

Human Rights and Clinical Psychology in the United Kingdom from 1948 to 2018: A Critical Historical Analysis

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Abstract

Human rights morality and law represent an authoritative way to challenge systems of oppression that can have a deleterious impact on people's mental health. Clinical psychology and human rights uphold similar underlying principles such as dignity, respect and equality. Clinical psychologists often work with individuals who have experienced, and continue to experience, human rights violations. However, the individualising technologies of the profession continue to be criticised for not challenging abuses of power and the perpetuation of social inequalities.

This research aimed to critically investigate the historical conditions that have given rise to the relationship between clinical psychology and human rights. Documents relating to the professional practice of clinical psychologists in the United Kingdom were analysed using thematic analysis underpinned by critical realism. These findings were incorporated into a three-tiered framework of macro, meso and micro influences.

Analysis showed that the few explicit references to human rights in the documents relating to the practice of clinical psychology were not sustained or developed into later documents. Most often appeals to human rights were vague and there was no discussion about professional obligations to integrate standards in everyday practice, service design or policy. In addition, these standards only upheld a narrow range of human rights which limited the ethical vision of the profession as it was developing. This pattern of engagement with human rights across the history of clinical psychology was explored by reference to transhistorical, global, national and professional pressures. The research concludes by exploring the implications for a renewed clinical psychology more aligned to human rights morality and law.

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1. INTRODUCTION

1.1. Overview

As long as the moral authority of the scientific community remains unchallenged from within, history will be seen either as irrelevant, or as an occasion for celebration. It is when that authority becomes questionable, when the professional community is divided in some profound way, that a critical disciplinary history has a significant contribution to make. (Danziger, 1994, p. 478)

The passage above highlights the orientation of this study. This history of clinical psychology is critical in order to generate renewed ideas about a possible future for the profession. Although clinical psychology is a relatively young disciplinary body of knowledge and practice (Hall, Pilgrim & Turpin, 2015), the world is rapidly changing in response to a growing awareness about the relationship between mental health and justice (Rose, 2019). Commitments by influential global actors such as the World Health Organisation (WHO), the Movement for Global Mental Health and World Bank have meant that mental health is emerging at the international level as a human development imperative (United Nations [UN], 2017). The 2030 Agenda for Sustainable Development aimed to ensure healthy lives and promote well-being as important for realising the human right to health (UN, 2015). The protection of people's human rights is viewed as being fundamental to promote and preserve mental health (Dudley, Silove & Gale, 2012). Increasingly, mental health and human rights are seen as universally valued outcomes and possibly the twin headline projects of modernity (Dudley et al., 2012). However, historically, people with mental health difficulties have been subject to inequalities associated with the violation of fundamental human rights (Kelly, 2016, UN, 2017). Compared to people without such difficulties, they die earlier (Ventriglio, Gentile, Stella & Bellomo, 2015), experience extreme poverty (Murali & Oyebode, 2004) and face discrimination in clinical and social domains (Kurs & Grinshpoon, 2017). This global picture of systematic and widespread injustice has been described as a moral failing of humanity (Kleinman, 2009).

In the United Kingdom (UK), the relationship between mental health and human rights cuts across law, national policy and local practices. For example, mental health legislation in England only meets 55.4% of the human rights standards established by the WHO for reviewing domestic law (Kelly, 2016). Kelly (2016) has argued that the legislation that complies least with the WHO standards relates to the economic and social rights of those deemed to have mental health disorders. Improving mental health and well-being is increasingly prioritised in a range of such proposals by governments, hospitals, schools, employers and charities (Alexandrova, 2018). At the same time, however, the proliferation of policies regarding mental health can also be characterised by a relative silence about its relationship to wider concerns relating to human rights. A prominent example of this is evident in the current Government's Green Paper entitled *Transforming Children and Young People's Mental Health Provision* (England and Wales Department of Health and Social Care and Department for Education, 2017). The social determinants of mental health were not addressed in the original draft and, instead, the policy proposals focused solely on improving access to treatment. However, that focus on services did not extend to the human rights of those accessing treatment. Those working in mental health services acknowledge the threats to civil liberties and human rights, and the iatrogenic effects of supposed mental health care (Kinderman, 2014; Szmulker, 2018). These concerns include the disproportionate number of people from black and minority ethnic groups held under section (Singh, Greenwood, White & Churchill, 2007) to the effectiveness of interventions for psychosocial difficulties relating to poverty, urbanicity and childhood adversity (Pilgrim, 2018).

The current study will explore how clinical psychology has engaged with these concerns about human rights and mental health. Human rights offer a particular way of thinking about the ethical, political and legal dimensions of both mental health and the profession of clinical psychology. This introduction will explore the nature of this relationship by surveying the history, theory and dilemmas relevant to both fields.

1.2. Human Rights

Human rights are fundamentally moral principles that aim to protect people from political, legal and social injustice (Nickel, 1987). They belong to everyone by virtue of being human and express people's deepest interests in freedom and safety (UN, 1948). Raz (2010) argued that a human right arises when a universal human interest is sufficient to justify imposing correlative duties on others. Legal frameworks have developed to codify a number of these moral obligations that are owed to other people (Tasioulas, 2010). Examples of human rights include the right to a fair trial, the right to freedom from torture (mental or physical) inhuman or degrading treatment and the right to the highest attainable standard of physical and mental health.

1.2.1. Grounds for Human Rights

This section will explore how philosophers and political theorists have sought to establish a theoretical basis for claims that people make for human rights. Human rights have become increasingly prominent in domestic and international discourse (Sen, 1999). However, they are sometimes viewed as rhetorically powerful but lacking in substance (Posner, 2008). The inherent dignity of the human person is mentioned in the preamble to a number of central human rights instruments (Tasioulas, 2013). A recognition of this dignity is often presented as the basis for the equal and inalienable rights of all members of the human family (UN, 1948). However, there is no sustained discussion in these instruments about the foundational assumptions of human rights in moral and political thought.

One view is that human rights are primarily established through the creation and enactment of laws. This argument is responsive to the intuitive line of reasoning that rights without a legal duty are at best aspirational and at worst empty (Bentham, 1792/1843). However, grounding human rights in legal institutions does not do justice to the ways in which they have meaning in people's lives. Sen (2006), for example, has argued that social monitoring and activist support by groups such as Amnesty International and Human Rights Watch can serve to advance unacknowledged human rights. However, advocating for human rights does not necessarily mean seeing them as embryonic legal claims. Sen

(2006) contended that the Declaration on the Right to Development in 1986 was motivated by the idea that “the ethical force of human rights is made more powerful in practice through giving it a high-profile social recognition and an acknowledged status, even when no enforcement is instituted” (p. 2919). In fact, sometimes making human rights legally enforceable can have unwanted consequences. Ferraz (2009) has shown that making the right to health justiciable in Brazilian courts has led to a transfer of health resources away from poorer groups because wealthier people can afford the cost of enforcing their legal right to health.

Tasioulas (2012) has outlined an alternative conception of human rights as primarily ethical claims, grounded in universal human interests and human dignity. On this view, human rights mark the threshold at which each individual’s interest generates correlative obligations on others to promote and protect those interests. Individual human rights serve a number of universal interests of the putative right-holder (Tasioulas, 2012). For example, the human right to health serves one’s interest in health but also other interests that health enables such as forming friendships and having the freedom to achieve goals (Tasioulas & Vayena, 2016). However, many human interests are insufficient to generate a correlative duty on others for their fulfilment. For example, it would advance the interests of a patient in the advanced stages of renal failure to have a transplanted kidney (Neier, 2006), but it does not follow that the patient has a human right to someone else’s kidney. Tasioulas (2012) argued that universal human interests must operate in cohort with each person’s inherent dignity, such one that person’s interests cannot be traded off against another’s. While it is possible to advance the interest of someone experiencing organ failure through donation, the correlative duty is too burdensome for any duty-bearer to fulfil. Therefore, a wrong is not necessarily committed by impairing, or leaving unpromoted, another person’s interests (Tasioulas & Vayena, 2016). An advantage for clinical psychologists of viewing human rights as primarily ethical claims is that it recognises how they can operate at the everyday level of ordinary citizens and can inspire activism and criticism outside the formal institutions of international law.

1.2.2. The Emergence of Human Rights

The different contexts in which human rights emerged, and how they came to gain international prominence, has been the focus of significant disagreement (Alston, 2013). Ishay (2004) has argued that human rights discourse can be discerned in the great texts of many ancient civilisations and world religions from the Code of Hammurabi to the Analects of Confucius. A western vision of human rights came to dominate global affairs because distinct humanistic elements that developed over time were revealed as the best form of governance (Ishay, 2004). This linear history seeks to justify human rights through an appeal to the progressive refinement of its norms in a succession legal and constitutional reforms (Alston, 2013). However, it may be anachronistic to conclude that these early laws and treaties contain elements that are continuous with human rights. Dudley et al. (2012) argued that it is mistaken to identify a concern for human rights in policies that are morally congenial. These laws were often responses to local injustices and do not claim to apply universally (Klug, 2015). In addition, many of them were not based on equality for all people in virtue of their humanity and arguably continued to reproduce various class inequalities.

Tierney (2004) argued that jurists, particularly church lawyers, played a crucial role in developing the modern language of human rights. The twelfth century marked a renaissance in religious life, especially relating to the individual domains of assessing guilt, consent to marriage and scrutiny of one's conscience (Tierney, 2004). These individual concerns arose alongside intense and elaborate discussions about rights and liberties. Traditionally, the natural right designated an objective share in material or social goods, reflecting the state of the moral human world and not the isolated soul (Fleischacker, 2005). However, the twelfth century canonists, in trying to develop a universal structure of jurisprudence for the church, recognised that the term natural right was used in different ways across religious texts (Tierney, 2004). Sometimes it referred to an objective view of the moral human world but, at other times, its usage designated a more subjective sense as a power, force or ability inhering in the individual. This primarily meant an ability to discern the right thing to do through the human faculties of reason and will. Tierney reasoned as follows:

Once the old concept of natural right was defined in this subjective way the argument could easily lead to the rightful rules of conduct prescribed by natural law or to the licit claims and powers inhering in individuals that we call natural rights. Soon the canonists did begin to argue in this way and to specify some such rights (Tierney, 2004, p. 6).

By the fourteenth century some natural rights were recognised such as the rights of the poor to basic necessities, the right to defend oneself in a court of law and the rights of those who were not Christian. In migrating from a divinely ordained objective position in the social order, to a subjective power of the individual, natural rights became discoverable psychological properties discerned through practical reasoning (Stenner, 2004). From here, other notable treaties that laid the platform for human rights were drawn up including the English Bill of Rights in 1689, the French Declaration on the Rights of Man and of the Citizen in 1789 and the US Declaration of Independence in 1776.

The universalism that is distinctive of human rights is said to have arisen following the end of the Second World War and the vivid depictions of the liberation of the Nazi death camps (Dudley et al., 2012). These atrocities and the subsequent Nuremberg trials shockingly demonstrated the consequences of racist and nationalist ideologies (Utley, 1992). The UN was established in 1945 in order to protect succeeding generations from the scourge of war which had brought untold sorrow to mankind (UN, 1945). A United Nations Commission on Human Rights was established in 1946. The committee met for the first time in January 1947 and appointed a task force, chaired by Eleanor Roosevelt, that drafted the Universal Declaration of Human Rights (UDHR). The subsequent adoption of the UDHR sought to establish internationally recognised human rights norms and institutions to promote international peace and security over the globe (UN, 1948).

1.2.3. Key International and Regional Human Rights Instruments

The catalogue of human rights now consists of approximately 50 core normative propositions outlined in the founding instruments of the UN (Alston, 1991). These were expanded by further specialised UN treaties, a half-dozen regional human rights treaties, and hundreds of international norms in the areas of

labour, refugees, armed conflict and health (Marks, 2013). This collection of human rights law is enriched by declarations, public reasoning and activism (Marks, 2013).

The 30 items canonised in the UDHR range from political and civil rights to social, cultural and economic rights. Alston and Goodman (2013) have noted that the intention to further develop the UDHR into a single and comprehensive legally binding convention was controversial from the start. Some communist countries objected that the social, cultural and economic rights outlined in the UDHR were too minimal (Alston & Goodman, 2013). A number of factors, including the Cold War, slowed progress and the United States began to qualify its commitment to the concept of universal human rights. As a consequence, the decision was taken to codify the rights enshrined in the UDHR through two principal treaties. The International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) were approved in 1966. The ICCPR guarantees protections covering areas such as the individual's physical integrity, procedural fairness, equal protection, political freedoms and the right to political participation. The ICESCR aims to secure human rights to education, food, housing and health.

There are questions about whether certain rights have been privileged in these treaties. Only the human rights enshrined in the ICESCR are subject to progressive realisation, the obligation that a state must do its utmost to promote and preserve these rights to the full extent of its available resources. Civil and political liberties are not subject to progressive realisation even though it takes financial resources to promote and protect some of those norms such as the right to a fair trial and recognition before the law. Indeed, the preamble to the ICESCR states that the ideal of free human beings enjoying freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy economic, social and cultural rights, as well as civil and political rights. Since the 1970s, the debate has involved important considerations between the global north and south. These include claims that developing countries should not be held to the same standards and that respect for human rights by poorer states must be linked to international aid, trade and other concessions (Hunt, 2006). Hunt (2006) has argued that the decline of communism and widespread

embrace of free-market capitalism within globalisation has meant that economic, social and cultural rights will remain controversial and that their status will have important implications for other aspects of human rights law.

