "rather than primarily targeting our efforts at individuals, the most effective way to reduce rates of 'psychosis' might be to reduce inequality in society" (DCP, 2017, p. 114) and recommends interventions aimed at social structures (e.g. Johnstone & Boyle, 2018). These practices emphasise the inter-connectedness of individuals and their social context, which challenges the individualistic and autonomous subjectivities privileged by neoliberal strategies. This demonstrates a shift in the profession's positioning from supporting the

state's strategies to challenging a neoliberal hegemony and subjectivity. This shift may reflect a confidence from the profession afforded by its increased number and status (Hall et al., 2015). However, the continued dominance of individualistic interventions is evidenced by the prominence of CBT in training and NICE guidelines. Moreover, clinical psychologists may not have the training, knowledge or tools to intervene at the social level (Hawks, 1981).

In the neoliberal era, clinical psychology interventions appear to have developed using technologies of individualisation and responsibilisation and technologies of the self to instruct autonomous and independent ways of being, effecting neoliberal processes of governmentality and subjectification. Clinical psychology practices have also become more standardised and replicable, which furthers the efficiency of these neoliberal processes and enables their examination. However, there is increasing evidence of interventions which emphasise social action and subjectivities that position the individual as inherently inter-connected with their social context.

3.6 Evaluation

Clinical psychology evaluations are a 'core competency' of clinical psychology practice (BPS, 2006a). The profession has defined their purpose as to "evaluate the effectiveness, acceptability and broader impact of interventions (both individual and organisational)" in order to "inform and shape practice" (BPS, 2006a, p. 4). Evaluations support a 'scientist-practitioner' discourse and provide scientific authority for clinical psychology practice. This section will consider how evaluations have been used to demonstrate the effectiveness of therapeutic approaches; clinical psychology services; and ongoing psychological interventions. As well as providing a scientific justification for the profession and its cost to the NHS, evaluations appear to serve neoliberal strategies through the normalisation and examination of productive and autonomous subjectivities.

In relation to demonstrating the effectiveness of therapeutic approaches, clinical psychologists have used evaluations to compare interventions and demonstrate an empirical and objective authority for the use of various treatments. Beck and

colleagues' (1979, referenced in BPS, 1983b) 'Cognitive Therapy of Depression' standardised the intervention, meaning it could be replicated and compared to other treatments using the 'Randomised Controlled Trial' (Rosner, 2018). Cognitive therapy flourished in a socio-political environment governed by the comparison and competition of commodities in a marketplace. Other texts referenced in the 1983 BPS Suggested Readings (BPS, 1983b) also emphasise the importance of providing evidence of their effectiveness (e.g. Smith et al., 1980; Turner et al., 1981). Turner and colleagues' book states that its treatment is described in operational and replicable terms. The DCP (1980, p. 32) specifically promotes the use of novel interventions that are "amenable to the research methodologies in which psychologists have special expertise". The practice of evaluations can be seen to influence the development of clinical psychology interventions to create standardised and replicable 'products' that can be compared with others, in alignment with a market ideology. This also enables their examination by governing bodies.

In 1990, the DCP noted that "The market economy climate of present government policies … emphasis on competitive tendering and profit making may well be incompatible with making decisions based on assessments of need… There will be a challenge for clinical psychologists to devise appropriate research and monitoring tools to demonstrate the effectiveness of more costly procedures" (DCP, 1990c, p. 10). Four years later, the DCP asserted that "systematic inquiry to test and evaluate new ideas" leads to innovation "firmly grounded in evidence" (DCP, 1994, p. 2). Despite some concern within the profession, the precarious and competitive neoliberal climate appears to have had an overriding impact on the development of professional practices. In the context of the growth of EBP in the early 2000's, evaluation became a "critical and integral part of the clinical psychologist's work. All activities and interventions need to be evaluated" (DCP, 2001, p. 4). The 2002 collaboration between BPS and CORE explains the need to measure outcomes in order to provide high-quality care of demonstrated effectiveness in response to the government's reforms to the NHS (e.g. First Class Service, Department of Health, 1998). The 'Marketing Strategy Resources for Clinical Psychologists' (DCP, 2007a) further stresses the need to demonstrate the "value/impact and benefit of interventions at both a micro level (how individuals respond) and a

macro level (benefits to the health economy)" (p. 7). The 2011 Guidelines for Clinical Psychology Services (DCP, 2011b) suggests that quality and effectiveness of services can be ensured through 'capturing outcomes', a practice that the BPS states should be mandatory (BPS, 2012). These documents demonstrate how evaluations have become increasingly important to the profession in response to supporting governmental strategies.

The evaluation of service user outcomes have been used to demonstrate the effectiveness of ongoing psychological interventions and services. Evaluation measures implicitly list experiences that are seen as 'problematic' and in need of examination. Five key evaluation measures identified from the documents were analysed: CGAS (Shaffer et al., 1983); PHQ-9 (Kroenke & Spitzer, 2002); HONOSCA (Gowers et al., 1999); GAD-7 (Spitzer et al., 2006) and CORE-OM (Evans et al., 2000). These measures cover a wide range of predominantly individual experiences which reflects the increasing psychologisation and examination of human experience. This enables a neoliberal subjectification whereby parts of individuals can be separated off, reformed and improved (Hayward, 2021) in the pursuit of 'indefinite progress' (Miles, 1981). The emphasis on producing outcomes is apparent in NICE clinical guidance and NHSE commissioning standards. These outcomes reflect neoliberal values by emphasising autonomy, recovery (e.g. NHSE, 2021), productivity (e.g. NICE, 2009; NICE, 2011a; NHSE, 2013/14a) and employment (e.g. NHSE, 2013/14b). The NHS Five Year Forward View for Mental Health (Mental Health Taskforce, 2016) also specifically emphasises that psychological therapies should focus on supporting people into employment and that "outcomes should be holistic and reward collaborative working across the system (e.g. stable housing, employment)" (p. 68). The call for outcomes based on these criteria is answered by the profession, who emphasise cost-effective, evidence-based (e.g. DCP, 2014b), time-limited (e.g. BPS, 2012) and manualised 'packages of care' that teach skills for 'recovery', "participation in society" (e.g. DCP, 2012, p. 13), independence, and "promote resilience and coping, enabling employment" (DCP, 2014b, p. 7). These outcomes are criticised by critical service user group RITB who critique the neoliberal appropriation of 'recovery' to suit a market ideology and "reject employment as a cure or objective all must aspire to" (RITB, 2014).

During the later 2000's, there is evidence of growing criticism of EBP, and an increasing emphasis on the authority of 'Practice-Based Evidence' (PBE) (e.g. DCP, 2013; BPS, 2019) and values (e.g. BPS, 2018; 2019). This could be seen as resistance to the emphasis of neoliberal governmentality on outcomes that can be defined, examined and compared at a distance. However, outcomes based on the "wellbeing and recovery principles" are still promoted (BPS, 2019, p. 8), This may convey a cautious resistance to neoliberal governmentality while still appeasing its employers. It could also suggest that the profession is drawing on a combination of 'technical' and 'indeterminate' practices in an attempt to emphasise its specialist contribution and protect its professional jurisdiction.

Evaluations appear to have become an increasingly important aspect of clinical psychology practice. Evaluations draw on discourses of science, improvement and progress, which obscure professional and socio-political agendas and norms. Evaluations utilise technologies of examination, normalisation and individualisation to increase an individualistic psychologisation and promote subjectivities of autonomy and productivity. They also provide a means of examining clinical psychology practices from a distance and ensuring that the state's objectives and strategies are being effected in line with a neoliberal governmentality.

3.7 Consultation and Leadership

Early clinical psychology discourse emphasised practices of research and assessments (Eysenck, 1949), involvement in treatment and some training (Hall et al., 2015). In the age of neoliberalism, the number of 'indirect' clinical psychology practices (e.g. teaching, training, supervision, service delivery, consultation and leadership) have grown significantly, particularly consultation and leadership practices. The growth of these practices can be connected with professional problems and strategies and neoliberal strategies of governmentality. In particular, these practices extend the reach of a neoliberal government at a distance through the dissemination of technologies of power

(e.g. individualisation, responsibilisation, normalisation, examination) and technologies of the self (e.g. self-examination, self-reform).

After 1979, the context of managerialism and the 'hostile climate for professionals' created by Thatcher's policies (Pilgrim & Treacher, 1992) presented new problems and opportunities for the profession. McPherson and Sutton (1981, referenced in BPS, 1983b) explain that economic recession and the demand for cost-effectiveness led to the drive for more efficient psychological practices. They advise 'giving psychology away' to families and teams and greater involvement with organisational and social systems. They also recommend psychologists learn negotiation and confrontation skills to influence people in managerial or governmental roles. However, Koch (1986, referenced in BPS, 1990), contends that clinical psychologists should not give away their skills, but disseminate psychological information to help staff cope with challenges. In this context, the BPS note the 'professional problem' of "the clinical psychologist's role and function, including management, within the health and social services" (BPS, 1979/80, p. 7). The 1980 DCP 'The Psychological Therapies' document specifies that psychologists should balance one-to-one therapeutic work with "training or advice-giving" (p. 41) to other professionals. The 1985/86 Regulations for the BPS Diploma in Clinical Psychology states that the development and organisation of clinical services is a 'professional issue'. A year later, the Regulations assert that practices should include "assessments and ways of modifying the behaviour of individuals, groups or institutions" (BPS, 1986-1987). This demonstrates how the profession was grappling with the context of managerialism and the drive to innovate more efficient practices.

The MAS review emphasises 'indirect' clinical psychology 'skills' and the role in organisational and managerial aspects of healthcare for improving efficiency and cost-effectiveness of services. Specifically, the review suggests that "skill-sharing" can efficiently help "other disciplines think in a psychological way", with the aim of "strengthening the functioning of individuals" (p. 90). The framing of indirect practices as 'skills' operationalises and standardises the practices (and the technologies they draw on), making it possible for them to be bought, sold or transferred, like commodities in a marketplace (Harper, 1989). There has

been some resistance to the 'commodification' of clinical psychology practices- in 1988, the Nottingham NHS psychologists asserted that "Clinical psychologists don't have 'unique characteristics' or 'core competencies' (half-baked concepts uncritically taken over from Taylorist 'scientific management')" (Pilgrim & Treacher, 1992, p. 155). However, the skills-based approach was favoured by Thatcher's NHS managers (Pilgrim & Treacher, 1992), which may explain why it was privileged by the profession. Indirect skills can therefore be seen to serve neoliberal strategies through the use of technologies of individualisation, responsibilisation and normalisation- evident in discourse such as 'strengthening the functioning of individuals'. The emphasis on indirect skills also provided professional opportunities to further their jurisdictional legitimacy in a competitive environment. For example, the DCP cites the MAS recommendations to argue that clinical psychologists have the same right to lead services as their medical counterparts, and that there should be "open competition for leadership/coordination roles" (DCP, 1990b, p. 2).

Following the introduction of the purchaser-provider split in the NHS and Community Care Act (1990), the increase in competition and precarity leads to a more assertive drive by the profession towards marketing indirect clinical psychology skills. The profession emphasises that "transmitting skills and expertise to others" is an "expectation for all psychologists" (DCP, 1995a, p. 42) and that among clinical psychology's many 'products', "the most cost-effective use of the scarce clinical psychology resources lies in 'consultancy' - teaching, training, supervision, research and project work, to increase the level of psychological skills in the service as a whole" (DCP, 1995b, p. 18). In the 2000's 'leadership' becomes a dominant discourse (e.g. DCP, 2004; BPS, 2007; DCP, 2007a; 2007b; BPS, 2008; DCP 2010b; 2021). The profession notes that because of the "increase in providers of services leading to competition" (DCP, 2007a, p. 8), they must show service managers and commissioners "what they are getting for their money" or risk being viewed as "an expensive alternative" (DCP, 2007b, p. 16). The profession emphasises the need for leaders who are "business-minded, politically aware, [and] demonstrate alignment to the organisations strategic objectives" (DCP, 2007b, p. 12) and using consultancy and leadership skills to meet key commissioning targets e.g. "improved outcomes", "value for money" and "reduction in waiting

times” (DCP, 2007a, p. 12). Understanding and applying leadership theories and models became a required learning outcome of clinical psychology training (BPS, 2008) and HPC registration (HPC, 2009). This is linked with a discourse of improving the “quality and efficiency of health services” (DCP, 2010b) and “helping provider and commissioning organisations ensure that clinical governance standards are maintained” (DCP, 2014b, p. 8).

The preceding paragraph shows how professional problems to do with increased competition created by neoliberal policies were addressed by focusing on meeting governmental standards and targets. A neoliberal government at a distance is effected by using targets and ‘outcomes’ which promote subjectivities of autonomy and productivity (see preceding section). The dissemination of “psychological mindedness” to other healthcare providers (BPS, 2019, p. 8) spreads a predominantly individualistic psychologisation to other healthcare professionals, teaching technologies of responsibilisation, normalisation and examination. These can be internalised by individuals who can use technologies of the self (e.g. self-examination, self-reform) to change their subjectivities and behaviour. Consultation and supervision also serve a similar strategy for clinical psychologists, with the explicit aim to “maximise their responsibility for appropriate self-care” (BPS, 2017, p. 13).

3.8 Reflective Practice

Pilgrim and Treacher (1992) contend that clinical psychology eschewed reflexivity in the separation of the ‘scientific’ profession from philosophy. They argue that ‘scientism’ has been a hallmark of the profession since its inception, but that it reached its “most advanced form in the marketing days of the 1980s” (p. 174). However, the profession carries a tension between perspectives and models that emphasise science and humanism (Richards, 1983). The emergence of reflective practice in the 2000’s provides the profession with a practice that can be used to address the problems associated with an over-emphasis on scientific and technical knowledge and practices. Reflective practice also appears to be related to social and political contexts, and could be seen to be in alignment with or in opposition to neoliberal strategies.

In the 1990's, a new discourse is introduced into BPS and DCP publications that asserts the importance of 'personal change and development' for change, development and innovation in clinical psychology (BPS, 1993/94), and 'personal awareness' for relationships with clients (DCP, 1995a). These departures from scientism could be seen as conditions of possibility for the introduction of the 'reflective-practitioner model' as a core identity of clinical psychology a decade later (BPS, 2005; BPS, 2008; HPC, 2009; BPS, 2010). The reflective-practitioner model draws on evaluation skills and self-awareness to promote "self-reflection and critical reflection on practice" (BPS, 2005, p. 38). Professional documents emphasise how reflective practice can be used to develop greater awareness of "socio-cultural and economic contexts" of practices (e.g. BPS, 2007, p. 28; BPS, 2008). Reflective practice can be used within other practices, such as formulation and therapy, to bring awareness of "one's own thoughts, feelings and reactions as a therapist as well as one's own position in terms of professional status, gender, class, ethnicity and so on, and how these impact upon the therapeutic process" (Johnstone & Dallos, 2014, p. 2). A "critically reflective stance to the evidence base" is also recommended to avoid the risk of applying research findings in a "reductionistic and formulaic fashion" (BPS, 2019, p. 31).

The emphasis on social awareness and critical perspectives emerges in a social context which increasingly highlights the impact of social context for psychological wellbeing (e.g. Shields & Price, 2001) and more generally, leading to the 2010 Equality Act. In this context, professional documents emphasise the importance of addressing the gap between scientific theory and clinical practice (BPS, 2007) and moving beyond a "narrow 'technical-rational' application of research to practice" to incorporate critical evaluation and intuition (DCP, 2011a, p. 7). This demonstrates a professional motivation to balance an emphasis on scientific and technical skills with alternative, more humanistic, practices. This may also be related to the context of EBP, which clinical psychologists generally responded to by emphasising their scientific discourse and practices, but which left some fearing that their role and practices were becoming diluted through the standardisation of practices and adherence to guidelines (e.g. Lilienfeld et al., 2013). Moreover, the emphasis on 'indeterminate' professional capacities such as awareness and intuition may

also have served to protect the profession from threats to its professional jurisdiction created by the "fragmentation and routinisation" of its practices (Pilgrim & Treacher, 1992, p. 184).

Reflective practices can also be seen to be connected to neoliberal governmentality by demonstrating how clinical psychologists can disseminate psychological knowledge in indirect work with mental health teams. Documents promote reflective practice as a means for "achieving improved outcomes from teamworking" (BPS, 2007, p. 3) and fostering "psychologically informed thinking" in Multi-Disciplinary Teams (DCP, 2012, p. 24). Reflective practice is endorsed as a way of facilitating "constructive solutions" to team problems "informed by psychological models and formulation" (DCP, 2012, p. 25). This is achieved through various practices, including reflecting on team processes; developing procedural knowledge gained through experience; managing conflicts; seeing situations from alternative perspectives; owning projections (BPS, 2007); and transferring knowledge and skills to new settings (BPS, 2005). This chapter has demonstrated that 'psychologically informed ways of thinking' predominantly promote technologies of power of normalisation, examination, individualisation, ideological manipulation and responsibilisation, and that outcomes promote autonomous and productive subjectivities. Reflective practice that disseminates an individualising and responsibilising psychologisation could thus function to serve neoliberal strategies of governmentality and subjectification.

The development of reflective practice as a core aspect of clinical psychology's identity appears to be linked to professional and neoliberal strategies. However, reflective practice could also be seen to undermine neoliberal technologies of individualisation by drawing attention to the social context of individual psychological problems and clinical psychology practices. This dichotomy exposes a tension within the profession, which is demonstrated by a quote from the 2017 BPS Practice Guidelines regarding the role of reflective practice in overcoming biases: "political realities may lead the psychologist to make compromises; while there is nothing wrong with compromises, their constant use may mean a decline in overall standards" (BPS, 2017, p. 12). Although

some within clinical psychology may aspire to reflect critically on social factors, the dominant individualistic psychology model is reinforced by 'political realities'.

3.9 Social Awareness: Cultural Competency and Social Action

An increase in statements about the importance of social context on peoples' mental health is evident from professional documents from the mid-1990's. A professional discourse of diversity and cultural competency appears to be privileged in professional documents, reflecting the increase of consumerism and technologies of individualisation associated with neoliberalism. However, there is also evidence of an alternative professional discourse that emphasises social action.

The 1995a DCP Professional Practice Guidelines notes the 'relevance' of "race, culture, gender and class differences" (p. 13) to 'psychological health' and to professional relationships with clients and colleagues. The document emphasises the importance of practitioner self-awareness and respect for client's values in order to provide accessible and non-stigmatising services which "enhance self-efficacy, self-worth and personal dignity" (p. 18). In the 2000's, the profession appears to respond to calls from within the service user and survivor movement to ensure that all mental health professionals should receive mandatory training on 'racial and cultural awareness' (e.g. Mental Health Foundation, 2000). Documents emphasise how clinical psychologists should not be affected by prejudice (e.g. HPC, 2003; 2008) and develop the necessary knowledge and values to adapt their practices to work with clients from diverse backgrounds (BPS, 2005; DCP, 2010). There is a clear emphasis on professional autonomy in recognising 'developmental needs' and developing 'skills' (e.g. BPS, 2005; DCP, 2010) or "cultural competencies" (e.g. DCP, 2011b, p. 8). These documents highlight the social and professional problem of the negative impact of social inequalities on the accessibility of services. However, the solutions offered in these documents privilege the development of 'skills' by individual practitioners. This furthers the individualisation of social structures and responsibilisation of individuals for overcoming them. This is aligned with neoliberal governmentality, which extends control over individuals while leaving the social context and conditions unchanged (Younis, 2021).