Multilateral human rights treaties have further developed the content of the rights that were expressed in a more condensed manner in the two covenants (Alston & Goodman, 2013). It has been argued that all seven of these international conventions have a bearing on mental health and well-being (Patel, in press). While there have been appeals for a specific treaty for people with mental health difficulties (Plumb, 2015), the most recent treaty relevant to mental health is the Convention on the Rights of Persons with Disabilities (CRPD). It came into force in 2008 and was ratified by the UK in 2009. The UN Committee on the Rights of Persons with Disabilities, which monitors how the convention is being put into practice locally, reviewed the UK in August 2017. The UN Committee expressed concern that adequate provisions were not being taken to apply the principles of the convention to all areas of life, that disabled people were not sufficiently involved in decision-making and that more could be done to embed the social model of disability into practice (UN, 2017).

The European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) entered into force in 1953. It has developed extensive human rights jurisprudence which applies to almost a quarter of the nations in the world (Alston & Goodman, 2013). The Human Rights Act (HRA) incorporated the rights from the ECHR into UK domestic law in 1998, affording a legal mechanism for breaches of the ECHR in UK courts. Public authorities, such as the NHS and its employees (including clinical psychologists), are seen as duty bearers and responsible for upholding the rights of service users, or rights bearers (HRA, 1998). It is questionable whether the ECHR and the HRA have been successful in protecting socio-economic rights to health, social care and housing at a time of increasing privatisation of public services (Palmer, 2007). Other important legal frameworks relevant to clinical psychologists in the UK include the Mental Health Act 1983, amended 2007, and the Mental Capacity Act 2005 which are apparently predicated on human rights principles (Greenhill & Golding, 2018). However, Szmukler (2018) has argued that overall

legislation in the UK does little to resolve the historical tensions between medical paternalism and patient self-determination.

1.2.4. Contesting Human Rights

Moyn (2010) has challenged the conclusion that human rights gained moral ascendancy shortly following the end of the war. He alleged that the Holocaust played a small role in post war debates about human rights, arguing that the Nuremberg trials did not concentrate primarily on the specific plight of the Jews but the war crimes of the Nazis. He also maintained that the related genocide convention was not conceived in similar ways to the itemisation of human rights. Moyn (2010) contends that a necessary aspect of human rights universalism is international advocacy for justice and equality beyond national borders. However, he demonstrated that international politics actually “illustrates the persistence of the nation-state as the aspirational forum for humanity until recently” (Moyn, 2010, p. 212). He argued that human rights discourse came to occupy a space left derelict by the fall of other projects to establish utopias such as communism, pan-Africanism and nationalism. On this account, human rights only adopted a truly global outlook, regardless of its universalist language, in 1977 at the start of Jimmy Carter’s presidency and when Amnesty International won the Nobel Peace Prize. More recently, Moyn (2018) has asserted that the human rights movement has arisen alongside an increasingly international and deregulated economy and done little to challenge the growing economic inequalities that characterise neoliberal capitalism. Although there has been significant criticism of Moyn’s empirical and normative claims about human rights (Alston, 2013; Blackburn, 2011; McCrudden, 2014), his account illustrates the precarious development of moral norms alongside entrenched power relations and vested interests.

Other challenges focus on the Eurocentrism of human rights. The American Anthropological Association expressed concern in 1947 that the UDHR might privilege values prevalent in America and Western Europe (Engle, 2001). The moral and political ideologies of human rights are often seen as another process where dominant nations impose value systems and institutions on the rest of the world. It has been further argued that the unfulfilled goals of human rights’ universalism relate to these prescriptions being seen as a form of

postcolonialism (Matua, 2002). These criticisms are important but they do not neglect the emancipatory aims of human rights (Gaita, 1998), deny the heterogeneity of non-western values (Sen, 1999) or discard cross-cultural normative claims as arbitrary altogether (Bonnet, 2015). In fact, activists in many countries across the globe have made use of human rights to advance agendas relating to welfare and social justice (Ignatieff, 2001). However, the challenge of theoretical systems that have evolved in one social environment being uncritically exported to another is not unique to human rights. In particular, the interventions of clinical psychology, predicated on models of health developed in the global north, have increasingly spread to other countries as non-western systems have become globalised (Fernando, 2017).

1.3. Clinical Psychology

Constructing a history of the broader discipline of psychology, from which clinical psychology arose, presents a number of challenges (Danziger, 2013). Like the human rights movement, Danziger (2013) argued that there were no uncontroversial proposals for unification and that psychology could be characterised by disagreement rather than assent. While acknowledging the force of this argument, it will be argued that continuity can be traced through the foundations of psychology. The systematic scrutiny of human nature, or the individual human mind, understood in mechanistic terms will be shown as the hallmark of psychology from which clinical psychology emerged.

1.3.1. The Foundations of Psychology

Stenner (2004) stated that the roots of psychology bear a relation to the changing ideas of natural law discussed in the previous chapter. The subject matter later called psychology emerged around the modern rebirth of natural rights and the weakened influence of Christianity in European culture. Rights were now considered to reside in each individual prior to and outside of their involvement in any specific community or society (Stenner, 2004). Stenner claimed that natural law had previously been established by the authority of the church. As that authority diminished, the grounding of morality was articulated in terms of human nature and the philosophical tradition of natural rights emerged. These studies of human nature were self-consciously scientific and, therefore,

resembled modern day psychology. What is crucial about Stenner's contention is that these psychological theses provided the groundwork and legitimacy for political proposals. Philosophers as varied as Descartes, Spinoza, Hobbes and Hume elaborated theories about the passions, affects, appetites and imaginations of humans as a prelude to their thoughts about the political order (Stenner, 2004). Therefore, psychology, with roots in seventeenth century natural philosophy, was inextricably bound up with the articulation of rights and the justification of a political order.

Richards (2010) has demonstrated that although there are discernible elements of theorising consistent with modern-day psychology, the questions posed in the 18th century were markedly different. He suggested that questions concerning the nature of the immortal soul, the substance of the mind or how to master the passions represent continuities only because they demonstrate a form of reflexive discourse about human nature. According to Richards (2010), this reflexive discourse did not develop into psychology before 1850 because the methodologies of the scientific revolution were not used to clarify common-sense psychological categories and the unitary mind had not crystallised in western thought. Psychology was also undoubtedly influenced by evolutionary thinking which provided a particular way of viewing humanity's place in world (Richards, 2010). Pilgrim (2008) has shown how the discipline still bears the legacy of the discriminatory way in which these writings were interpreted in relation to gender, class and ethnicity. In this context, "beliefs and behaviours that were deemed unacceptable and alien to polite (white-European) society became symptoms and pathologies in models of illness or formulations of deviance concocted by doctors ('alienists' and 'mad-doctors', later called psychiatrists) and clinical psychologists" (Fernando, 2017, p. 5).

1.3.2. Applied Psychology

Applied psychology developed alongside a western cultural notion of pathology and drew little from other cultural traditions. Distressing thoughts or feelings that might have been considered the domain of religion were increasingly seen as a matter of health (Fernando, 2017). Rose (1985a) has illustrated how during that period of liberalism the sovereignty of the individual was a central political value. The self was viewed as having a deep interiority that was fundamentally

psychological and could be understood, and importantly managed, by the scientific technologies of the growing discipline. In this context, the management of psychological existence became one of the central ethical demands of the time (Rose, 1998), not just confined to the cultural elite but something that permeated the whole of society (Thompson, 2006). The existence of psychology as complex of discourses, practices and authorities used in schools, clinics, factories and the army provided the basis for the development of applied and clinical psychology (Danziger, 1990; Rose, 1985a). The prominence of the scientific method gave rise to the possibility of new socio-political structures for the administration of knowledge and expertise about human well-being. Biomedical ways of understanding lived experience came to dominate. Although madness can be seen as a transcultural phenomenon, the extent of reductionism and medicalisation was peculiarly western (Fernando, 2014; Pilgrim, 2014a).

During this time, when individualistic, scientific and Eurocentric ideas dominated, psychology started to professionalise. The official beginning of psychology in Britain can be traced back to the Psychological Society in 1901 which added the prefix British in 1906 to avoid confusion with another group named The Psychological Society (Newnes, 2014). The aim of the British Psychological Society (BPS) was to advance scientific psychological research and to improve working relations between investigators specialising in different branches of psychology (Hall et al., 2015). Hall (2007) has noted that the way that the BPS functioned was central to the development of clinical psychology in Britain. It was initially comprised of the educational, industrial and medical sections (Hall et al., 2015). At the beginning, membership was reserved for people who were recognised as having taught or published work in psychology that had particular value.

In the 1930s the BPS set up the “Professional Status Committee” which led to the establishment of a professional register. At this stage the BPS was still both a learned society and maintained an open membership (Hall et al., 2015). A significant step in the BPS’s history came in 1941 when it became legally incorporated as a limited company because this was a necessary first step towards obtaining a Royal Charter (Jackson, 2018). This initiated a governing

body of elected officers and representatives of the three sections, as well as editors of relevant journals, which made decisions regarding communications with outside bodies (Hall et al., 2015). One year after the BPS became a limited company, Hall (2007) has noted that the first recorded meeting for a group practising psychology took place. At that time, the meeting was comprised exclusively of educational psychologists and it was suggested that they form a group in the BPS. The BPS Council agreed to set up that group in 1943 as a committee that would be subordinate to the Council and have no direct representation from it. This became known as the Committee of Professional Psychologists, Mental Health (CPP (MH)). The CPP (MH) assumed responsibility for professional aspects of the work of all psychologists then working in child guidance, education or health settings. While most of these psychologists were identified as educational psychologists, other early members of the CPP (MH) were identified as lay child psychotherapists and play therapists at the Tavistock Clinic. This happened in the context of increasing professional specialisation and the valuation of science to solve social problems. This fertile ground, built on the legacy of British empiricism, laid the foundations for the scientific method that would become prevalent in clinical psychology (Pilgrim & Patel, 2015).

In 1958 membership of BPS was closed and reserved only for those who had a recognised qualification in psychology. A Royal Charter was finally obtained in 1965 when the president, Donald Broadbent, made an application to the Privy Council (Jackson, 2018). This gave the BPS the right to be consulted on a range of government issues and protected the title of its membership (Hall et al., 2015). Today, the BPS is recognised as the professional membership which sets standards for psychologists, provides support for its members throughout their careers and promotes the public understanding of psychology (Jackson, 2018). However, one of the most crucial aspects in the development of clinical psychology happened in the context of evolving demands in a nationalised health service (Pilgrim, 2010).

1.3.3. The Birth of Clinical Psychology and Legal Reform

The Beveridge Report published in 1942 proposed reforms to the systems of social welfare and it became increasingly clear by 1944 that legislation for a

national health service was imminent. By the time the National Health Service (NHS) Act passed through Parliament in 1946, members of the CPP MH knew that they needed to engage with these structures. The concurrent development of clinical psychology with the NHS was different from older health professions such as nursing and medicine (Pilgrim, 2010). From the start, clinical psychology was uniquely shaped in response to the demands of the world's largest publicly funded healthcare provider. The right to the highest attainable standard of health is partly secured through the principles of services that should be comprehensive, universal and free at the point of delivery (Weait, 2013). Although the profession developed in this context of welfarism, that has much in common with the philosophy of human rights (Weait, 2013), it was also shaped by other social processes.

Clinical psychologists often worked under particular legal and regulatory constraints depending on the client group they were treating (Hall, 2007). The mental hospitals in which psychologists worked were regulated by the 1930 Mental Treatment Act where patients could be defined as legally insane by a magistrate without seeking the opinion of a psychiatrist. The mental deficiency hospitals were regulated by the Mental Deficiency Acts of 1913 and 1927. Patients under both of these Acts of Parliament were overwhelming poor and their position was created by social rejection arising from perceived burden or threat (Pilgrim & Patel, 2015). Burton and Kagan (1983) argued that giving relief to the able-bodied poor in the same way would have undermined labour mobility and the market which would have forced wages up. In this way, the segregation of those deemed insane in asylums may have contributed to the development of free-market economy at this time (Burton & Kagan, 1983). Medical supervisors had formal responsibility for all of the patients and, therefore, had enormous legally sanctioned power. Kelly (2016) has argued that the absence of mental health from human rights discourse throughout this period was related to different factors, including the lack of a clear definition of mental illness, the paucity of effective treatments and the exclusion of those with mental health difficulties from most forms of political and societal participation.

Over the next few years, psychologists achieved recognition as a graduate level profession. In 1957 the Ministry for Health recognised the first three training

courses in clinical psychology at the Tavistock Clinic, the Institute of Psychiatry and the Crichton Royal Hospital (Pilgrim & Treacher, 1992). In 1959 the Mental Health Act passed, which repealed previous legislation, and enabled institutions to develop more community-oriented services which had already started through individual initiatives since the 1930s (Hall, 2007). At this point in time, the CPP MH had now achieved a formal position within the NHS and as a Division within BPS (Hall, 2007).