However, there is also evidence of an alternative, more critical discourse and practices which emphasise collective action targeting social structures. For example, the DCP 'Guidelines for Clinical Psychology Services' (2011b) advises "questioning the use of mainstream traditional psychological practice" (pp. 8-9). The DCP revised[7] document 'Understanding Psychosis and Schizophrenia' suggests that "rather than primarily targeting our efforts at individuals, the most effective way to reduce rates of 'psychosis' might be to reduce inequality in society" (p. 114). The document recommends a range of psychosocial and psychological interventions, including some family and community interventions among predominantly individualistic therapies. The 2017 BPS Practice Guidelines notes that "[Social] exclusion is typically a result of poverty and/or belonging to a social minority group" (p. 36). The document argues that "promoting social inclusion is a broader task than promoting equality and tackling discrimination and stigma. It requires psychology professionals to address wider structural issues in society which maintain excluding processes and power differentials" (p. 36). The document also notes that the recent government Prevent Strategy is a contentious area of practice, and that psychologists should "ensure they focus on their core role, working in a non-stigmatising way" (p. 44). This marks a noteworthy departure from the emphasis on the fulfilment of governmental strategy in earlier years, and constructs alternative subjectivities for people as inter-connected with their environment.

The profession therefore appears to have responded to the problem of social inequalities and the inaccessibility of services through the promotion of both an individualising and responsibilising 'cultural competency' model and a more critical 'social action' model. The co-existence of these models creates a tension of conflicting perspectives and subjectivities. Pilgrim and Patel (2015, p. 58) assert that the profession of clinical psychology contains "liberal adaptive and more critical or oppositional voices" in relation to intolerance and racism, which have combined to produce "the current contested and unresolved 'equality and diversity' legacy". The 'diversity' model may be used appease critical voices from within the profession and its service users, but appears to

[7] The document was revised following criticism that it did not engage sufficiently with the experiences of people from black and minority ethnic communities

support a more individualistic and consumerist perspective (Foster, 2015). For example, the HCPC (2015) 'Standards of Proficiency for Clinical Psychologists' states that registered psychologists must "be aware of the impact of culture, equality and diversity on practice" (p. 8). More recently, the 2019 BPS 'Standards for the Accreditation of Doctoral Programmes in Clinical Psychology' emphasises "Understanding the impact of differences, diversity and social inequalities on people's lives" (p. 19) and states that qualified clinical psychologists must have "the skills, knowledge and values to work effectively with clients from a diverse range of backgrounds" (p. 14). However, neither document mentions the need for skills, knowledge and values that address social context and structural issues.

The importance of recognising and acting on social inequalities has become more evident within clinical psychology, with varying consequences. On one hand, 'cultural competency' is presented as a 'skill' (or commodity) that clinical psychologists must 'have'. Possessing 'cultural competency' can broaden clinical psychologists' client population and potentially further a neoliberal subjectivity through technologies of individualisation and responsibilisation, thus enabling a neoliberal government at a distance. On the other hand, an awareness of social context can be used to critically examine professional and socio-political practices leading to changes in practice (such as social action) and alternative ways of being available for people who receive and provide these practices. Contemporary documents reflect this dichotomy, but tend to privilege a discourse of diversity and 'cultural competence'. This could be seen as evidence of the pervasive impact of neoliberalism on clinical psychology practice, which has the power to transform potentially subversive practices into individualistic commodities.

3.10 Service User Involvement

Clinical psychologists have historically placed themselves alongside service users, particularly when speaking out against psychiatric practices (Harper, 2010). However, even by 2001, Newnes notes that the profession "is not conspicuously interested in advocacy and user involvement" (p. 18). This is reflected in the documents analysed in this study. Despite the NHS and

Community Care Act (1990) emphasising service user involvement and empowerment, there is little mention of service user involvement in clinical psychology practices in the 1990's. Since then, service user involvement has been defined differently across different documents and practices over time, linked to different strategies and subjectivities. However, this analysis suggests that individualistic practices and subjectivities are privileged by professional discourse, in alignment with neoliberal strategies of governmentality and subjectification.

The DCP (1994) Core Purpose and Philosophy of the Profession states that "Clinical psychologists will treat all people - both clients and colleagues - with dignity and respect and will work with them collaboratively as equal partners towards the achievement of mutually agreed goals" (p. 2). However, this is not defined or discussed further in the document, reflecting Carpenter's (1994) concern that there are difficulties in moving beyond mere rhetoric of involvement and empowerment. Barnes (1999) argues that Conservative government policies wanted to increase consumer activity and reduce professional power, constructing limited ways of being as a 'customer' or 'consumer' to be satisfied, in line with a neoliberal subjectification.

It is not until 2005 that the BPS specifies that qualified clinical psychologists must be able to work with "users and carers to facilitate their involvement in service planning and delivery" (p. 26). The 2007 BPS document 'New Ways of Working for Applied Psychologists in Health and Social Care: Working Psychologically in Teams' also suggests that psychologists have skills in involving users and carers, and that this can be used in "achieving improved outcomes" (p. 3). Barnes (1999) asserts that the New Labour government drew on ideas of 'partnership', which privileged more egalitarian and humanistic ways of being. However, this still accords with a neoliberal subjectification as the 'partnership' is directed towards fulfilling outcomes defined by professionals in terms of autonomy and productivity, fostering technologies of the self. Similarly, the 2012 DCP 'Commissioning and Delivering Clinical Psychology in Acute Adult Mental Health Care' states that "clinical psychologists enable service users to actively participate in their treatment and recovery, thus reducing length of stay and improving the patient experience" (p. 5).

These different approaches accord with neoliberal subjectivities that emphasise autonomous ways of being. The promotion of an autonomous subjectivity is also evident in the NICE guidance for 'Service user Experience in Adult Mental Health' (2011b), which states that the aim of working with people using mental health services is to "foster their autonomy, promote active participation in treatment decisions and support self-management" (p. 7). By contrast, Foster (2015) advocates for a more 'democratic' approach to service user involvement that constructs ways of being for service users as experts of their experience. This aligns with the National Survivor User Network (NSUN, 2014, p. 5) assertion that "the views and experiences of people who use services have equal weight to the scientific and research evidence".

The BPS (2017) Practice Guidelines has utilised the term 'experts by experience' to promote a more democratic approach to service user involvement. The guidelines state that "it is best practice for psychologists to work collaboratively with clients and Experts by Experience in developing and delivering all aspects of psychological services" (p. 23). This is reported as necessary to "ensure that the application of psychological research and theory is understood by and adapted appropriately to the client group and context, which may differ from the populations on which the research was based" (p. 23). Despite the change in terminology, this quote emphasises the professional strategy of increasing the psychologisation of human experience, to be 'understood by' or 'adapted to' different client groups. If this psychologisation privileges individualistic, autonomous and responsible ways of being, its dissemination could be seen to further a neoliberal governmentality (at a distance) through technologies of the self.

Service user involvement has understandably come under criticism by service user and survivor groups. RITB (2018) produced a satirical guide for involvement, which recommends: "[be] suitably compliant and ensure that pesky service user tick box is filled" and "put aside any expectation that structural inequalities between service users will be acknowledged or countered". Picking up on the confusingly mixed messages about equality, the guide states that "Remember that when it suits we are all human and all experience distress and

are the same. This is collaboration, we are equals. Until we are not…". NSUN (2021) reported that some service users "talked about being treated like a commodity to be used, rather than a person to be appreciated" (p. 42). In a report titled 'Tickboxes and Tokenism? Service User Involvement Report 2022' service user group 'Shaping Our Lives' shares how some people experienced involvement as "intrusive and were left feeling invaded" (Batty et al., 2022, p. 6) whereas others felt empowered to make meaningful change.

Similarly to practices associated with 'social awareness' in the preceding section, service user involvement appears to have the potential to challenge neoliberal subjectivities and strategies by privileging service user accounts over psychological explanations. However, it appears to more often become commodified as a 'competence' or tick-box, which serves neoliberal strategies of governmentality (at a distance) and subjectification through increased consumerism, and the promotion of autonomous and productive ways of being.

3.11 Summary of Analysis Chapter

The analytical interpretation developed in this section has used tools and questions derived from a FGA in order to critically examine documents relating to the practice of clinical psychology. Eight practices were identified and analysed in terms of the power relations underlying their development, using Foucault's analytical concepts and Rose's (1999a) perspectival dimensions. The development of these practices has been analysed in relation to neoliberal strategies of governmentality (i.e. control of people's behaviour from a distance using market principles) and subjectification (i.e. the construction of self-governing citizens who work on themselves to be autonomous, self-reliant, productive etc.).