1.3.4. The Development of Clinical Psychology

The handful of clinical psychologists emerging around that time were predominately located in settings dominated by psychiatry. Any scientific authority derived from proficiency at psychometric testing was no challenge to the institutional power of their medical colleagues (Pilgrim, 2010). Despite concerns that therapy was too value-laden to be properly scientific, clinical psychologists gradually moved into the traditional medical territory of treatment (Pilgrim & Treacher, 2002). The Trethowan Committee was set up to explore the role of clinical psychologists in the NHS in light of these increasing responsibilities. The Trethowan Report in 1977 sought to establish more independence and autonomy for psychologists. Another key step in the development of the profession was in response to the shortage in trained clinical psychologists in the NHS. Accordingly, the Manpower Planning Advisory Group (MPAG) was commissioned by the Department of Health to review clinical psychology in the UK. The MPAG commissioned a report from the Management Advisory Service (MAS). The Review of Clinical Psychology Services identified the core competencies of clinical psychologists and emphasised the scientist-practitioner model of training (MAS, 1989). It highlighted the now familiar stepped care framework of intervention at various levels with an increasingly sophisticated understanding and application of various psychological theories. Importantly, various disciplines in healthcare could make use of psychology in this way but the report placed clinical psychologists as being most suitable for intervention at the highest level. The value of clinical psychologists was in their unique application of psychological skills learned through a scientific model of training (Division of Clinical Psychology [DCP], 1994). Subsequent documents highlighted core competencies that included delivering therapy, conducting research,

communicating to varied audiences and improving service delivery (DCP, 2010). However, Pilgrim (2010) has shown that clinical psychology was still very dominated by a particularly reductionist view of science that had largely ignored more interpretive forms of scientific endeavour. The challenge is that clinical psychologists research and engage with human experience that exists in dynamic and open systems (Pilgrim, 2010). Clinical psychology theory has implicit ideas about people and their social worlds and, therefore, is entangled with ethics and ideology.

1.3.5. Clinical Psychology, Equality and Justice

The diverse activities of clinical psychologists have different implications for the discipline's relationship with human rights. While the values of clinical psychology are connected to those of human rights (DCP, 2010), psychological knowledge has continued to be used in ways that sustain inequalities and violate human rights law. For example, psychology has been used to justify the eugenics movement (Pilgrim, 2008), develop enhanced interrogation techniques, that could constitute torture, (Harper, 2004; Patel, 2003) and, more recently, frame structural failings of unemployment as individual psychological deficits (Friedli & Stearn, 2015). Patel (in press) has argued that clinical psychologists often overlook how their practices may breach human rights by pointing their finger at the failings of psychiatrists.

Patel (2003) has maintained that human rights violations require the foundations of social and structural inequalities, marginalisation, exploitation and the abuse of power. There is increasing evidence that these social factors, especially adverse experiences in childhood, social disadvantage, poverty and inequity are related to mental health difficulties (Friedli, 2009; Rogers & Pilgrim, 2003; Rogers & Pilgrim, 2013; Smail, 2005; Wilkinson & Pickett, 2009). However, social inequality has always been peripheral to the theory of clinical psychology (Boyle, 1997). Boyle (2011) insisted that clinical psychology had not engaged sufficiently with social context because it threatened its professional identity and its status as a scientific discipline concerned with apparent social and political neutrality.

The marginalisation of social context has led to an individualism in the theory and practice of clinical psychology (Smail, 2005). Ignoring the political context of distress has caused theories and practice in clinical psychology to emphasise individual responsibility for psychological health (Smail, 1993). A focus on alleviating individual suffering and distress, while important, has stunted the potential contribution that clinical psychology can make to understanding the continuation of injustice, inequality and human rights violations (Patel, 2003). There are also important ethical questions about the continued use of individual treatments to alleviate the psychological impact of adverse social conditions. From this perspective clinical psychology does not challenge the political order (Boyle, 1997), and in so doing tacitly endorses the continued violations of human rights (Patel, 2003).

There are, however, pockets of practice that explicitly endorse a more socially orientated vision for clinical psychology. Recently, there have been calls in the profession to move beyond individual treatment and start to develop a more comprehensive preventive approach to psychological distress (Harper, 2017b). Clinical psychologists have identified the promise of community psychology (Smail, 1994), liberation psychology (Afuape, 2011), and activism to develop a more ethically responsive profession (McGrath, Walker & Jones, 2016). For all their differences, these approaches all emphasise the importance of clinical psychologists working in a more systematic manner to address avoidable injustice in the world and endorse a commitment to focusing resources towards those who are structurally disadvantaged in society. There are also clinical psychologists in the UK who explicitly use a human rights framework in their practice (e.g., Greenhill & Whitehead, 2011; Patel, 2011). However, the relationship between human rights and mental health has a complex history (Hunt & Mesquita, 2006), and its relevance to the theories and practice of clinical psychology necessitates further exploration.

1.4. Human Rights and Clinical Psychology

The most recent iteration of the “Core Purpose and Philosophy of the Profession” uses very similar language to that found in human rights instruments. It describes clinical psychologists’ work as being “based on the

fundamental acknowledgment that all people have the same values and the right to be treated as unique individuals” (DCP, 2010, p. 2). Kinderman and Butler (2006) argued that psychological theory could support the promotion of human rights by reducing the gap between the law and everyday practice. However, there still remain pertinent questions about the extent to which clinical psychology as a discipline has advanced people’s human right to health (Patel, 2003). For many years, the human right to health was similarly overlooked by the international human rights community (Hunt, 1996). This started to change in the 1990s with a growing recognition of the importance of securing economic, social and cultural rights in relation to public health developments in the prevention of disease (Hunt, 1996). However, Hunt (2016) has argued that the human right to health remained under theorised as a result of its relative neglect in comparison with civil and political rights. In many ways, this relative neglect was most clear in the relation to mental health (Gostin & Gable, 2004). This section will explore how health has been understood across instruments relating to human rights. It will conclude by questioning how the content of the human right to health relates to the practice of clinical psychology.

1.4.1. The Human Right to Health in History

Tobin (2012) has argued that numerous civilisations have had an awareness of the need for collective action, humanitarian, economic or political, to address the health of individuals. However, the precursors to the UDHR did not contain any references to health. A growing awareness of the importance of health in international law can be traced to the distinctive philosophy of rights that developed in Latin America (Tobin, 2012). Tobin (2012) demonstrated how these constitutions placed much greater emphasis on the economic and social entitlements of the poor and working classes. However, Tobin (2012) also cited the importance of the strategic role that health played in efforts to maintain global peace through the League of Nations following the First World War. The Health Organisation and the Office International d’Hygiene Publique, that were later subsumed into the WHO, looked beyond epidemics and considered non-communicable diseases, housing, malnutrition and physical fitness within the remit of public health (Tobin, 2012). The first mention of health, relevant for illuminating the current understanding of health in international law, came from The Constitution of the WHO which stated the following:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. (WHO, 1946, p. 1)

The ideas contained in this definition continued to shape the WHO's definition although the UN treaty system managed to also avoid some of its vague terminology by excluding reference to words such as complete, social and well-being (Marks, 2013). Two years later, a reference to health was included in Article 25 of the UDHR:

Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (UN, 1948).

Morsink (1999) examined the challenge of arriving at a precise agreement about the content of this particular article. One of the key considerations was the number of different areas covered in Article 25. Merging the right to medical care into an article with a list of other items, left the obligations associated with the rights more ambiguous and open to differing interpretations (Morsink, 1999; Toebe, 1999). The vagueness that surrounds Article 25 was resolved in the drafting of Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) which simply stated that "the States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (UN, 1966, p. 1). Marks (2013) has noted that a salient feature of this definition was that it went well beyond healthcare and offered a positive definition of health. In this way, it borrowed significantly from the WHO's constitution even though a leadership change in 1953 meant that during the drafting of the ICESCR the WHO were more concerned with treatment as opposed to social medicine (Marks, 2013).

Variations on this commitment to the human right to health in international law can also be found in other major UN treaties (Toebe, 1999).

1.4.2. The Content of the Human Right to Health

The human right to health is notoriously complex and it is important to operationalise it precisely in order to make sense of its counterpart duties (Hunt & Mesquita, 2006). Any theory of human rights is grounded in a plurality of interests as demonstrated earlier. Tasioulas and Vayena (2016) showed that the right not to be tortured is grounded in one's interest in autonomy, freedom from pain and desire to form relationships built on trust. They argued that the right to health is not just grounded in our interest in health, but also in the interests that being healthy allows one to realise such as having a family, or being able to accomplish certain personally meaningful goals. General Comment 14, by the Committee on Economic, Social and Cultural Rights, affirmed that the right to health is not a right to be healthy. Instead, it has been interpreted as placing obligations on duty-bearers to facilities, services and conditions that are conducive to the realisation of physical and mental health (Hunt & Mesquita, 2006). This framework outlined freedoms, entitlements, non-discrimination, participation, monitoring and accountability as core elements of the right to health.

Both the WHO's definition and General Comment 14 include the social determinants of good health, such as housing, employment, environmental safety, education, economic development and gender equality. However, Tasioulas and Vayena (2016) have argued that the human right to health has been interpreted in ways that are overly inclusive. These other human rights should not be included as they are specifically protected by other mechanisms and such interpretations result in health becoming too broad to be operationalised coherently (Toebe, 1999). Jamar (1994) has maintained that some aspect of the human right to health must remain distinct from other human rights for it to have meaning. There will be some overlap between different human rights in certain cases but the human right to health would be too burdensome to operationalise and monitor if it absorbed all rights that had a positive bearing on people's health (Tasioulas & Vayena, 2016). These theorists maintain that the normative content of the right to health should be confined to

obligations regarding health services and some public health measures that are not already covered under other human rights. The place of mental health in the human right to health also demands attention.

1.4.3. A Human Right to Mental Health?

A corollary of the argument above is that clinical psychologists, and other allied health professionals, adopting a human rights framework to promote mental health need to focus on the range of human rights instruments and not just the right to health. Securing people's human right to mental health may necessitate securing their human rights to other goods (such as political participation, education and equality before the law) that are not primarily justified by their interests in mental health. It underlines that human rights are interdependent, indivisible and interrelated and that a violation of one right can impair other rights (Patel, in press). For example, Patel (in press) has shown that violating a person's access to healthcare can impair a person's engagement with education, leading to poverty and exclusion that can further impair their health.

In the ICESCR, both physical and mental health are defined in a positive way under the same article. Health, viewed in this way, is defined as the effective functioning of the standard human physical and mental capacities (Daniels, 2008). Keller (2017) has argued that our understanding of what constitutes proper functioning is less clear for the human mind than the body. Daniels contended that bodily health is achieved when the parts of body perform their functions well. Examples include when the heart pumps blood around the body efficiently or the lungs and associated muscles contribute to perform gaseous exchange. However, it is more difficult to determine the proper function of the human mind, and the purpose of our thoughts, feelings and beliefs (Keller, 2017). The WHO have proposed one way of defining positive mental health as:

A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. (WHO, 2004, p. 59)

Wren-Lewis and Alexandrova (in press) have shown that this positive definition of mental health has roots in WHO's constitution about health being more than an absence of disease. On this account it is not enough to be free of a mental disorder, you also need to flourish in your community (Wren-Lewis & Alexandrova, in press). However, this definition proposes an overly ambitious notion that good mental health is realised by coping with stress, working productively and making a contribution to the community. Failing to realise these potentialities may not represent a problem with an individual's mind but the actual job market (Friedli & Stearn, 2015), or the resources needed for civic participation (Savage, 2001). Keller (2017) has contended that positive conceptions of mental health always express a moral or political ideal about how people should live and relate to each other. Therefore, any vision of the highest attainable standard of mental health may be specific to different ideologies, religions and cultures. This will involve disagreement about what constitutes true mental health and, therefore, require a process of meaningful public deliberation.

1.4.4. Relevance to Clinical Psychology

Mental health should be a concern of distributive justice and there are sound reasons to consider that we have a right to good mental health (Keller, 2018). The common and historical use of the phrase mental health tends to be synonymous with professionals and services that are associated with the diagnosis and treatment of people with mental disorders (WHO, 2001). This document also argued that any conception of mental health also encompassed the promotion of well-being and the prevention of mental disorders (WHO, 2001). Patel (in press) has outlined key principles that are relevant to applied psychologists. Drawing on those ideas, four broad areas are identified where human rights are considered relevant to the practice of clinical psychology.

1.4.4.1. *Mental Health Services*: Services are increasingly focused on technical, short-term therapies designed to facilitate service users' recovery (Bracken & Thomas, 2005, Harper & Speed, 2012; McGrath & Reavey, 2016). In addition, service users in secure settings are also subject to involuntary treatment on the grounds of medical necessity or danger and are subject to conditions that make coercive practices more likely (UN, 2017). Rose (2019) has pointed out that the

vast majority of people who might be eligible for psychological treatment do not access services. This argument may overestimate the prevalence of distress because of overly sensitive survey instruments or reflect an increased awareness and recognition of mental health in society. However, it may also be the case that the contexts where clinical psychologists train and work, as they are currently designed, do not meet the human rights standards of being available, accessible, acceptable or of sufficiently good quality.