This section has explored how clinical psychology predominantly appears to have positioned its practices in alignment with governmental strategies in the age of neoliberalism. This appears to have reciprocal benefits for neoliberal strategies of governmentality and subjectification and also the profession, in a climate of competition and precarity. Scientific and technical clinical psychology practices that promote autonomous subjectivities for people have been

privileged and alternatives have been subjugated, particularly between the 1980's and early 2000's. These practices draw on technologies of power such as normalisation (e.g. assessment), ideological manipulation (e.g. formulation), individualisation (e.g. intervention), examination (e.g. evaluation) and responsibilisation (e.g. service user involvement) and promote individualistic psychological knowledge. These practices have increasingly expanded across people and experiences through the normalisation and examination of more areas of human life. These practices and technologies have been 'packaged' as standardised products (or commodities) which allows for their replicability and dissemination through consultation and leadership practices. This increases an individualistic psychologisation of human experience and the promotion of self-governing citizens through technologies of the self (e.g. self-examination, self-help and self-improvement strategies) aimed at changing behaviour and ways of being. This enables a neoliberal subjectification and governmentality (at a distance).

However, there is also evidence of clinical psychology practices that resist neoliberal strategies of governmentality and subjectification through the promotion of alternative subjectivities and practices that focus on social structures and inequalities, particularly in the later 2000's. The development of critical reflective practice, social awareness practices (e.g. social action) and meaningful service user involvement offers critiques and challenges to the dominant focus on individuals, scientific-technical practices and subjectivities. Nonetheless, it appears that these practices can become transformed into commodities and targeted at individual subjectivity or behaviour change in service of neoliberal strategies, subjugating the more radical and subversive aspects.

The next section will discuss and critically evaluate the analytical interpretation developed here and its implications for practice, policy, research and training.

4. DISCUSSION

4.1 Discussion Chapter Overview

Following a recap of the study aims, this chapter will discuss the extent to which the research questions have been addressed by this study. Subsequently, this chapter will explore the implications of the study for clinical practice, policy, research and training. A critical evaluation of the study's limitations, contribution, rigour, credibility and reflexivity will then be presented, followed by some concluding comments.

4.2 Discussion of Analytical Interpretation in Relation to Study Aims and Research Questions

4.2.1 Summary of Study Aims and Research Questions

This study aims to extend previous critical analyses of the development of clinical psychology practices (e.g. Richards, 1983; Rose, 1985; Pilgrim & Treacher, 1992) in response to appeals from the literature for greater reflexivity and historical analysis in clinical psychology (e.g. Hall et al., 2003; Pilgrim, 2010; Bunn, 2001). Previous literature has highlighted the need to develop an awareness of factors that influence professional practice in order to avoid replicating harmful aspects of dominant discourses (e.g. Schwarz, 2018; Walsh et al., 2014). Following research that has highlighted the pervasive and harmful impacts of neoliberalism on people's wellbeing (see section 1.3.5), this study seeks to extend the awareness of the impact of neoliberalism on clinical psychology practice. The study also aims to produce a nuanced interpretation of the specific mechanisms by which neoliberalism influences professional practice, using concrete examples. This study has focused on the impact of neoliberal governmentality and subjectification in order to develop an interpretation of power relations and processes underlying neoliberalism's impact on clinical psychology practices. This study also intends to provide implications for professional practice, policy, research and training.

To meet these aims, this study intends to address the following research questions:

- What is the impact of neoliberalism on clinical psychology practice?

- How have neoliberal processes of governmentality and subjectification impacted on specific clinical psychology practices?
- What are some of the other relevant contextual factors that have influenced the development of clinical psychology practices?

The following sections will consider how these research questions have been addressed in the current study.

4.2.2 What is the Impact of Neoliberalism on Clinical Psychology Practice?

In response to the initial research question, the analytical interpretation advanced in this study has asserted that neoliberalism has had a significant impact on the development of clinical psychology practices. Clinical psychology practices contained a variety of different perspectives, approaches and discourses in the 1960's (Pilgrim & Patel, 2015) and 1970's (Richards, 1983). However, the documents in the analysis demonstrate that clinical psychology practices have predominantly privileged values associated with a neoliberal ideology since the 1980's.

A neoliberal ideology promotes markets as the best means to allocate resources, as well as individual autonomy and competition (Coburn, 2000). Clinical psychology practices appear to have become more standardised and replicable in the neoliberal era, meaning that they can be evaluated for their outcomes and compared with alternatives, like commodities in a market. This is especially evident from the analysis of interventions, which have increasingly emphasised their efficiency and cost-effectiveness by demonstrating the outcomes of manualised therapies in terms of increasing individual autonomy. Furthermore, the analysis of consultation and leadership practices suggests that clinical psychologists have commodified their practices as 'skills', 'products' and 'packages of care' in order to transmit their practices to other healthcare professions. This can be linked to NHS and governmental documents, which have stressed the need for skill-sharing in service of greater efficiency and cost-effectiveness of services (e.g. MAS, 1989). This corroborates research that has emphasised the development of a 'factory model' of clinical psychology services in response to neoliberal policies (e.g. Gezgin, 2019).

4.2.3 How have Neoliberal Processes of Governmentality and Subjectification Impacted on Specific Clinical Psychology Practices?

This study has focused on the impact of neoliberal processes of governmentality and subjectification in order to understand the mechanisms by which neoliberalism impacts of clinical psychology, using practices as concrete examples. The analysis has demonstrated how different clinical psychology practices have supported and enabled these processes using technologies of power and technologies of the self.

Across the analysis, different practices seem to utilise different technologies to support the construction of autonomous, responsible and productive ways of being and behaviour for individuals, in line with neoliberal subjectification and governmentality. Assessments appear to have increasingly expanded across a wider range of human experience, dividing people into parts to be judged using technologies of normalisation and examination. Formulations have predominantly emphasised an understanding of these experiences in individualistic psychological terms, which appear to draw on technologies of individualisation and ideological manipulation. Interventions can be seen to have provided the means for individuals to change their own behaviour or ways of being using the technology of responsibilisation. Individuals learn to change parts of themselves in alignment with neoliberal subjectivities, which are made desirable using the technology of normalisation. Evaluations further reinforce the normalisation and examination of neoliberal ways of being by defining the criteria of successful interventions in terms of autonomy and productivity. Individuals are encouraged to internalise an individualistic psychological understanding of their experiences and reform their ways of being and behaviour in line with psychological norms, using technologies of the self (e.g. self-examination, self-help and self-management). A neoliberal subjectification produces self-governing citizens through an individualistic psychologisation, which is justified and upheld by these multiple practices. This produces desired behavioural changes from citizens, enabling a government at a distance, which is characteristic of neoliberal governmentality.

An individualistic psychologisation using technologies of individualisation and responsibilisation has been disseminated across healthcare institutions and

society using consultation and leadership practices, and reflective practice. Social awareness practices and service user involvement practices can also be seen to privilege an individualistic psychologisation. However, in more recent years there appears to be an increase in resistance to neoliberal strategies. Critical reflective practice, meaningful service user involvement and social action appear to have contributed to this development.

4.2.4 What are Some of the Other Relevant Contextual Factors that have Influenced the Development of Clinical Psychology Practices?

This study also attempted to develop a nuanced analysis by exploring some of the contextual factors that have influenced clinical psychology practices over this period. The contextual factors discussed earlier (section 1.5) emphasised the importance of factors such as the development of the profession within the context of the NHS, the move to community care settings and clinical psychology's relationship with psychiatry. The analysis has explored how these factors have interacted with neoliberalism. For example, clinical psychology appeared to use the climate of marketisation to further its jurisdictional legitimacy by asserting that there should be open competition with psychiatry for leadership positions.

4.3 Implications of this Study

This study aims to empower clinical psychologists and service users with more awareness of the impact of neoliberalism on clinical psychology practice. This study's analysis has provided an interpretation of the mechanisms and power relations underlying the impact of neoliberal subjectification and governmentality on clinical psychology practices. Consequently, this study can provide implications for ways that the profession can challenge and resist these neoliberal processes. This section will address the implications of this study's analysis for clinical practice, policy, research and training.

4.3.1 Clinical Practice

This section will discuss clinical practice implications for the practices included in the analysis. Clinical psychologists who aim to challenge a neoliberal hegemony can pose critical questions of their practices. These questions are

intended to bring the technologies of power and self into conscious awareness and provoke discussions within the profession and with service users in order to lead to more informed choices about the practices they use. These questions could also be used in the development of alternative practices.

4.3.1.1 *Assessment and evaluation:* The analysis suggested that clinical psychology assessments and evaluations use technologies of normalisation and examination to divide individuals into parts to be judged against norms that promote neoliberal values (e.g. individualism, autonomy, productivity). Critical questions that could be used to challenge a neoliberal hegemony could include:

- What attribute of a person or group[8] does the assessment practice imply is problematic?
- Where has the idea that this is problematic come from? What social and political discourses is this related to?
- What experiences, ways of being and behaviour are positioned as desirable or undesirable by the assessment?
- Does the assessment promote qualities of individualism, autonomy and productivity? What qualities are subjugated or neglected as a consequence?
- Are there alternative experiences, ways of being or behaviour that service users could find more useful? Why?
- Does the person or group want this experience or activity to be placed under scrutiny, by themselves or a professional? Why?

4.3.1.2 *Formulation:* The analysis suggested that formulations in the neoliberal era have predominantly emphasised an understanding of human experiences in individualistic psychological terms, by using technologies of individualisation and ideological manipulation. Critical questions that could be used to resist neoliberal processes of governmentality and subjectification could include:

- What ideologies and assumptions support this framework or explanation of human experience?

[8] A group here could refer to a couple, family, organisation, service, community etc.

- How are these linked to wider social and political ideologies and discourses?
- What ways of being or behaviour are positioned as desirable or undesirable by this formulation?
- Does this formulation explain problems of human experience by privileging individual factors? What factors are subjugated or neglected as a result?
- Are there alternative explanations of human experience that service users could find more useful? Why?

4.3.1.3 *Intervention:* The analysis has suggested interventions in the neoliberal era have increasingly focused on teaching individuals to change themselves in line with a neoliberal subjectivity using technologies of normalisation and responsibilisation. Critical questions that could be used to resist neoliberal processes of governmentality and subjectification could include:

- What attribute of a person or group does the intervention imply is problematic?
- Where has the idea that this is problematic come from? What social and political discourses is this related to?
- What ways of being or behaviour are positioned as desirable or undesirable by this intervention?
- Does the intervention promote qualities of individualism, autonomy and productivity? What qualities are subjugated as a consequence?
- Are there alternative experiences, ways of being or behaviour that service users could find more useful? Why?
- What are the methods by which the intervention aims to meet its aims?
- Does the intervention place the responsibility for change on the individual? Why?

4.3.1.4 *Consultation, leadership and reflective practices:* The analysis asserted that consultation and leadership practices have largely developed in the neoliberal era as ways of promoting a neoliberal subjectivity by disseminating an individualistic psychologisation of human experience. Critical questions that could be used to challenge this process could include:

- What clinical psychology ideas and practices are being privileged in reflective practice, teaching, training, consultation and service delivery practices? What are the assumptions and ideologies underlying these practices?
- What are the aims of these practices? How are these being evaluated?
- How do these aims relate to wider social and political ideologies and discourses?
- What behaviours and ways of being are positioned as desirable or undesirable by these practices?
- Do these practices promote autonomous and productive ways of being for healthcare workers and their service users?
- Are there alternative behaviours and ways of being which healthcare workers and service users could find more useful? Why would they find them more useful?
- Do these practices privilege a psychological explanation focused on the individual?
- Are there alternative explanations that healthcare workers and service users could find more useful? Why would they find them more useful?

4.3.1.5 *Social awareness practices:* The analysis asserted that social awareness practices in the neoliberal era have predominantly used technologies of responsibilisation and individualisation to put the responsibility for overcoming social inequalities on individuals, which reinforces an individualistic psychologisation. Critical questions which could challenge this process could include:

- What are the assumptions and ideologies underlying practices that aim to increase social awareness and address social inequalities in clinical psychology?
- How do these relate to wider social and political discourses?
- What alternative ideologies and practices are subjugated as a result?
- Do these practices privilege a psychological explanation of social inequalities focused on the individual?
- Are there alternative explanations that healthcare workers and their service users could find more useful? Why would they find them more useful?

- Does the practice place the responsibility for change on individual service users or healthcare workers? Why?
- Who or what outside of the individual would need to change in order to address social inequalities? How could this be done?

4.3.1.6 *Service user involvement practices:* The analysis has suggested that service user involvement practices in the neoliberal era have predominantly developed to serve neoliberal strategies of governmentality and subjectification. This is achieved by promoting the individual autonomy and responsibility of service users, using technologies of individualisation and responsibilisation. This process could be resisted by posing critical questions, such as:

- What are the assumptions and ideologies that underlie practices used to involve service users in clinical psychology practices?
- What are the aims of service user involvement practice?
- How do the aims and assumptions of service user involvement practices relate to wider social and political discourse and ideologies?
- What are the behaviours and ways of being that are positioned as desirable or undesirable for service users in this practice?
- Do these practices emphasise individual, autonomous and responsible behaviours and ways of being? Why?
- Are there alternative behaviours and ways of being that service users could find more useful? Why?

4.3.2 Policy

Implications at the level of clinical practices are important. However, there is a danger of over-emphasising the responsibility of individual practitioners and services if implications at the policy level are not also considered. Previous research has emphasised the importance of policy-level changes for shifting the focus from the individual level to wider systemic and social levels (e.g. Afuape et al., 2016).

The analysis highlighted how clinical psychologists have been compelled to adapt their practices in line with neoliberal targets because the profession has been subject to technologies of precarity and examination. Clinical

psychologists could critique the evaluation measures that are used to evaluate the effectiveness of their services using critical questions (such as those suggested in section 4.3.1.1). Clinical psychologists could construct new evaluation measures that emphasise alternative measures of success beyond the level of the individual (e.g. measures of the impact of the service on the local community) and campaign for their use by commissioners of services. Clinical psychologists could also campaign for increased reassurance and longer-term funding for healthcare services to address the climate of precarity. This could involve aligning with groups who have been working to reduce the climate of marketisation and competition in the NHS e.g. 'Keep Our NHS Public'.

4.3.3 Research

This study has had a broad focus across eight different clinical psychology practices. Future research could focus on a single practice and use quantitative and qualitative research methods to develop a deeper understanding of how different aspects of neoliberalism impact the practice, from different theoretical positions. Future research could use the findings from this study as a potential starting point, and use the questions developed in section 4.3.1 as research or interview questions in order to go into greater depth in each of the practices. For example, qualitative interviews with healthcare staff and service users could look into their views on the behaviours and ways of being that are positioned as desirable or undesirable by service user involvement practices. Research participants could also be asked for their views on how these relate to wider social and political discourses and what alternative practices they think would be more useful. As a FGA privileges the subjective interpretation of the researcher, further research in this area from alternative perspectives would be beneficial for adding alternative interpretations.

This study has focused on neoliberal processes of governmentality and developed an analysis of macro power relations in line with the research aims. However, a more micro-level analysis is generally recommended for Foucauldian genealogical methodologies (Kearins & Hooper, 2002). Future research could develop a more nuanced analysis of micro-power relations using subjugated knowledges and data sources that relate to specific practices (e.g.

funding applications for new services for service delivery practices; or service user feedback for service user involvement practices).

4.3.4 Training

In a paper on the impact of neoliberalism on clinical psychology training, Dudley (2017, p. 53) asserts that “It is vital for the future of clinical psychology that trainees are well equipped to fight against iatrogenic practice and collusion with a continuation of this damaging ideology”. In order to resist supporting and enacting neoliberal strategies of governmentality and subjectification, clinical psychology training courses could promote practices that offer alternatives to individualistic and technocratic practices that promote neoliberal ways of being. Clinical psychology courses could encourage trainees to critique the practices that they are being taught to use, which could be done using the critical questions developed in section 4.3.1. The continued socioeconomic disparities in training also needs to be addressed (Newnes, 2014) in order to broaden the range of perspectives, discourses and practices in the profession.

4.4 Critical Evaluation

4.4.1 Limitations

The time span of 1979 to present day has been used for practical reasons, as this marked the start of Thatcher’s premiership and the introduction of her neoliberal policies, and also gives a defined time range from which to collect data. However, this risks reifying neoliberalism as a singular entity that was completely new in 1979 and remained unchanged since. Policies, subjectivities and technologies attributed to neoliberalism have been present in other ideologies (e.g. Kipnis, 2008). Characterising a broad range of policies, practices and processes since 1979 as ‘neoliberal’ risks reifying neoliberalism as a uniform entity or stage of history. A more in-depth analysis may have been possible with a shorter time-frame or a more precise focus on one or two particular practices. A survey of eight clinical psychology practices over four decades within the time constraints of a doctoral thesis has compromised the amount of depth that this study has been able to go into.

Furthermore, this analysis has relied heavily on official publications by the BPS and DCP, as well as publications from governmental bodies, as these have had a clear role in defining and determining clinical psychology practice. However, this approach to data collection neglects the 'local', 'discontinuous', 'disqualified', 'illegitimate' knowledges which Foucault (1980, p. 81) asserted should be used in genealogical research to provide an "insurrection of subjugated knowledges". Although some service user documents were included for this very purpose, the over-reliance on documents from disciplinary powers could has privileged these accounts, potentially further subjugating marginalised alternatives.

Latour (2004) cautions that it is necessary to be critical of critique. A critical approach can serve personal, professional and socio-political strategies which aim to question or undermine certain discourses or practices. Critique also uses technologies of power to produce and subjugate different knowledges, subjectivities and explanations (e.g. critical examination). I attempted to remain mindful of my own prejudices and motivations for this research (see sections 2.8 and 4.4.5). However, subjectivity and political motivations are not discouraged in Foucauldian methodologies. Hook (2005) contends that genealogy intends to serve projects of political criticism.

4.4.2 Credibility

Spencer and Ritchie (2012) assert that in order to establish credibility, it is important to evaluate the data selection and the plausibility of the interpretation.

The data used in this study were documents that relate to the core practice of clinical psychology since the introduction of neoliberalism in England. Logically, this predominantly comprised BPS and DCP documents. As well as reading various historical accounts by other authors (e.g. Pilgrim & Treacher, 1992; Rogers & Pilgrim, 1996; Hall et al., 2015) the addition of government, NHS and service user documents enabled a data triangulation, which was used to contextualise and corroborate the developing interpretation. Due to the development of online technology, more documents were available for more recent years. However, the BPS Suggested Readings for the Diploma in Clinical

Psychology from 1983 and 1990 provided a rich source of texts that were also included in the analysis.

The plausibility of the narrative interpretation can be evaluated using Willig's (2001, p. 148) four questions for assessing quality in studies using a social constructionist epistemology:

1. Does it tell a good story?
2. Does it tell a story which is clear, internally coherent and sufficiently differentiated?
3. Does it generate new insights for readers?
4. Is it convincing?