1.4.4.2. Non-Discrimination and Attention to Vulnerable Groups: Clinical psychologists often work with people who have faced discrimination in services and society. Multiple aspects of social identity are important to consider when elaborating how human rights are relevant to mental health. These include the different social locations that people occupy because of gender (Boyle, 1997), employment status (Friedli & Stearn, 2015) or class (Pilgrim & Rogers, 2003). It is important to consider how demographic variables interact with accessibility, quality of care and the likelihood of abuse in clinical psychology services. A key indicator in this respect is racial inequality in the mental health system where clinical psychologists work (Fernando, 2017). Patients from minority ethnic groups are consistently overrepresented in compulsory orders under the Mental Health Act (Szmulker, 2018). In addition, there is evidence that schizophrenia is a particularly racialised diagnosis, affecting black men in particular (Fernando, 2017). People from minority ethnic communities continue to face discrimination outside mental health services in employment, housing and the criminal justice system (Griffiths, 2018). This is happening in the context of an increasingly hostile environment as a consequence of the 2014 Immigration Act which has meant that not everyone in the UK can exercise their right of free access to primary care.

1.4.4.3. Participation and Inclusion: General Comment 14 stated that “a further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels” (UN, 2000). The service user or survivor movement offers an authoritative perspective on participation in mental health. Those who identify as having used or survived services have made significant contributions to research and delivery in mental health (Dillon, 2010; Longden, 2013; Longden, Corstens &

Dillon, 2013; Rose, 2003). In addition, this scholarship has challenged the authority of professional conceptions of mental distress and recovery (Campbell & Rose, 2010). An ongoing issue for the mental health community is the extent to which the testimony and research of service users is taken seriously. Those in minoritised social positions can be subject to credibility deficits owing to social prejudices (Fricker, 2007). Mental health service users are particularly vulnerable to this kind of epistemic injustice given negative stereotypes about mental illness (Crichton, Carel & Kidd, 2017; Kurs & Grinshpoon, 2017). This can result in service user consultation being little more than a technology to legitimise managerial decisions (Harrison & Mort, 1998). Service user involvement represents an alternative to the power and knowledge base of clinical psychology that can scrutinise whether its professed commitment to human rights translate into everyday practice.

1.4.4.4. The Social Determinants of Mental Health: As explored previously, mental health is partly socially determined with mental health outcomes strongly related to patterns of poverty and forms of discrimination. Securing individuals' right to mental health depends on addressing how the health of socially disadvantaged groups is related to exposure to environmental risks and resources (UN, 2017). More recently, the UN (2018) stated that "addressing societal and community-level concerns can improve the mental health and well-being of all people" (p. 14). As discussed above, some have argued that the normative content of the right to health should not include the social determinants of mental health. Therefore, realising people's right to mental health might necessitate promoting numerous interdependent human rights outside the usual role of clinical psychologists. These social determinants arise and continue outside the control of mental health services, meaning that treatment for the adverse psychological impact they have on individuals may be redundant (Pilgrim, 2018). Engaging with human rights raises important questions about whether clinical psychologists should address the well-being of the population by moving beyond individual therapy to prevent the root causes of mental distress.

1.5 Rationale

This opening chapter has sought to demonstrate how the practice of clinical psychology is connected to the forms of political, legal, and social injustice that human rights morality and law seek to prevent. The closing section of this chapter will explore why this research is being carried out and what specific questions will guide the study.

1.5.1. Justification

Psychology is a moral science (Brinkmann, 2011), and it has been argued that human rights and clinical psychology share similar values (Butchard & Greenhill, 2015; Kinderman, 2007). However, clinical psychology has not engaged consistently with human rights obligations (Patel, 2003). A central claim in this study is that clinical psychologists have both moral and legal obligations to engage with human rights and, therefore, this relationship needs to be understood in greater detail. Viewing human rights primarily as ethical claims is more relevant to the practice of clinical psychology because it highlights their significance in the everyday interactions in mental health services. This argument underlines the importance of Eleanor Roosevelt's claim that securing the global aims of human rights requires concerted action from citizens in local contexts (Roosevelt, 1958). This moral imperative is codified in UK law such that the state and public authorities have a legal responsibility to respect, protect and fulfil people's human rights. The HRA provides guarantees that all staff working for the NHS, or for bodies carrying out public functions, have individual human rights but are also seen as being duty-bearers.

Patel (in press) has stated that governance structures in psychology often fail to adequately address human rights principles. This can lead to inadequate monitoring and processes of accountability where potential or actual breaches of human rights occur (Patel, in press). Hagedaars (2016) has argued that psychologists who believe psychology should more actively protect and promote human rights have argued for explicit references to human rights in the ethical codes of psychologists. The instantiation of human rights in documents relating to the practice of psychologists has rarely been the focus of discussion or critique (Gauthier, 2018), and the influence of legislation on clinical

psychology has not been researched (Patel, in press). The methodologies of the natural sciences have dominated the profession almost since its inception (Pilgrim & Patel, 2015). The scientific advances in the profession and outside continue to deliver important evidence about the relationship between health and human rights. These include the effectiveness of clinical interventions, access to services, experiences of involvement in services and the social determinants of mental health difficulties. However, science is one value amongst many (Midgley, 1992), and there are questions in relation to clinical psychology that also demand ethical consideration. Looking at the relationship between human rights instruments and clinical psychology affords an important perspective on distinctly ethical aspects of the profession within a scientific framework. A fuller understanding of clinical psychology's relationship with human rights is necessary to understand professionals' obligations towards others and the profession's position in a liberal democracy.

1.5.2. Aims and Research Questions

Harper (2017a) has argued that wider definitions of clinical relevance should be incorporated into clinical psychology research. This current study aims to focus on the moral dimensions of clinical psychology through the duties associated with human rights. The research will focus on clinical psychology as a whole rather than the human rights dilemmas that are pertinent to particular specialities such as those working with people with learning disabilities, children and young people or older adults. Just as the scientific method is seen as relevant for all clinical psychologists, this research maintains that the moral and legal norms of human rights have relevance across all practice in the profession. This broad focus will be achieved through an exploration of the extent to which human rights have been instantiated in policies and professional guidance relevant to clinical psychology in the UK since the UDHR in 1948.

The relationship between the profession of clinical psychology and human rights will be explored. Explanations for these patterns will be developed before critically evaluating the relevance of human rights principles and practice for the future of the profession. The following questions are proposed to guide the research:

- What is the nature of the relationship between clinical psychology and human rights?
- What were the historical conditions that could explain the relationship between clinical psychology and human rights?
- What are the implications of engaging more with human rights for the training, practice and research in clinical psychology?

1.5.3. Implications

This research can contribute to understanding mental distress less in terms of individual pathology and more as a response to relative deprivation, social injustice and the violation of fundamental human rights (Friedli, 2009).

Understanding how human rights and clinical psychology have related to one another over time may generate new areas of inquiry that could have a bearing on the training, practice and research in clinical psychology. It may be argued that an exploration of human rights is more relevant in disciplines directly concerned with medicolegal jurisprudence, bioethics, political science or international development than clinical psychology. However, this study contends that interdisciplinary knowledge is crucial to understanding the complex relationship between human rights and mental health and underlying the current research is a conviction that at the very least human rights are not incompatible with the theory and practice of clinical psychology. In fact, human rights offer a particular way of thinking about mental health that reflects its ethical and political dimensions.

2. METHOD

This chapter starts by outlining the ontological and epistemological commitments orienting the research. An initial argument defends the view that understanding mental health and human rights demands attention to both realist and constructionist positions. It will then be demonstrated why document analysis has been considered the most suitable procedure within this framework to answer the research questions. The ongoing ethical awareness necessary in research will provide a means to explore the various dilemmas that may emerge during the process. The chapter will close by examining how my social position, values and world view may have influenced the research up to this point.

2.1. Methodology

2.1.1. Background

While the distinction between methodology, methods and epistemology can become blurred in qualitative research (Carter & Little, 2007), Chamberlain (2015) has argued that the methodology is the framework underlying the plan of action for conducting the research. Often research in clinical psychology does not include discussions of epistemology (Harper, 2017a). Whether or not these are made explicit during the research process, all researchers have assumptions about the world that guide research agendas, practice and conclusions (Chamberlain, 2015). Methodology and epistemology often influence one another, and sometimes might be incommensurable (Carter & Little, 2007). For example, epistemology also influences clinical encounters because a psychologist's understanding of people and systems often relate to their preferred theoretical orientation (Harper, 2017a), and method of intervention (Papadopoulos, 2001).

Following the postmodern turn, researchers have also begun to recover a serious concern for ontology (Pilgrim, 2014b). The focus on discourse and deconstruction was useful to question the truth claims of traditional psychology. However, Parker (2002) acknowledged that focusing solely on epistemology

can collapse into a form of discursive idealism in which texts are viewed as being the only objects of knowledge. Furthermore, epistemological positions that view texts as the only source of empirical relevance can actually serve ideological functions that maintain oppression because “they reproduce rather than challenge dominant bourgeois conceptions of academic knowledge as in principle *separate* from the world and as *independent* of moral-political activity” (Parker, 2002, p. 71). In order for research to be politically expedient it must also theorise constructions as being shaped by the possibilities and constraints of the material world (Sims-Schouten, Riley & Willig, 2007). Therefore, critical realism has been adopted in the current research because both epistemology and ontology are considered important for exploring the historical and material conditions that have influenced human rights in clinical psychology.

2.1.2. Critical Realism

Bhaskar (1978) developed a systematic transcendental realist account of science with the central contention that the nature of reality cannot be reduced to human knowledge of reality. Critical realism is the name now used for this philosophical framework that steers a middle course between positivism and strong versions of social constructionism (Pilgrim, 2014b). Subsequent researchers have applied these ideas to debates in the social sciences (Archer, 2010; Porpora, 2015), and mental health (Pilgrim & Bentall, 1999; Pilgrim, 2014b). More recently, Patel and Pilgrim (2018) have shown that critical realism is a useful resource for highlighting the complexities of psychologists working with people who have experienced human rights violations associated with torture. Critical realism allows a questioning approach to be taken towards what counts as knowledge in the discipline of clinical psychology (Pilgrim, 2014a). It affords a framework for asking questions about whether the ideological bases of clinical psychology, with a strong emphasis on quantitative research and evidence, limit certain questions being asked in research. Although critical realism does not deny the importance of epistemology for researchers, it asserts the primacy of ontology for analysis and discussion (Pilgrim, 2014b). The existence of the world is viewed as independent of human attempts to grasp the nature of reality. This is because, in some senses, understanding the world is always mediated by current historical and sociocultural ideas. However, within critical realism there is still a place for the role of theory to improve our

understanding of the world. Although ideas need to be contextualised by time and place, some accounts are more rationally compelling than other accounts. Therefore, researchers need to exercise judgemental rationality in order to appraise which explanations best fits with the available data.

Ontological realism, epistemological relativism and judgemental rationality comprise the triad of claims that determine critical realism's unique contribution to scientific inquiry (Pilgrim, 2014a). There are specific advantages to using critical realism to explore the relationship between clinical psychology and human rights. Reality is viewed as being differentiated and stratified which allows researchers to attend to both meaning and causes (Pilgrim, 2014b). At the transitive dimension events are mediated by experience and, therefore, involve some level of interpretation (Bhaskar, 1978). However, critical realism also posits an intransitive dimension where events occur, beyond human experience. Causal laws and patterns of events characterise this level of reality which is part of the same reality as the transitive dimension. The primary goal of a critical realist analysis is achieved by referring to this stratified reality that includes a consideration of the influence of causal mechanisms (Fletcher, 2017). However, Chamberlain (2015) has argued that the distinction between ontology and epistemology is difficult to describe and maintain in practice because discussions about one inevitably slide into a discussion of the other. The challenge, then, for critical realist research is to proceed tentatively with scientific inquiry and attempt to express in thought the structures of things that act independently of thinking (Bhaskar, 1978).

2.1.3. A Tiered Approach

A qualitative methodology was chosen because it affords rich descriptions of phenomena (Harper, 2012), and allowed an investigation into both the meaning that human rights had for clinical psychology and the causes of this relationship. The analysis incorporated a multi-level systemic framework to explore both proximal and distal influences on the politics of clinical psychology (Pilgrim, 2011; Pilgrim & Rogers, 1999). Firstly, the emergence of human rights in clinical psychology was situated in the macro context of world history. This explored how the global context for an emerging moral outlook was expressed in terms of individual human rights and how this came to have relevance for clinical

psychology. It investigated the critical points in history to explain what forces affected how human rights were incorporated into clinical psychology following the UDHR. The meso context explored the role of specific institutions that were developing alongside developments in human rights legislation. This included the beginning of the NHS around the time of progressive optimism about social justice and economic security following the war (Pilgrim & Patel, 2015). The micro level investigated how the projects and pressures internal to the discipline of clinical psychology can explain its relationship to human rights.