In order to develop a clear and internally coherent interpretation that could provide new insights, I focused on furthering my understanding of these topics and developing a consistent methodological approach. Harper (2013) advises that the quality of qualitative methods depends on immersion in theoretical and empirical literature. I therefore dedicated a large part of time to immersing myself in academic literature on the history of clinical psychology; neoliberalism; and Foucault's methods. This was challenging as Foucault avoided divulging a precise method for a genealogical analysis. In developing a consistent methodology using a FGA, I was aided by reading the work of several theorists who have provided guidance for Foucauldian analyses (Kearins & Hooper, 2002; Rose, 1999a; Arribas-Ayllon & Walkerdine, 2008), while also attempting to allow the research to find its own "methodological rhythm" Tamboukou (1999, p. 215). I also used discussions with my supervisor to explore the novelty and coherence of the analysis and interpretation, and to differentiate between different aspects of the interpretation in the analysis. Immersion in literature and data triangulation were used to develop a convincing interpretation, through the identification of contextual information that corroborated or conflicted with the emerging interpretation. The study's ability to generate new insights is explored below in section 4.4.4. Whether or not the study tells a good story will be left to the reader's judgement.

4.4.3 Rigour

Foucault's genealogical methodology has been criticised for lacking objective standards with which to evaluate it. Lotringer (1989, p. 326) argues that although this criticism is "not without foundation, it is in the end without force". Seeing all accounts as socially constructed, Foucauldian analyses are more concerned with producing a critical interpretation that has the power to destabilise dominant narratives than producing a 'valid' account. Normal standards of validity are themselves constructed within dominant discourses (Kearins & Hooper, 2002). Therefore, this study has attempted to utilise principles of academic rigour to aid the thoroughness and precision of the study.

In order to meet these standards I have attempted to ensure that the analysis and discussion have been kept consistent with the methodological tools outlined in section 2.5. I have tried to provide evidence that the analytical interpretation is grounded in data through the consistent use of quotes from data sources. I have also followed the advice of Wright Mills (1959), who advises keeping a record of notes of theoretical and empirical material as well as reflections. Researcher reflexivity (see section 4.4.5 below) can be used to bring an awareness to the researcher's "own intrinsic involvement in the research process" (Burr, 2015, p. 172) and counteract the tendency towards positivism and making alternative truth-claims that are not grounded in the context from which they were constructed.

4.4.4 Study's Contribution

This study corroborates previous critical historical accounts (e.g. Pilgrim & Treacher, 1992; Hall et al., 2015) and academic studies (see section 1.4) which have suggested that contemporary clinical psychology practice has been strongly impacted by neoliberalism. However, this study has added a unique contribution to the literature by presenting an interpretation of the specific mechanisms and power relations by which neoliberalism has impacted clinical psychology practices. This analysis has been based on historical documents, which has enabled an interpretation of a complex relationship grounded in empirical sources. The majority of the previous research on the relationship between neoliberalism and clinical psychology has rested on theoretical grounds.

Although Foucauldian-inspired analyses of psychology practice have been conducted of the profession (e.g. Richards, 1983; Rose, 1985), this study extends the analysis to include the past 40 years. Clinical psychology practice has changed greatly in that time and an understanding of power relations using Foucauldian methods has much to add to our understanding of what happened, and to our interpretations of why it happened. Furthermore, the analysis has suggested that clinical psychology's relationship with neoliberal ideology has changed over time, with evidence of greater resistance to neoliberal ideology in more recent years. There does not appear to be any studies in the literature that has highlighted this pattern of resistance in clinical psychology.

By using a FGA of the specific mechanisms, processes and technologies used in clinical psychology practice to support neoliberal strategies, this study also contributes by identifying ways that professional practice can counteract neoliberal strategies (see section 4.3). Furthermore, this study itself acts to counter neoliberal discourse through a critical historical analysis that asserts that clinical psychology practice has not developed purely through the innovation and progress of scientific methods used to solve human problems, but in response to professional, social and political problems. This interpretation therefore contributes to destabilising the truth claims of neoliberalism and mainstream clinical psychology practice that emphasise a narrative of linear progress.

4.4.5 Reflexivity

This section will draw on Willig's (2001) distinction between personal reflexivity and epistemological reflexivity in order to explore the ways in which personal experiences and the epistemological and methodological approach have influenced the study.

4.4.5.1 *Personal reflexivity:* Conducting this research has been challenging in the context of trying to understand my own feelings about living in a neoliberal society and using clinical psychology practices. This has had implications for me personally and professionally. I have been in clinical psychology training, developing my own professional practice alongside writing

this thesis, and have been increasingly conscious about the impact of the practices I use on the people I have worked with. I have felt drawn towards curiosity and openness in order to understand the implications of the practices I have been trained to use. At the same time I have felt drawn towards finding answers and certainty in order to complete clinical work and this thesis. During this research, I have attempted to stay aware of this tension and balance a not knowing approach with an interpretation grounded in research and documents. This has led me to adapt my professional stance from a position that overtly criticises neoliberalism to one that more openly questions the impact of neoliberalism and other dominant discourses on people's lives, from their perspectives.

I have been aware that different researchers would have chosen different documents and generated different interpretations. I have attempted to acknowledge the influence of my background and my prejudices against neoliberalism on the research. For example, my position of social privilege may have steered me towards selecting documents that represent the dominant discourse and away from documents representing more marginalised perspectives. To counteract this, I attempted to incorporate service user accounts in the think tank and analysis documents, although the vast majority of the documents included in the analysis were drawn from BPS and DCP archives. I also tried to remain aware of the tendency within my training towards critique. I proactively sought positive accounts of the impact of neoliberalism on clinical psychology practices. For example, I discussed with my supervisor how the increasing focus on people's wellbeing may have served to change people's attitudes about talking about painful experiences, which may have a positive impact on reducing levels of shame.

4.4.5.2 *Epistemological reflexivity*: A social constructionist epistemological approach has led me to focus on the social and historical construction of clinical psychology practices. This approach has explored how neoliberalism impacts on clinical psychology practice, which has assumed that neoliberalism has had an impact on clinical psychology practices without first testing this assumption. Using a FGA has enabled an analysis of mechanisms and power relations underlying the impact of neoliberalism on clinical

psychology practice, but it has also presented challenges. Translating Foucauldian concepts and principles into an analysis has been difficult as Foucault did not delineate a precise method. This has made it difficult to establish methodological rigour, a common criticism of Foucault's work (e.g. Mills, 2003). Despite the fact that Foucault aims to highlight contingency (Smart, 1983), his methods can been criticised for giving the appearance of the inevitability of social phenomena and structures. This analysis has not been able to demonstrate how practices could have developed in a different way if conditions had been different. Foucault's methodology has also been criticised for a lack of honesty, reliability and empiricism (Wehler, 1998), leading others to contend that this approach has no ability to propose positive solutions (e.g. Taylor, 2014). This criticism reflects this study's implications, which have identified critical questions that rely on the answers of respondents for potential solutions.

This study could have been attempted using a number of different epistemological and methodological approaches. Using a positivist epistemological framework I could have constructed a questionnaire to investigate whether clinical psychology practices lead to changes in behaviours or ways of being associated with neoliberalism. This might have been able to show more definitively whether neoliberalism does have an impact on clinical psychology practice, and demonstrate the extent to which different practices support or enable neoliberal processes, but would have lacked the analysis of how they do so. A relativist epistemological position could have used interviews to explore clinical psychologists' or service users' perspectives of the impact of neoliberalism on clinical psychology practices. However, this would have lacked a historical analysis to contextualise the perspectives in. I also considered using a critical realist epistemological position, which may have led to more of an emphasis on the implications of neoliberalism's impact on clinical psychology practices for service users' lives.

4.5 Concluding Thoughts

In the era of neoliberalism, clinical psychology practice appears to have developed to predominantly support and enable neoliberal strategies of

subjectification and governmentality. Clinical psychology practices can be seen to utilise technologies which aim to change people's behaviour and ways of being in line with a neoliberal hegemony. This has potentially damaging consequences, as neoliberalism has been associated with a wide range of individual and social problems. In more recent years, there is increasing evidence of resistance to neoliberal strategies from within the profession, which has emphasised alternative discourses and practices in professional documents. However, practices of resistance have exhibited a tendency towards becoming diluted and commodified in service of neoliberal strategies. This study could contribute to practices of resistance by offering an interpretation of the power relations and mechanisms which underlie the impact of neoliberalism on clinical psychology practices. Critical questions have been developed which could be used to generate greater awareness of the influence of neoliberalism on practices and lead to the development of alternative practices. Staying faithful to Foucault's research intentions to "write for users, not readers" (Foucault, 1994, p. 523-524), this study therefore hopes to offer tools which can be used by others to destabilise the 'truth regime' of neoliberalism.