2.2. Methods

2.2.1. Data Sources

Different sources were considered for gathering data in the current study. Interview methods are often used to gather data in qualitative research (Potter & Hepburn, 2005). However, the research questions, and any subsequent interview schedule, demand historical knowledge about the profession beyond the core competencies of clinical psychologists. In addition, ethnographic methods were considered too specific to capture the broad focus of the research. In this instance, documents represented the best source for the historical purposes of the research for a number of reasons. Documents are a ubiquitous aspect of the formation and performance of contemporary life (Rapley & Gees, 2018). Bowen (2009) identified two purposes of documentary material relevant to the current study. The first of these is that documents provide important information on the context in which people operate. They give researchers historical insight into specific issues and indicate the conditions that constrain the phenomena under investigation (Bowen, 2009). Bowen (2009) also argued that documents provide a way of tracking change over time. In the current research, this included comparing how the ways in which human rights were instantiated in clinical psychology ethical standards may have evolved alongside wider societal concerns.

2.2.2. Data Selection

Data sources in the current research included official documents produced by bodies that regulate professional practice relevant to clinical psychology in the UK. This included documents from the government, NHS, the BPS, the DCP

and the Health and Care Professions Council (HCPC). Rapley and Gees (2018) maintained that sampling is crucial when working with documents. They have suggested that sampling procedures are inevitably iterative because accessing one document will draw the researcher's attention to more material that should be engaged with. Key sites for this study were the BPS's administrative archives and Senate House Library. Both have substantial archives containing publications, correspondence, reports and working papers relevant to the practice of clinical psychology. The archivists at both sites supported me over a number of weeks and highlighted documents relevant to the study. I also accessed the catalogue at the Wellcome Collection but, unfortunately, relevant collections had not been archived and were not currently available to the public.

Data was included in the analysis if it met the following conditions:

- 1) Is a governmental or professional-body document relating to the practice of clinical psychology in the UK. A document was considered relevant to the practice of clinical psychologists if the profession is mentioned directly. Secondly, a document was considered relevant where it related directly to mental health and where the legal requirements, or legal recommendations, relate to the practice of clinical psychology.
- 2) Was written after the UDHR in 1948.

Data was excluded from the analysis if it met the following conditions:

- 1) Is a legal or professional-body that is not related to the practice of clinical psychology. Such a document does not mention either the professional, or legal or ethical codes of conduct that are relevant to the practice of clinical psychology.
- 2) Was written before the UDHR.

This iterative process developed over the course of approximately one month. These searches revealed that 70 documents met the criteria to be included in the research. Eleven of these documents were unavailable which meant that 59 documents were retrieved. After close reading of these documents, 31 were considered to provide a firm basis for answering the research question (Appendix A). All of these documents were analysed, coded fully and helped to establish the themes discussed in the analysis. However, it was not possible to

include extracts from all 31 documents in the final analysis section of the report. There were a number of reasons for this decision. Firstly, there was not always a change in content between documents analysed. For example, there were almost not editorial changes between the 1977 and 1978 'Ethical Principle for Research with Human Subjects'. In these instances, where possible, the earliest example was included as an extract. Another reason was the professional guidelines for clinical psychologists were prioritised over those of psychologists in general as this was often more appropriate to answering the research question. For example, although the various codes of conduct for psychologists, written between 1985 and 2018, provided rich material during the coding process, they are also written a level of abstraction in order to be relevant for all psychologists. This meant that often documents that were more directly related to the practice of clinical psychology were chosen. This resulted in a final dataset of 15 documents which were included in the analysis and is attached as Appendix B. The flowchart below details the process of refining the dataset.

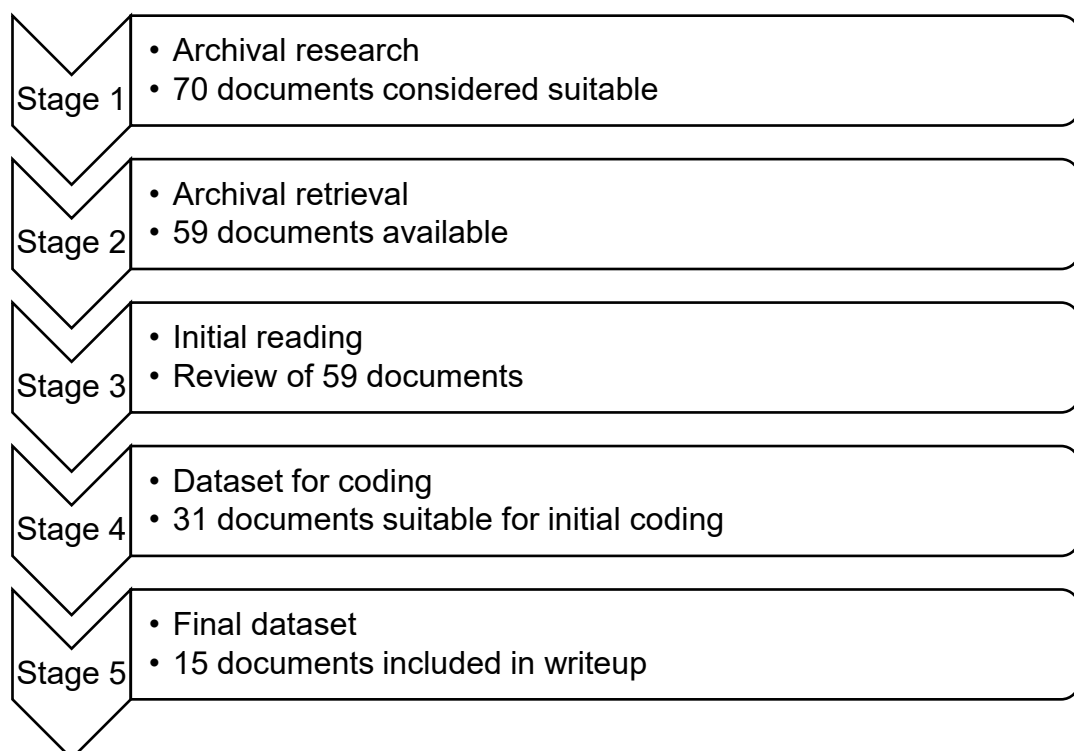


Figure A. A graphical representation of the data collection and selection process that yielded 31 documents for detailed coding to develop themes, of which 15 were presented in the analysis section of the current study.

2.2.3. Data Analysis

The study conducted a qualitative analysis of documents in the public domain relevant to the practice of clinical psychology in order to explore the extent to which they have been influenced by human rights. Rapley and Gees (2018) have argued that a neutral documentary analysis is not possible because documents were engaged with in a specific context and at a specific time. They suggested that there has been a change in social scientific analysis of documents in recent years from solely analysing the content of the document to understanding the ways in which they are used and developed (Rapley & Gees, 2018). This analysis sought to explore the factors that influenced how the documents changed over time because of the specific work they were expected to do in a particular context. The texts were analysed using inductive thematic analysis (Braun & Clarke, 2006). Inductive thematic analysis was chosen, as opposed to a deductive approach, to ensure that the themes identified were closely linked to the data. This method is not committed to a theoretical position and, therefore, allowed novel meanings and implications to shape the results (Braun & Clarke, 2006). The research adhered to the six steps of thematic analysis. After familiarising myself with the documents, I conducted the initial coding (Appendix C). This included giving a name to small extracts of data in the documents.

Following this, I organised the codes into broader themes. I continued to review these themes and named them for the purposes of the analysis (Figure B). This stage of the analysis was more explicitly informed by critical realism. I explored the extent to which the elaboration of professional standards and appropriate activities for clinical psychologists was shaped by wider social factors. The analysis was not motivated by the argument that the frameworks that clinical psychologists were operating under were only mediated by historical and cultural ideas. The professional practice guidelines of clinical psychologists were seen as also reflecting demi-regularities, or somewhat stable patterns across time and culture (Pilgrim, 2015). In this way, the analysis was respectful to the importance of culture but also recognised that the development of the profession was not solely a function of prevailing cultural trends. This approach elucidated both the position of human rights norms with respect to the profession as it developed and proposed tentative reasons for this position.

2.2.4. Ethics

The analysis was carried out on documents in the public domain. Therefore, NHS and University of East London ethical approval in relation to recruitment, informed consent and confidentiality was not required. However, a main contention of this research is that human rights should be the concern of everyone and their promotion not limited to formal procedures or legislation. In a similar way, research involves engaging with ethical dilemmas beyond mandatory guidelines. Brinkmann and Kvale (2017) have argued that ethical questions cannot be settled once and for all before a research project has begun but demand continued sensitivity throughout the process.

Suzuki, Ahluwalia, Arora and Mattis (2007) illustrated that the meaning of texts is not transparent and requires interpretation on the part of the researcher. Willig (2017) has argued that a researcher has a certain amount of power in relation to deciding which aspects of data to highlight, how they are to be understood and the conclusions that can be drawn from them. From a critical realist perspective, this highlights the ethical significance of judgmental rationality in distinguishing between my own assumptions as a researcher and the phenomenon under investigation. Therefore, it was important to provide rationally compelling grounds for prioritising a certain interpretation of the social world. This necessitated approaching the data with a degree of modesty about how much it can reveal and being open to interpreting the data in alternative ways (Willig, 2013). The extent to which the research conformed to these standards will be monitored throughout but evaluated systematically in the concluding chapter.

Parker (2005) has argued that all research serves a political purpose because it either challenges or supports prevailing political, economic and cultural structures that only benefit a proportion of society. Therefore, it was also important to consider and address the wider ethical and political consequences of the knowledge produced by the research (Brinkmann & Kvale, 2017). Clinicians who do not identify as practising within a human-rights framework might read the content in the research as an attack on their practice. Secondly, adopting a critical perspective towards human rights could be read as tacit support for a status quo that arguably legitimises on-going practices of abuse,

discrimination and structural inequality. Some level of controversy and disagreement is inevitable in research that concerns fundamental moral, legal and political principles. I do not expect everyone who reads this work to necessarily agree with the impetus behind this research or the implications that will be drawn from it. Therefore, it is important to perform a rigorous analysis of the data from which credible conclusions can be drawn. This will help ensure that any dissemination of these ideas stimulates an informed debate about the purpose of clinical psychology in society.

2.3. Reflexivity

Pilgrim (2014b) argued that the researcher cannot dispassionately comment on social reality from the outside because the questions, analysis and conclusions are derived from the processes in a particular society. How I influenced and shaped the scientific process as a researcher, therefore, should be considered during the enquiry. This includes the influence of the research question, how the design of the study and method of analysis influenced the findings. Willig (2013) distinguishes between two reflexive positions that invite different questions on the contribution of the researcher. Personal reflexivity involves considering how my “values experiences, interests, beliefs, political commitments, wider aims in life and social identities” shape the research (Willig, 2013, p. 10).

Epistemological reflexivity invites consideration of how my assumptions about the world and knowledge shaped the research.

2.3.1. Personal Reflexivity

Bhaskar (1978) stated that empirical work is mediated, often not consciously, by the limits of our knowledge, the assumptions of the culture and norms in the researcher’s immediate social setting. The consequences of ignoring this cognitive limitation, bias or distortion often result in what Bhaskar calls the ontic fallacy. The idea for this project began with an unease about the neglect I perceived around complex issues of social injustice in clinical psychology. Part of this, no doubt, related to my background studying philosophy and the central place that theories of justice hold in certain branches moral and political philosophy. It also related to the discussions that I have had on training with my cohort, teachers and supervisors about the what it means to say that mental

health, and the professionalisation of mental health practice, is political. Out of these concerns, human rights became an orientating commitment for this research. I believe that I was drawn to human rights in particular because it offers a socially authoritative and morally compelling way of approaching dilemmas in the field of mental health.

An important lesson that I have learnt during training has been the importance of maintaining complexity when trying to understand phenomena in mental health (Papadopoulos, 2007). I have tried to apply this learning both in my clinical work and research. It was important to remain aware that my initial perception that human rights had been neglected in clinical psychology could have limited the analysis. One of the challenges with adopting a critical perspective in this research was to avoid polarisation. I had to make a conscious effort to ensure that the analysis was neither a celebration of clinical psychology's relationship with human rights nor a subversive deconstruction. In order to answer the third research question of where progress may be possible in the future, it was necessary to remain sensitive to the complexity of the profession's engagement with human rights in a way that avoided a simplistic history. I had to let myself be constantly surprised by the data when perhaps it did not conform to my intuitions, or where its conformity was in a way that I had not expected.

Human rights are one way of looking at the world and, therefore, it is necessary to recognise how this might have shaped the knowledge produced about clinical psychology in this research. For example, this approach might presume that the concerns of human rights and justice must be accorded priority over other interests and claims in mental health. Promoting and protecting human rights may be a necessary component of a good clinical psychologist but it may not be sufficient. For example, I might do the right things for my clients, but lack emotional depth or an inability to come alongside their problems, making it difficult to form meaningful relationships in therapy. Therefore, an exclusive focus on human rights-based approaches to mental health care can fall short of fulfilling the aims of improving mental health and well-being.

2.3.2. Epistemological Reflexivity

Pilgrim (2014b) has urged researchers to avoid the epistemic fallacy of presuming that the theorised concepts produced by scientific methods simply describe reality. This occurs when researchers commit the error of oversimplifying the correspondence between the theories in mental health and the experiences they seek to describe. I thought about how the epistemological position that I have adopted in previous research in psychology might have influenced my approach to the current study. I conducted a thesis for my Psychology MSc on masculinity that was heavily influenced by the work of Michel Foucault. Following this, I became interested in constructionist approaches which inevitably made its way into the literature that I have cited in this current study. It is arguable that one key difference between Bhaskar's critical realism and Foucauldian approaches to discourse analysis is that the former emphasises ontology whereas the latter emphasises epistemology (Pilgrim, 2015). On reflection, I recognise that some of the claims I made during my analysis may have been shaped by my prior reading of constructionist approaches to clinical psychology as well as those informed by critical realism.

As discussed in the previous chapter, clinical psychology is a heterogeneous discipline composed of numerous specialities, theoretical orientations and health settings. The extent to which it makes sense to call anything clinical psychology, and hence to understand how it may operate, is achieved in this research through professional documents that serve to regulate and meet the objectives of the discipline. However, documents are not necessarily a precise and complete record of events as they occurred (Bowen, 2009). Therefore, documentary research will inevitably shine a spotlight on particular areas of practice and potentially leave other areas untouched which could have had a bearing on the conclusions. However, the regularities identified in the research can give rationally credible ideas about the generative mechanisms that constitute clinical psychology's relationship to human rights. This underlines the importance of being tentative in my conclusions and the extent to which the knowledge derived from the research may have implications for the profession. It also emphasises the importance of critically evaluating the research which will be considered in the final chapter.

3. ANALYSIS

In this chapter the findings from the documents are interpreted and discussed. The analysis is structured under three broad sections which each contain three interconnected subordinate themes. The initial section describes the profession's ambivalent engagement with human rights. It analyses how the tensions inherent in these documents have caused it to place the interests of the profession and the furthering of science above those of the individual. The subsequent section maps those aspects of human rights that the profession has engaged with in more depth. It examines why these particular rights have been the focus of professional practice in clinical psychology. It then demonstrates how the interdependence of human rights creates dilemmas when only certain rights are considered. The final section elaborates aspects of human rights that the profession has engaged with less but that offer possibilities for the future. The challenges that these avenues of practice have for clinical psychology are also considered.

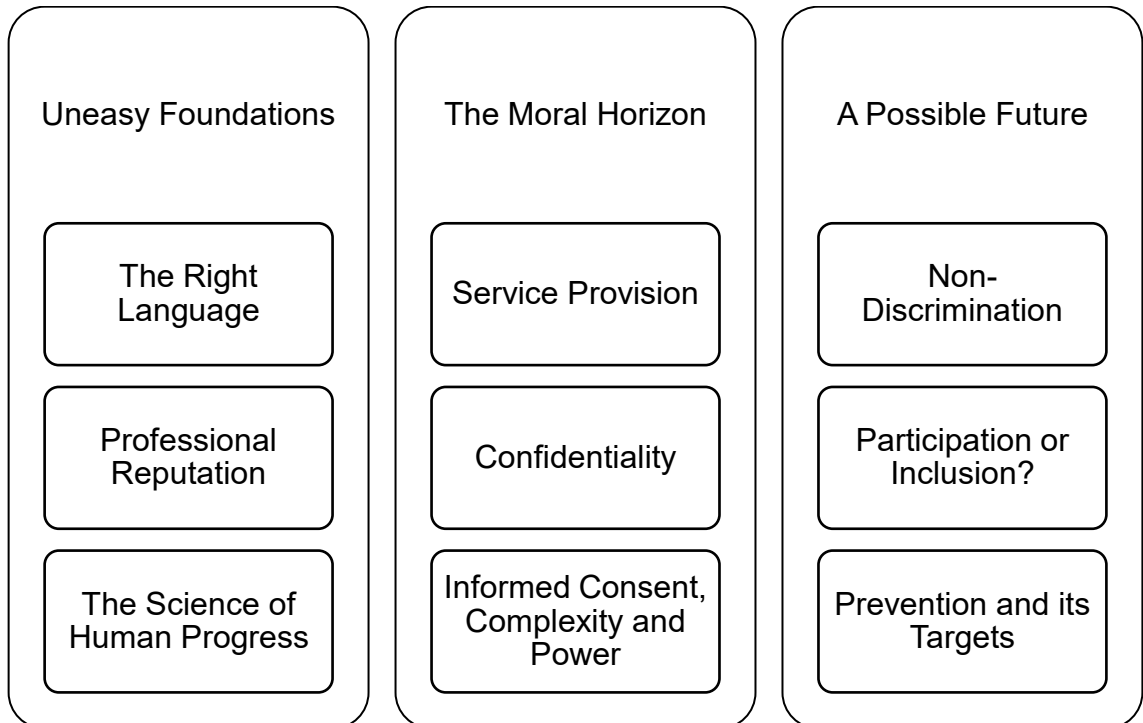


Figure B. An overview of the three main section and three subordinate themes that demonstrate the relationship between clinical psychology and human rights.

3.1 Uneasy Foundations

This section demonstrates how references to human rights in the documents relating to the practice and philosophy of clinical psychology lack coherence, consistency and substance. It explores the tensions between the professional and scientific aspirations of clinical psychology and the ethical and legal obligations of human rights.

3.1.1. The Right Language

In 1973 the DCP published the first guidance specifically aimed at the professional practice of clinical psychology. These guidelines were revised in 1983 and the section below, concerning the political implications of psychological knowledge and practice, represented the first sustained effort to outline the responsibilities of clinical psychologists in relation to human rights.

- 13.1 Psychologists do not condone, use or participate in the application of psychological knowledge or techniques in any way that infringes human rights.
- 13.2 Psychologists refuse to advise, train or supply information to anyone knowing that this individual intends to use the knowledge or skills imparted in such a way that human rights are infringed.
- 13.3 Psychologists refuse to take part in the process of diagnosis where it is apparent that the purpose of this is to limit the individual's scope for political action, whether by hospitalization or some other means, to discredit his or her views or to constitute a form of punishment for political activities.

(DCP, 1983, p. 21)

There a number of significant aspects to these statements. Firstly, the practice of clinical psychology is situated in a wider context and politicised. Clinical psychologists' activities are constructed as having political implications with respect to participation, credibility and punishment. A number of commentators view the negative duties associated with human rights that the passage focuses on as relatively uncontroversial (Litchenberg, 2010). Pogge (2005) has even argued that efforts to end poverty should focus exclusively on the negative

duties of human rights as the requirements of positive duties can seem too onerous. However, Shue (1980) has shown that the distinction between a right requiring either negative duties, to refrain from action, or positive duties, to take action, rests on a false distinction. In this passage ensuring that psychological knowledge and practice is not misused to infringe someone's human rights requires both negative and positive actions. This involves not condoning and participating in the application of illegal practice but also making every effort to ensure that knowledge is not misused. Lastly, it also recognises the clinical psychologist's responsibilities with respect to infringing human rights but does not specify mechanisms by which an individual could be held accountable for those abuses. One could argue that the lack of professional accountability sustained the conditions for the historical abuses of power in clinical psychology.

The principles in these early documents represented "current thinking" in clinical psychology (DCP, 1974, p. 1), with the caution that they should not be regarded as "the final word" (DCP, 1983, p. 1). This first explicit outline of human rights in a professional document relating to clinical psychology could have prompted further discussion in the discipline to elaborate and develop these ideas further. However, subsequent editions of the guidelines published in 1990 and 1995 removed any mention of protecting human rights. The omission of human rights from clinical psychology is common. Discussion usually centres on the words and phrases that have become synonymous with the human rights movement. However, the language remains vague and there was never a specific reference to overarching mechanisms of accountability and process in the profession. The following extracts are from the Professional Practice Guidelines for Clinical Psychologists (1995), and the first edition of the Core Purpose and Philosophy of the Profession, published in 1994.

Clinical psychologists have a duty to provide services which are always in the interests of the client, which are accessible and non stigmatising and which enhance self-efficacy, self-worth and personal dignity.

(DCP, 1995, p. 18)

The work of clinical psychologists is based on the fundamental acknowledgment that all people have the same human value and the right to be treated as unique individuals. Clinical psychologists will therefore treat all clients and colleagues with dignity and respect, and work with them as equal partners towards the achievement of mutually agreed goals.

(DCP, 1994, p. 2)

Both of these documents refer to interests, respect and dignity acknowledging that the same values underpin clinical psychology and human rights. The challenge is that, as previously discussed, dignity and interests ground human rights but should not be identified with human rights (Tasioulas, 2012). A statement of values can become aspirational rhetoric unless these pronouncements are linked to counterpart obligations, clear lines of accountability, an acknowledgement of past wrongdoing in the profession and a clear commitment to change.

There could be number of reasons for this vagueness. Tasioulas (in press) has argued that the corrosion of the idea of human rights, and attendant anxiety about the expansion of human rights, has been in part perpetuated by a confusion between interests and rights in international human rights law (IHRL). The period when the first drafts of these documents were written could also be characterised by political ambivalence about human rights and the extent to which the protections under the ECHR should be incorporated into domestic law. There were a number of unsuccessful attempts through the 1970s and 1980s to introduce draft bills of human rights through parliament (Hoffman & Rowe, 2003). However, in the 1990s there was more support for national human rights legislation, given the work of campaigning organisations and a new government (Feldman, 1993). These external forces can account for some of this ambivalence but it is also important to explore the internal pressures relating the objectives of the emerging discipline of psychology.

3.1.2. Professional Reputation

This section explores a consequence that the professionalisation of clinical psychology had on its relationship with human rights. As discussed earlier,

clinical psychology started to professionalise from 1942 (Hall, 2007). In 1960 the BPS established two separate divisions of professional psychologists in England and Scotland. The rules, outlining the aims of the division, were approved by the BPS Council on 19th March 1960.

3. The aims of the Division shall be

- (a) to promote the highest professional standards in the application of psychological principles to educational and clinical problems;
- (b) to extend the contributions which psychological knowledge can make towards the solution of these problems;
- (c) to promote the efficiency and usefulness of its members by setting up a high standard of professional training and conduct;
- (d) to do all such other things as may be incidental or conducive to the attainment of the above aims.

(English Division of Profession Psychologists (Education and Clinical) Rules, 1960, p. 33)

These aims prioritise furthering the professional standing of clinical psychology. The main focus of the division is “to promote” and “to extend” the contribution of its membership and psychology in general. It is taken for granted in that statement that psychological knowledge and principles can solve educational and clinical problems. A public relations exercise is needed to ensure that psychologists have opportunities to demonstrate their “efficiency” and “usefulness” in society.

Four years after the DCP was established in 1966, the Clinical Services Standing Committee became responsible for coordinating the process of documenting professional practice in the division. In the first professional guidance document the reader is reminded that the clinical psychologist, “bears responsibility for humanity as a whole” and works in the “best interests of humanity” (DCP, 1973, p. 2). While this statement does not mention human rights, the globalised ethic reflects the language used in the instruments of the UN. There was the familiar refrain that “the psychologist only feels bound by the interests of the patient” (DCP, 1973, p. 5), and a reminder that “the psychologist’s first care is the welfare of any patient” (DCP, 1973, p. 5).

However, the document does not explicitly mention human rights. It only refers to civil rights that an individual can claim as a member of a particular society (Martin, 1980).

- c. The psychologist recognises the rights and reputations of learning societies, organisations, or employing authorities, under whose aegis he works. Products of his normal employment are the property of the employer and their release for the psychologist's use and/or publication is only consequent on agreement and normal practice of the employing authority.
- d. Criticisms of the personal, professional and ethical conduct of a properly qualified psychologist colleague are never made publicly but through the appropriate channels of the British Psychological Society.
- e. A psychologist respects the rights of the psychologist in training to reasonable personal privacy and his right to develop his individual orientation within his professional skills.

(DCP, 1973, p. 7)

The only time that rights are mentioned is in relation to societies, organisations, employers and psychologists in training. There is no acknowledgment, or attempt to elaborate, the civil or human rights of the people who psychologists see in therapy or research. Assigning rights to certain people over others can be traced back further in the wider profession. The earliest Standards of Conduct for Professional Psychologists state that "the teacher of psychology should in general respect the right of the student to maintain a reasonable degree of privacy" (BPS Annual Report, 1955, p. 19). These standards were published shortly after the UK ratified the European Convention in 1951 but the only mention of rights is in relation to trainees. They outline a prohibition on the "use of psychological techniques primarily for entertainment or in any other way inconsistent with the best interests of the person" and acknowledge that the "welfare of the person concerned is the psychologist's responsibility" (BPS Annual Report, 1955, p. 19). The standards do not mention that acting against a patient's best interests may mark an infringement of that person's human rights.

A picture emerges, that can be traced back to the initial documents of the BPS, where only certain groups and organisations are explicitly designated as rights-holders. As the profession of clinical psychology was emerging it was more concerned about its reputation than acknowledging and promoting the human rights of the people it worked with. The privileging of professional interests perhaps underlines the reasons for a scepticism about the influence of the psychological professional in contemporary society (Rose, 1985a), and uncertainty about whether clinical psychology has challenged the inequalities of power that create the conditions for human rights violations (Patel, 2003).