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6. APPENDICES

6.1 Appendix A: Glossary of Key Relevant Foucauldian Terms

Table 1

Glossary of key relevant Foucauldian terms

Foucauldian term	Meaning
Emergence	The origins or 'moment of arising' of particular social structures, practices or discourses
Descent	The subjugation of social structures, practices or discourses
Discourse	Defines the limits of what is included and excluded as reasonable and qualified knowledge within a social domain/discipline (e.g. science, psychology, sexuality)
Disciplinary power	The power of governing bodies in society to uphold discourses and influence people's subjectivity and actions
Governmentality	The processes by which disciplinary power is used to produce conformity and govern the conduct of individual subjects and populations
Subjectification	The processes by which disciplinary powers govern the identities and actions of people by making them subjects of or to a discourse
Technologies of power	The processes by which discourses are regulated and passed down to subjects by bodies who hold disciplinary power
Normalisation	A technology of power. The process by which something becomes normalised or desirable for people to be or do
Examination	A technology of power. The process by which people are observed and rewarded or punished

	depending on their adherence to, or deviation from, the norm
Individualisation (and responsibilisation)	A technology of power. The process whereby social difficulties (and the responsibility to address them) are located within individual subjects.
Technologies of the self	The processes by which people set themselves rules of conduct, and act to transform their identities in line with their desired or valued ideas of themselves
Subject	A term that captures the possibilities and constraints that are available for people to internalise as their identities or 'selves'

6.2 Appendix B: Academic Sources Cited in Scoping Review

Table 2

*Academic sources cited in scoping review (**citation search additions shown in bold**)*

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6.3 Appendix C: Extract from Table used to Collate Analytical Codes and Notes and Develop Analytical Interpretation

Figure 2

Analytical Table Extract: Codes and Notes

Source	Practice?	Perspectival Dimensions: Problematizations Explanations Authorities Technologies Subjectivities Strategies	Notes (interpretation of code)	Contextual factors	Relationship to neoliberalism
DCP **2010** Clinical Psychology Leadership Development Framework		**Authorities / Strategy /** Explanation "Effective leadership for clinical psychologists at all career stages can be strengthened by an **awareness of personal qualities and values**, and by the **application of our professional skills and knowledge**. Our core psychological competencies and relationship **expertise in engagement and collaboration** can serve as valuable tools for effective leadership. However, this document sets out a continuing developmental framework for leadership behaviour which is both incremental and cumulative **from pre-qualification**, to **director levels of the profession**. As such it may inform pre-qualification training curricula and both personal and organisational programmes of continuing professional development. It may serve as a reference point for career progression (e.g. through the knowledge and skills framework) and as **benchmark criteria for recruitment at various bands of the profession**. Most fundamentally it aims to both inform, and be a tool to promote, personal and professional development for all members of the profession" **TECHNOLOGIES / STRATEGIES / EXPLANATION** WHY DO I WANT LEADERSHIP **SKILLS**? CLINICAL DRIVERS ▪ Effective **team working** is associated with clear and effective leadership (Oyett, 2007). ▪ The development of **care pathways** - lead on psychological issues within the pathway to **improve client outcomes.** ▪ To sensitively and confidently lead on psychological **assessment and formulation** in teams. ▪ To take a lead on **clinical governance** issues in teams and organisations. ▪ **Mental Capacity Act 2007** (MHA, 2007) – new roles and responsibility for Psychologists when leading as approved clinicians (AC) and responsible clinicians (RC). ▪ Clinicians are expected to display leadership behaviour to ensure **quality services for patients**, as identified in the **Knowledge and Skills Framework (DoH)** PROFESSIONAL DRIVERS ▪ Leadership is seen as vital for the effective implementation of **New Ways of Working** (NWW) for Applied Psychologists (Lavender & Hope, 2007). ▪ NWW highlights the importance of leadership in order to **improve access** and availability of psychological therapies and services. ▪ **The need to market clinical psychology** services as identified within the document 'Understanding customer needs of Clinical Psychology Services' (DCP, 2007a) and the need to implement the DCP Leadership Strategy (BPS, 2007b). STRATEGIC DRIVERS ▪ Across the United Kingdom there are a number of strategic initiatives that call for the **modernisation** and **reform** of health care services. While specific strategies vary across the four nations (e.g. *'New Horizons', 'Better Health Better Care', 'Bamford Review', 'Designed for Life'*), and whilst these particular initiatives will no doubt further evolve, there is a common and likely enduring aspiration towards service redesign and new ways of working to improve the **quality and efficiency** of health services. For all health professionals **this will require sharpened skills and competencies related to strategic team work (at service/organisational and health economy levels)** and **effective leadership**. **Given the precedence of the leadership agenda at a strategic governmental level,**	**AWARENESS serving LEADERSHIP strategy (explanation for awareness practice)** **Authority: EXPERTISE IN COLLABORATION** **Strategy: Improve outcomes** **Strategy: clinical 'GOVERNANCE' (Leadership in teams)** **Strategy = improves access and availability** **Strategy: Improve efficiency** **Strategy: Increase indirect practices to contribute to health economy**	(Austerity) AGENDA FOR CHANGE (NWW AP) Working psychologically in teams (NWW AP) Working psychologically in teams **Desire for better access to therapy** **MODERNISATION & REFORM OF SERVICES (New Horizons, Better Health Better Care, Bamford Review)**	**Leadership = top of the hierarchy (WINNER)** **'Skills' - a COMMODIFICATION** **IMPROVE OUTCOMES** **GOVERNMENTALITY** **CONSUMERISM** **Gov @ distance** **MARKETISATION** QUALITY & **EFFICIENCY** **COMMODIFICATION** **GOV @ DISTANCE**

6.4 Appendix D: Final Dataset of 81 Documents Included in Analysis

Table 3

*Final dataset of 81 documents included in analysis (**documents from initial archival search shown in bold**)*

Beck, Rush, Shaw, Emery	1979	Cognitive Therapy of Depression
Pope	1979	The Mental Health Interview: Research and Application
British Psychological Society	1979-1980	Regulations for the BPS diploma in Clinical Psychology
Division of Clinical Psychology	1980	The Psychological Therapies
Smith, Glass & Miller	1980	The Benefits of Psychotherapy
McPherson & Sutton	1981	Reconstructing psychological practice
Turner, Calhoun & Adams	1981	Handbook of clinical behavior therapy
Miles	1981	The mentally ill in contemporary society
British Psychological Society	1983	Regulations for the BPS diploma in Clinical Psychology
British Psychological Society	1983	BPS diploma in Clinical Psychology: Suggested Readings
Division of Clinical Psychology	**1983**	**Guidelines for the Professional Practice of Clinical Psychologists**
Shaffer et al.	1983	Children's Global Assessment Scale
British Psychological Society	1985-1986	Regulations for the diploma in Clinical Psychology
Koch	1986	Community Clinical psychology
British Psychological Society	1986-1987	Regulations for the diploma in Clinical Psychology
British Psychological Society	1987-1988	Regulations for the diploma in Clinical Psychology
Management Advisory Service to the NHS	**1989**	**Review of Clinical Psychology Services**
Division of Clinical Psychology	**1990**	**Guidelines for the Professional Practice of Clinical Psychology**

British Psychological Society	1990	Reading Lists for the diploma in Clinical Psychology
Division of Clinical Psychology	1990	Psychological Therapy Services- the need for organisational change
British Psychological Society	1993-1994	Regulations A for the diploma in Clinical Psychology
Division of Clinical Psychology	**1994**	**Core Purpose and Philosophy of the Profession**
British Psychological Society	1994-1995	Regulations B for the diploma in Clinical Psychology
Division of Clinical Psychology	**1995**	**Professional Practice Guidelines**
Division of Clinical Psychology	**1995**	**Purchasing Clinical Psychology Services (Using Clinical Psychology: A Briefing Paper)**
Department of Health	1999	Mental Health: National Service Framework
Gowers et al.	1999	Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)
Evans et al.	2000	Clinical Outcomes in Routine Evaluation (CORE)
Division of Clinical Psychology	2000	Recent advances in understanding psychotic experiences and mental illness
Mental Health Foundation	2000	Strategies for living: A report of user-led research into people's strategies for living with mental distress
Division of Clinical Psychology	**2001**	**Core Purpose and Philosophy of the Profession**
British Psychological Society & CORE (UCL)	2002	Measuring Outcomes in Routine Clinical Practice
Kroenke & Spitzer	2002	Patient Health Questionnaire 9

The Health Professions Council	**2003**	**Your duties as a registrant: standards of conduct, performance and ethics**
Division of Clinical Psychology	**2004**	**Advice to employers of Clinical Psychology**
British Psychological Society	2005	Membership and Professional Training Board (Committee on Training in Clinical Psychology): Procedures for New Programmes Seeking Accreditation
Spitzer, Kroenke, Williams & Lowe	2006	Generalised Anxiety Disorder 7-item (GAD-7) scale
British Psychological Society	**2006**	**Code of Ethics and Conduct**
British Psychological Society	2006	Core Competencies – Clinical Psychology – A Guide
British Psychological Society	**2007**	**New Ways of Working for Applied Psychologists in Health and Social Care: Working Psychologically in Teams**
Division of Clinical Psychology	2007	Marketing strategy resources for clinical psychologists
Division of Clinical Psychology	2007	Leading Psychological Services
CORE (UCL) & Department of Health	2007	The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders
CORE (UCL)	2008	The competences required to deliver effective Interpersonal Psychotherapy (IPT)
CORE (UCL)	2008	The competences required to deliver effective Psychoanalytic/ Psychodynamic Therapy

British Psychological Society	2008	Criteria for the Accreditation of Postgraduate Training Programmes in Clinical Psychology
The Health Professions Council	**2008**	**Standards of conduct, performance and ethics**
The Health Professions Council	**2009**	**Standards of proficiency: Practitioner psychologists**
CORE (UCL)	2009	The competences required to deliver effective Humanistic Psychological Therapies
National Institute for Health and Care Excellence	2009	Depression in adults: recognition and management. Clinical guideline
Division of Clinical Psychology	2010	Clinical Psychology Leadership Development Framework
British Psychological Society	2010	Accreditation through partnership handbook Guidance for clinical psychology programmes
CORE (UCL)	2010	The competences required to deliver effective Systemic Therapies
Division of Clinical Psychology	**2010**	**Core Purpose and Philosophy of the Profession**
Division of Clinical Psychology	**2011**	**Guidelines for Clinical Psychology Services**
Division of Clinical Psychology	2011	Good Practice Guidelines on the use of psychological formulation
National Institute for Health and Care Excellence	2011	Common mental health problems: identification and pathways to care
National Institute for Health and Care Excellence	2011	Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services
British Psychological Society	2012	Care packages & pathways/Payments by Results for mental health services for adults