3.1.3 The Science of Human Progress

The danger of equivocating over human rights can be seen in the following extracts. They are taken from the first Code of Conduct for Psychologists (BPS, 1985), and the first Guidelines for the Practice of Clinical Psychology (DCP, 1973). These examples demonstrate that a concern only with interests and welfare can undermine the individual protections that human rights are intended to ensure.

The psychologist is committed to the application of his knowledge of psychology to assist in the relief of distress and the promotion of the well being of the patient. He places high value on objectivity and integrity in his methods and seeks to attain the highest standard in the services he offers within the limits of his employment.

(DCP, 1973, p. 2)

In all their work psychologists shall value integrity, impartiality and respect for persons and evidence and shall seek to establish the highest ethical standards in their work. Because of their concern for valid evidence, they shall ensure that research is carried out in keeping with the highest standards of scientific integrity.

(BPS, 1985, p. 1)

These extracts emphasise the scientific, objective and impartial standards in psychology. The supposed neutral application of scientific principles in these passages underlined the unique value of psychology and its potential

usefulness for society. The professionalisation of the discipline of psychology was bound up in claims to be scientific (Rose, 1985a). The scientific label conferred a status on psychology that legitimised its relevance to political institutions that influenced the types of knowledge that were worth producing and investing in (Danziger, 1990; Richards, 2010). In these extracts the application of scientific techniques was also bound up with ethics. In the first extract, specialist psychological knowledge is conceived as a means to alleviate distress, promote well-being and serve the best interests of humanity. In both extracts, the entanglement of science and ethics is emphasised by the fact that the psychologist places value on integrity, the wellbeing of the patient and respect for persons. The following extract, from the first Ethical Principles for Research with Human Subjects published by the BPS, outlines how this complex interplay between science and ethics can create challenging dilemmas when human rights are devalued.

Psychologists are committed to increasing the understanding that people have of their own and others' behaviour in the belief that this understanding ameliorates the human condition and enhances human dignity. These ethical values must characterize not only applications of psychological knowledge but also the means of obtaining knowledge. Performing an investigation with human subjects may occasionally require an ethical decision concerning the balance between the interest of the subject and the humane or scientific value of the research.
(BPS, 1978, p. 1)

This extract weighs the interests of the individual against the value of research findings for society. It was preceded by the DCP's statement that "a psychologist knowingly exposes a research animal or human subject to physical or emotional stress only when the problem is of considerable scientific significance" (DCP, 1973, p. 8). It also appears in the revision of those DCP guidelines, stating that "psychologists balance the possible risks to and distress of the patient against the likely value of the research findings before proceeding with the investigation" (DCP, 1983, p. 17).

These passages maintain that the outcomes of research in psychology may have scientific value of considerable significance that could improve the human condition. However, as the science of psychology is elevated the human rights of individuals become obscured. Individual human welfare is weighed against the potential value that science may have for society. Trade-offs of this kind are ethically problematic for at least two reasons. Firstly, the research described might undermine the well-being of individual participants without contributing to any improvement in the human condition. However, even if the research did demonstrably improve population well-being it may have done so at the expense of individual participants. These extracts are governed by the utilitarian principle of maximising the fulfilment of human interests that dominated British ethical thought until at least the 1970s (Tasioulas, 2013). However, aggregating the constituents of well-being can justify maximising larger group interests over those of an individual. Human rights specifically guard against the principle of maximising interests across persons because the harm committed to an individual can be justified by an appeal to the greater good. It appears that the dignity and respect discussed in the first theme can be overridden in the name of science and human progress.

Coercive interrogation and psychological torture used this same ethical reasoning because the knowledge extracted can maximise the interests of governments, society and group of individuals (Allhoff, 2003). Harper (2004) has outlined how psychology has been used in ways that transcend the legal and moral obligations of human rights. Without a clear understanding of ethical principles clinical psychology leaves its practice open to the types of exploitation, abuse and influence of power that its codes of conduct attempt to guard against.

3.2. The Moral Horizon

The human rights discussed in this section concern those that map the obligations between the medical professional and the patient. As discussed in the previous section, clinical psychologists are seen as unique providers of mental health care through the application of specialist psychological knowledge to improve psychological well-being and alleviate distress. The

recipients of that healthcare typically access a psychological service for support from a qualified professional. This socially and historically specific conception of healthcare has narrowed the profession's ethical viewpoint with respect to human rights.

3.2.1. Service Provision

Clinical psychology developed in the context of the NHS. The interplay between these systems, and wider socio-political factors, have shaped modern efforts to understand and alleviate psychological distress.

Generally clinical services are usually those in a medical/NHS context, dealing with clients who normally have the status of patient and who are suffering from a disease or disability for which they have sought the aid of a medical practitioner.

(DCP, 1973, p. 4)

Clinical psychologists provide services in conditions that are of a reasonable standard of comfort and safety, and bring any deficits in these conditions to the attention of their management. They attempt to deploy their resources in an equitable manner, and to inform their employers of difficulties in achieving this.

(DCP, 1990, p. 6)

Kinderman (2014) has shown the historical contingencies that gave rise to mental health services being located in the NHS as opposed to local authorities. However, an individual's experience of distress is not straightforwardly a matter of the mind or health (Pilgrim, 2014a), and it has been questioned whether this is the most suitable arrangement for service delivery (Kinderman, 2014). Clinical psychology rose to prominence and gained cultural legitimacy in medical contexts (Pilgrim, 2010), but a nationalised service for the treatment of mental distress is a recent and peculiarly western model (Fernando, 2017). In many places and times, a person who was suffering might have sought the counsel of a family members, their community or a priest (Fernando, 2017).

Our understanding of distress, and how it is best treated, alters the profile of human rights associated with it. Good quality services are seen as an important part of content of the human right to physical and mental health (UN, 2000). There is an admission in the passages below in the MAS report carried in 1989 and DCP professional standards written in 1983 that the provision of clinical psychology services falls short of demand.

We have observed that the current clinical psychology service is patchy in the range of services it offers. This is clearly a result of the rapidly expanding demand for services not being met by the investments in posts and, in particular, training posts, thus causing a wide gap between the demand for clinical psychologists and their supply.

(MAS, 1989, p. 153)

When, due to factors beyond their control, the services that psychologists provide are inadequate to meet demand, a system is applied which takes account of the urgency of need and other factors which would determine priority such that services are available to patients in an equitable fashion. When such conditions obtain psychologists make every reasonable effort to bring about an improvement in the facilities available to them in order that their service may more adequately meet the needs that exist.

(DCP, 1983, p. 10)

The clinical psychologist is advised to make every effort to improve the availability of services. Without tying service provision to the states' obligations under law it may seem overly burdensome for the individual clinician to ensure that services more adequately meet need. This argument should not be understood as suggesting that individual practitioners cannot do anything, but that improvements in service provision are more often a function of the socio-political contexts in which services are made available and that reference should be made to these contexts. A possible reason why there is not a connection between human rights and service provision in these documents is that it was not until 2000 that article 12 of the ICESCR was interpreted and the content of the human right more fully articulated (UN, 2000). The MAS report

almost anticipates some of the criteria against which service provision should be measured. It is argued that the criteria used to evaluate psychological services should be appropriateness, effectiveness, quality, efficiency and implementation (MAS, 1989). This echoes the United Nations' definition 11 years later that services should be available, accessible, acceptable and of good quality (UN, 2000).

One challenge for clinical psychology is the acknowledgment in General Comment 14 that people's health is related to their social conditions and to the realisation of other rights. Michie (1981) has argued that the model of traditional service provision, endorsed in these texts, ensure that clinical psychologists help only a selected population, in ways that do not challenge deleterious social environments, and tacitly endorse a medical model of practice. The result of this emphasis on service provision has been that the focus of ethical thought has been largely confined to the unique relationship between the medical professional and designated client.

3.2.2. Focus on confidentiality

All medical professionals, including clinical psychologists, are bound by the law and codes of conduct to ensure that medical information about service users remains private and confidential. In medical contexts the dilemmas around the processes and limits of confidentiality are protected under Article 8 of the HRA, the right to private and family life. This section will explore the main features of confidentiality in clinical psychology and demonstrate that confidentiality should be connected to the protection and promotion of other human rights.

Issues of confidentiality may pose difficult dilemmas, some of which have no ideal solutions. Whilst the need for confidentiality may be clearest within one-to-one therapy relationships, it is still crucial to be aware of its potential limits. Psychologists have a duty to share certain information with professional colleagues or carers, as and when necessary to the client's care. They may sometimes come under pressure to reveal confidential information, with or without a client's consent.
(DCP, 1995, p. 29)

Every effort is made to restrict invasion of privacy of the patient. Nevertheless, written and oral reports, but only those germane to the requirements of the patient's treatment, care and well-being, are made available to other responsible persons directly concerned with the case.

(DCP, 1973, pp. 4-5)

These extracts show the importance of privacy as well as its limits. However, the particular relevance that confidentiality might have to mental healthcare can be developed further. Radden and Sadler (2010) outlined two ways in which the right to privacy may demand particular ethical reflection for mental healthcare practitioners. Firstly, they underlined how privacy is valued in liberal societies and argue that users of mental health services have rights against the exposure of intimate details of their personal lives and the associated embarrassment and shame. Secondly, they argue that the distinctive negative consequences of stigma associated with categories of mental distress have few parallels in nonpsychiatric diagnoses with HIV being a notable exception (Radden & Sadler, 2010). The consequences of breaking confidentiality are explored in this passage below.

Psychologists recognize that their professional relationship with patients are based on trust and confidence and that in the course of intervention a psychologist may acquire intimate knowledge of a patient's personal life. Psychologists are aware of this position of privilege which they occupy in this respect and the emotional dependency which the patient may develop such that the latter becomes vulnerable to exploitation.

(DCP, 1983, pp. 29)

The resulting exclusion can have an impact on people's ability to secure other human rights such as those associated with work, liberty and freedom from discrimination. While it is important that confidentiality is emphasised throughout these documents, it is often treated in isolation and disconnected from other human rights. This relationship between power and human rights is also implicit in the following extracts.

Trainee psychologists make no attempt to conceal their trainee status from patients, colleagues or members of other profession. They recognize that in some instances it may be necessary to make explicit the implication of their trainee status for such matters as confidentiality and legal responsibility and the limitations upon these that status may impose.

(DCP, 1983, p. 12)

The rules about what information can be collected and under what conditions are connected to social stratification in terms of status, class and power (Marx, 2007). The guidance dictates that the psychologist should disclose their trainee status. There is an implicit recognition of the rules governing the disclosure of information. In this case the privacy of the clinical psychologist, or trainee clinical psychologist, is at stake. For the most part, the rules that govern the clinical encounter dictate a flow of information in a way that is not reciprocated by the therapist. A service user discloses intimate information about their life in the hope of an improvement in well-being or an alleviation of distress. Newnes (2014) has questioned the scope of what the patient should know about the therapist's life. It may be possible for the service user to discern a significant amount of information already given visible characteristics and demographics of the clinical psychologist. Given the close relationship between the therapist and the patient, and the very real possibility of abuse, should the service user have a right to certain information about the therapist that might affect their care? Clinical psychologists can judiciously disclose certain facets of their life that they deem to be clinically relevant. Newnes (2014), however, demonstrates that revealing useful aspects of the clinical psychologist's private life assumes that therapists can know how the service user will interpret the information which can only be made after the disclosure. These kinds of examples demonstrate how the power imbalances inherent in therapeutic relationships demand an ethical sensitivity with regard to the client's human rights and our obligations to protect those rights. This relationship between power and human rights is more fully articulated in the documents relating to consent.

3.2.3. Informed Consent, Complexity and Power

Manson and O'Neill (2007) argue that the history of informed consent in liberal thought can be traced back to the European Enlightenment. Debates about consent in politics and economics have been paralleled by discussions in medical ethics where it now plays a central role. The Nuremberg Code of 1947 followed the involuntary medical procedures perpetuated by the Nazis and focused on research participants giving voluntary consent. The following extract, from the Ethical Principles for Research with Human Subjects (BPS, 1978), illustrates the relationship between informed consent and psychological research.

Wherever possible the investigator should inform all participants of the objectives and, eventually, the results of the investigation. Where this is not possible the investigator incurs an obligation to indicate to the subject the general nature of the knowledge achieved by such research and its social value.

(BPS, 1978, p. 1)

Medical practice has moved from general consent to highly specific consent (O'Neill, 2004). An initial challenge with informed consent relates to specifying how much, and when, information should be given for consent to be considered as being informed (Brinkmann & Kvale, 2017). Manson and O'Neill (2007) have argued that the Helsinki Code has been redrafted numerous times since 1964 and that patients are expected to understand extremely complicated matters like research design, aims of the research and financial structures. They question whether the aims of fully informed consent can ever be realised under such conditions and how this leaves the ethical standing of research, given the inevitability of withholding and misunderstanding information. Following this, the requirements of informed consent have been extended from research to clinical ethics (Manson & O'Neill, 2007), and the next passages from professional practice guidelines from the same decade demonstrate the distinct dilemmas of informed consent in relation to treatment.