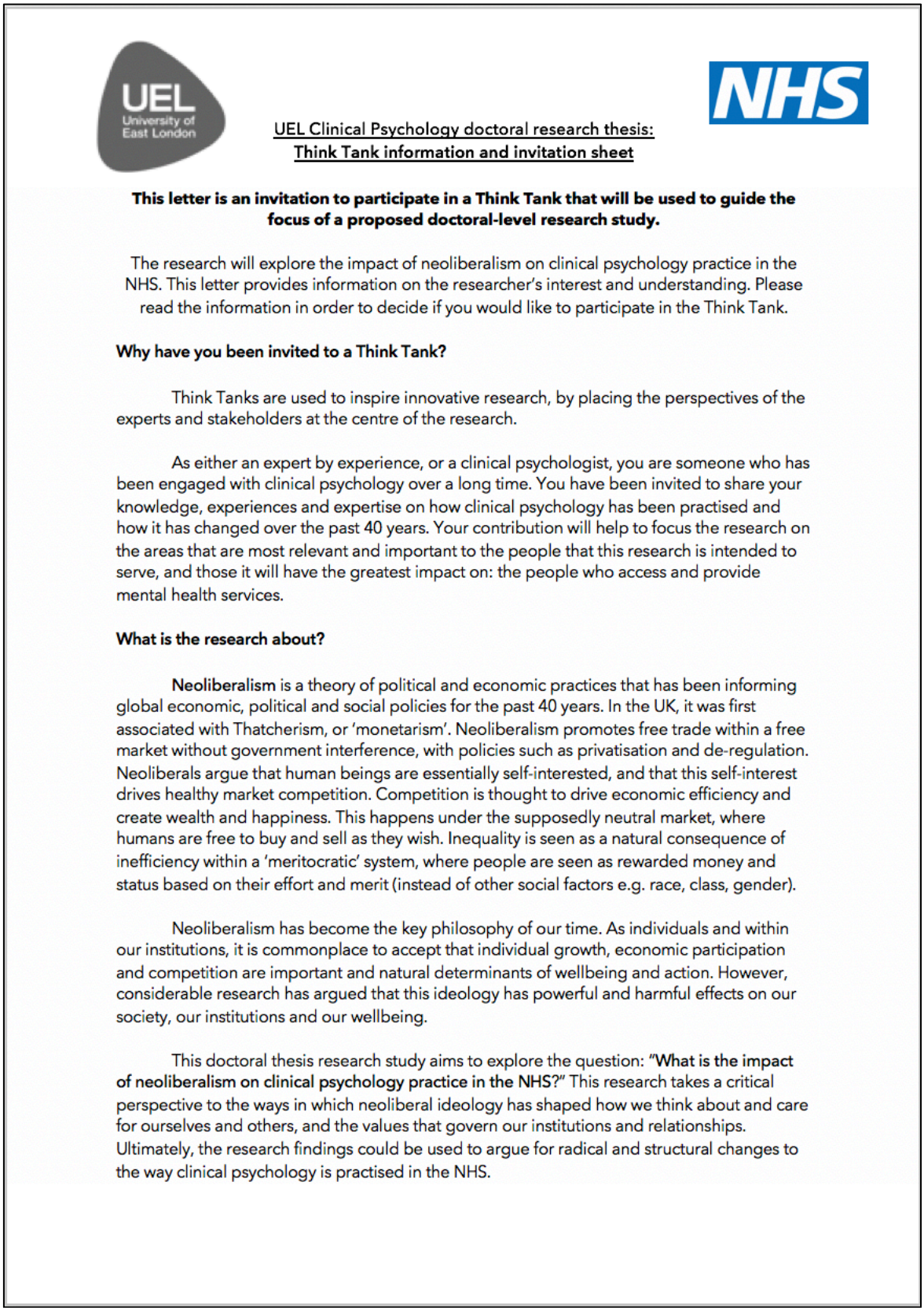
Division of Clinical Psychology	2012	Commissioning and Delivering Clinical Psychology in Acute Adult Mental Health Care
Division of Clinical Psychology	2013	Briefing Paper: Mental health clustering and psychological interventions
NHS England	2013/ 2014	NHS Standard Contract for Tier 4 Child And Adolescent Mental Health Services (CAMHS): Children's Services
NHS England	2013/ 2014	NHS Standard Contract for Severe Obsessive Compulsive Disorder and Body Dysmorphic Disorder Service (Adults And Adolescents)
Division of Clinical Psychology	2014	National Mental Health, Well-being and Psychological Therapies – the role of Clinical Psychology A briefing paper for NHS Commissioners
Johnstone & Dallos	2014	(Formulation in Psychology & Psychotherapy)
National Survivor User Network	2014	Influencing Mental Health Services: a Guide to Values-based Commissioning
Recovery In The Bin	2014	Key Principles
The Health & Care Professions Council	2015	Standards of proficiency: Practitioner psychologists
NHS Mental Health Taskforce	2016	Five Year Forward View for Mental Health
Division of Clinical Psychology	2017	Understanding Psychosis and Schizophrenia (Revised)
British Psychological Society	**2017**	**Practice Guidelines (Third Edition)**
British Psychological Society	**2018**	**Code of Ethics and Conduct**

Johnstone & Boyle (Division of Clinical Psychology)	2018	Power Threat Meaning Framework
Recovery In The Bin	2018	A Simple Guide To Co-Production
Recovery In The Bin	2018	#PTMframework Power Threat Meaning Threat Power Power Power, review by Scheherazade
British Psychological Society	2019	Standards for the accreditation of Doctoral programmes in clinical psychology
National Institute for Health and Care Excellence	2020	Depression: The NICE guideline on the treatment and management of depression in adults
NHS England	2021	Adult Low Secure Services Specification
Division of Clinical Psychology	2021	Leadership development and support for clinical psychologists working in health and social care
National Survivor User Network	2021	Lived Experience Leadership
National Survivor User Network	2022	Tickboxes and Tokenism? Service User Involvement Report 2022

6.5 Appendix E: Think Tank Information and Invitation Sheet

Figure 3

Think Tank Information and Invitation Sheet



UEL Clinical Psychology doctoral research thesis:
Think Tank information and invitation sheet

This letter is an invitation to participate in a Think Tank that will be used to guide the focus of a proposed doctoral-level research study.

The research will explore the impact of neoliberalism on clinical psychology practice in the NHS. This letter provides information on the researcher's interest and understanding. Please read the information in order to decide if you would like to participate in the Think Tank.

Why have you been invited to a Think Tank?

Think Tanks are used to inspire innovative research, by placing the perspectives of the experts and stakeholders at the centre of the research.

As either an expert by experience, or a clinical psychologist, you are someone who has been engaged with clinical psychology over a long time. You have been invited to share your knowledge, experiences and expertise on how clinical psychology has been practised and how it has changed over the past 40 years. Your contribution will help to focus the research on the areas that are most relevant and important to the people that this research is intended to serve, and those it will have the greatest impact on: the people who access and provide mental health services.

What is the research about?

Neoliberalism is a theory of political and economic practices that has been informing global economic, political and social policies for the past 40 years. In the UK, it was first associated with Thatcherism, or 'monetarism'. Neoliberalism promotes free trade within a free market without government interference, with policies such as privatisation and de-regulation. Neoliberals argue that human beings are essentially self-interested, and that this self-interest drives healthy market competition. Competition is thought to drive economic efficiency and create wealth and happiness. This happens under the supposedly neutral market, where humans are free to buy and sell as they wish. Inequality is seen as a natural consequence of inefficiency within a 'meritocratic' system, where people are seen as rewarded money and status based on their effort and merit (instead of other social factors e.g. race, class, gender).

Neoliberalism has become the key philosophy of our time. As individuals and within our institutions, it is commonplace to accept that individual growth, economic participation and competition are important and natural determinants of wellbeing and action. However, considerable research has argued that this ideology has powerful and harmful effects on our society, our institutions and our wellbeing.

This doctoral thesis research study aims to explore the question: "**What is the impact of neoliberalism on clinical psychology practice in the NHS?**" This research takes a critical perspective to the ways in which neoliberal ideology has shaped how we think about and care for ourselves and others, and the values that govern our institutions and relationships. Ultimately, the research findings could be used to argue for radical and structural changes to the way clinical psychology is practised in the NHS.

What will the Think Tank entail?

The Think Tank will run for 90 minutes and involve a group of clinical psychologists and experts by experience. It will begin with an introduction to the topic, and then you will be invited to share your views. The Think Tank will be structured: participants who have been experts by experience will be invited to share their views first, followed by clinical psychologists reflecting on what they've heard. The Think Tank will end with an open discussion with all participants.

A provisional date is set for: **Thursday 25th February, at 5:30pm**. This could be moved to a more convenient time to accommodate participants' needs. The Think Tank will take place online, using Zoom or Teams.

Compensation

Participants who complete the Think Tank will be compensated for their time with a £15 online Amazon voucher.

Right to Withdraw

Participants can withdraw from the Think Tank at any point in time, without giving a reason for their withdrawal.

Data

The Think Tank will not be recorded. Your email addresses will be kept by the researcher, Theo, to keep you informed of its progress and any publications that result from this research. However, if you would prefer not to be kept informed you will not receive any further information and your email address will be deleted.

Contact details

If you would like to be involved in this Think Tank, or if you have any questions, please contact the researcher: **Theo Sunley** by email on [redacted]

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor: [redacted] by email on [redacted]

Thank you for taking the time to read this.

N.B. Potential for further involvement: Based on the Think Tank discussion, the researcher will identify text sources to analyse for the basis of the research. The method of analysis will be a Foucauldian Genealogical Analysis- a critical and qualitative approach to analysing texts. If anyone of the participants would like to be involved in the analysis or the distribution/ dissemination of the research, this could be possible. However, unfortunately participants will not be compensated for this. Please enquire about this if you would like any further information or to express your interest.