Clinical psychologists should take into account the power imbalances which may reduce the voluntary nature of informed consent, considering

their own role in the process and those of other staff, family and carers. The impact of such imbalances is likely to be greatest in institutional settings and high-dependency services; it may also be particularly important when working with children and families. Empowering a client to make his or her own choice, independent of persuasive others, may be the most therapeutic course of action in some situations. (DCP, 1995, p. 23)

Clinical psychologists recognise that a client compulsorily detained for treatment under the provisions of the law or other directed by a court of law to receive treatment may not necessarily be in a position to withhold consent to intervention. In such cases, the obligation to make every effort to obtain valid consent remains. (DCP, 1990, p. 5)

One of the most controversial aspects of supposed mental health care is coercion (Szmukler, 2018). The involuntary treatment and detention of people is lawful for those deemed to be a risk and suffering from a diagnosable mental health disorder. Szmukler (2018) has argued that mental health law in England and Wales discriminates against patients because they can be subject to involuntary treatment even if they have capacity. In these extracts there is a recognition of the power imbalances in the relationships between mental health services and the recipients, users or survivors of those services. This raises the importance of conceptualising power when thinking about informed consent.

The BPS maintain that “the concept of informed consent relates to the client’s right to choose whether to receive psychological services, and to make this choice on the basis of the best information available presented in the most appropriate way” (BPS, 2017, pp. 48). O’Neill (2003) has argued that the way in which informed consent relates to autonomy, and exercising the human right to self-determination, is deeply obscure. She maintains that often informed consent protects choices that are “timid, conventional, and lacking in individual autonomy” as well as choices that are “assertive, self knowing, critically reflective, and bursting with individual autonomy” (O’Neill, 2003, p. 5). In contexts of coercion or compulsion the notion of empowering a client to make

their own choices and making an effort to obtain valid consent may seem like hollow guidelines. The rising rates of involuntary admissions, particularly for people from minority ethnic groups (Singh et al., 2007), relates to the cumulative disadvantages of unemployment, poverty and socio-economic status (Morgan et al., 2008). The relationship between informed consent and wider inequalities in society is not explored in these guidelines.

3.3. The Challenge of a Possible Future

This section explores the possibilities in the documents for a new clinical psychology oriented towards the concerns of human rights. It explores the development of non-discriminatory practice, working with people in everyday contexts and the challenges of public health approaches in clinical psychology.

3.3.1. Non-discrimination

Following the Sex Discrimination Act 1975, the Race Relations Act 1976 and the Employment Protection (Consolidation) Act 1978, the BPS released ethical guidance in relation to non-discrimination. Guidelines on the Use of Non-sexist Language were approved by the society's council in October 1987. This was followed by a statement on Sexual Harassment at Work and the Ethics of Dual Relationships, approved in May 1993, an Equal Opportunities Policy Statement which the council approved in February 1993 and the fully drafted policy which was approved in February 1994. All of these documents were written after the UK ratified the International Convention on the Elimination of All Forms of Racial Discrimination in 1969 and on the Elimination of All Forms of Discrimination against Women 1986. These various statements focus on definitions and language guidance but there is no reference to human rights. There is a recognition of good practice and duties in relation to course content, working environment, representation on committees and complaints procedures. This focus can also be seen in the 1983 guidelines and the latest edition of The Core Purpose and Philosophy of the Profession (2010).

Psychologists are sensitive to the need to tailor their services according to the individual characteristics of the persons receiving them, including such variables as age, sex and socio-economic and cultural background.

Where necessary, they seek special training, knowledge, experience, or advice to enable them to provide a competent service to particular population.

(DCP, 1983, p. 6)

The personal and professional skills of psychologists include the ability to work effectively with clients from a diverse range of backgrounds and to have an awareness of social and cultural factors. Whilst working at an appropriate level of autonomy they accept accountability to professional and service managers and recognise their own personal development needs.

(DCP, 2010, p. 7)

Working with people from diverse backgrounds is seen through the lens of competence across these documents. It becomes necessary to acquire knowledge to tailor interventions for those in receipt of services and to develop appropriate levels of cultural awareness. Patel (2010) has noted that the professional language of diversity has replaced the emphasis on antiracism and multiculturalism. In this context, the development of cultural knowledge and sensitivity is privileged at the expense of addressing racism, discrimination and whiteness (Wood & Patel; 2017).

The idea of competence has always been a prominent feature of clinical psychology in the UK. The aims of the Scottish Division of Clinical Psychologists (Educational and Clinical) were “to be concerned with all matters affecting professional competence, training and conduct of its members” (SDCP, 1960, p. 88). The psychologist also “recognises that there are boundaries to his competence” (DCP, 1973, p. 2), and “constantly endeavours to develop and maintain their professional competence (DCP, 1983, p. 5). Competence extended to administrative duties, psychological testing, working relationships with colleagues and the accurate assessment of more junior psychologists’ competence. From these appraisals of competence, the idea of specific competencies emerges in the guidelines (DCP, 1995). However, the notion of cultural competence has been criticised because it can imply a fixed point where sufficient knowledge and practice have been accumulated rather

than a constantly evolving process of critical reflexivity (Dogra, Vostanis, & Frake, 2007). Kirmayer (2012), while acknowledging some value in cultural competence as possible resistance against homogenous approaches to mental healthcare, warns of essentialising and commodifying culture into stereotypes that can further disempower patients. Discrimination can be perpetuated by seeing “race and ethnicity as unitary or an assumption that knowing about these cultures solves the problem of equality, fairness and availability of services” (BPS, 2017, p. 33). These recent Generic Practice Guidelines from the BPS provide a more insightful contribution to professional guidance around discrimination.

Psychologists should bear in mind the history of racism and the early development of western psychology and culturally biased testing in favour of white, middle-class children. Psychologists need to recognise that multi-ethnic groups are not homogenous groups and there are wide regional and local differences amongst these groups which can be split by language, dialect and regional variation.

(BPS, 2017, p. 33)

Black and minority ethnic (BME) LGBTQ people have to negotiate between the values and beliefs of mainstream and minority ethnic cultures. Cultural difference in norms, beliefs, and values can be a source of psychological stress. There may be no particular sexual and ethnic minority group to which a BME LGBTQ person can anchor their identity and obtain acceptance and support.

(BPS, 2017, p. 35)

The first passage situates the profession of clinical psychology in the wider context of racism in society and Eurocentricism in the development of psychological theories and practice. It is explicit about the importance of not homogenising groups. The second passage identifies the specific challenges that those with intersecting social identities, with respect to ethnicity, sexual orientation and age. There is also an acknowledgment of the psychological links between discrimination and identity and the potential for isolation and social exclusion. Although this is not explicit in this document, it underlines the

importance of conceiving of human rights as being interdependent with one another (World Conference on Human Rights, 1993).

3.3.2. Participation or Inclusion?

The relationship between participation and inclusion is complex and contested (Quick & Feldman, 2011). The CRDP contains perhaps the most authoritative statement in relation to inclusion. Inclusion is viewed as the existing and potential contributions that people can make to the well-being and diversity of their communities (UN, 2008). In the domain of civil and political rights, participation has been interpreted as the right to organise a political party, vote or express political opinions. In the context of the right to health, it has been understood as the right to participate in health-related decision-making processes. Quick and Feldman (2011) argue that participation and inclusion are different dimensions of public engagement. Participation involves inviting as many to contribute towards decisions, making the process as accessible as possible and trying to ensure that these opinions are representative. They argue that inclusive practice may enhance participation but that it also builds the capacity of communities to implement decisions and address issues as they arise over time (Quick & Feldman, 2011).

Applied psychologists have a role in making the case and creating the right conditions for effective user and carer participation.... Service user workers in teams can understand, empathise and communicate to health professionals the complexity of current service users' difficulties from a unique perspective. They can provide a voice and much needed advocacy.

(BPS, 2007, p. 32)

Service delivery competencies include working with service users and carers to facilitate their involvement in service planning and delivery, working with issues and mechanisms to facilitate organisation change, and developing and sustain effective partnerships with a range of commissioners and delivery systems.

(DCP, 2010, p. 7)

In these extracts, psychologists are positioned as being responsible for creating conditions that facilitate participatory practices for both service users and carers. The advantages, in the first extract from *New Ways of Working for Applied Psychologists in Health and Social Care* (BPS, 2007), include the ability to empathise with current service users and hold a psychosocial perspective in relation to their difficulties. This allows users participating in services to advocate for other service users by communicating with healthcare professionals. One of the challenges for participation strategies fulfilling their obligations under the human right to health is the extent to which they genuinely serve the interests of those involved. Arnstein (1969) demonstrated that participation can range from non-participatory strategies to tokenistic efforts that involve sharing information, inviting consolation or offering placation. As described earlier, this can include involvement to legitimise pre-conceived managerial decisions (Harrison & Mort, 1998). Arnstein defined more genuine approaches to participation as those that involve professional power being transferred in order to realise partnership, delegation and citizen control. Tritter and McCallum (2006) argued that Arnstein's model overly focuses on the transfer of a unitary conception of power to improve health-related practices and outcomes. It is also important to evaluate the user's satisfaction with the process and acknowledge that involvement is one part of a larger process that can lead to system-wide reforms (Tritter & McCallum, 2006). Halabi (2009) has questioned how the human right to participation in shaping health practice and policy relates to political participation and social inclusion. The extracts below highlight that inclusion relates to wider structural issues and human rights suggesting a broader vision for clinical psychology than working on an individual level with clients in services.

Social inclusion is the process where the needs of all members of communities and the groups which constitute them are recognised, prioritised and met, resulting in these individuals feeling valued and respected. 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.

(BPS, 2017, p. 36)

Contributors to this document made the point that teasing out the teamworking issues with respect to social inclusion was problematic in that all psychological practice should be concerned to promote inclusion as a human right.

(BPS, 2007, p. 52)

Those with mental health difficulties are often excluded from paid employment, housing, lifelong learning and participation (BPS, 2007). The notion that individuals are recognised, valued and respected links with the idea of full citizenship for those who have experienced mental health difficulties. The Generic Guidelines (BPS, 2017) state that psychologists are encouraged to promote equality, recognise the distress caused by exclusion and challenge social conditions that contribute to social exclusion and stigmatisation. The new ways of working document advocates a stronger vision that human rights should not be an addition to practice but a core element of practice. In addition to the scientist practitioner, it highlights the value of developing a rights-based practitioner identity for clinical psychologists.

These ideas link to community psychology that values community as the articulation of human hopes for diverse people to be welcomed and included (Kagan, Burton, Duckett, Lawthorn & Siddiquee, 2011). However, Smail (1994) has warned that community psychology's naïve utopianism can give way to a cynical pessimism associated with burnout. The theories of community psychology have also been described as being wholly political, with the psychological dimension undertheorised, which invites scepticism about the necessity of psychologists being involved with these projects (Newnes, 2014). Another challenge is with the notion of inclusion. Kagan et al. (2011) note that the idea of community is itself contested and that community can be oppressive for some people. For example, social cohesion does not afford resilience against mental health difficulties in a uniform way across social groups (Rogers & Pilgrim, 2014). Indeed, increased participation for women may actually increase symptoms often associated with a variety of diagnostic categories (Rogers & Pilgrim, 2014), which may relate to patriarchal expectations in some social networks for women to provide support for others (Manne, 2017). This

last challenge points towards the aims of intervention to improve specified outcomes for particular individuals or groups in the context of other public health initiatives.

3.3.3. Prevention and its Targets

A theme across these texts was that clinical psychologists can do more than therapy. The MAS report introduced the idea that psychological skills can be applied at three levels. Each level requires greater understanding of psychological theory, competence and flexibility. This section reviews how clinical psychologists being more than therapists relates to human rights.

It is important to emphasise that clinical psychologists may have their greatest influence on enhancing psychological well-being of service users by working at systemic levels. There will always be more demand than psychologists can fulfil, so by working with organisations to provide psychologically appropriate services, or by working in a staff development and supervision mode, clinical psychologist can ensure that many more users have access to psychologically informed practice than can be delivered by psychologists alone.

(DCP, 2001, p. 5)

When engaged in the planning and development of health care services and the formulation of health care policy, psychologists bring to bear their specialist knowledge so as to promote the psychological well-being of those in receipt of such services. In doing so psychologists acknowledge the influence that environment has on human behaviour, and they take account of this influence especially when involved in the planning or management of institutional care facilities.

(DCP, 1983, p. 10)

Having a greater impact at systemic levels in the first extract is defined as providing appropriate services, staff development and supervision. Therefore, this first model reinforces the traditional model of service delivery, encouraging improved access to clinical practice that is informed by psychological principles. The extracts emphasise giving away psychological knowledge, language and

techniques (Rose, 1998). Wright (2015) has argued that the concern psychology had for occupational growth and legitimacy ran in parallel with the idea of giving away the science of psychology and embedding itself in important institutions. This can also be seen in the second extract where, in addition to the development of health services, clinical psychologists are also involved in the formulation of policy. However, the formulation of policy is solely directed at improving the well-being of those accessing psychology services. Although there is an understanding that clinical psychology should influence the environment and work at other levels of intervention, these extracts do not directly address the underlying determinants of health. The MAS report more directly outlines preventative strategies in relation to clinical psychology.

The preventative dimension is grossly inadequate. There is a need for a more primary/prevention-focused service – amongst the “worried well” are tomorrow’s more seriously and chronically mental ill. Prevention is a more cost-effective alternative to waiting for individuals to become dependent on health services and consequently more expensive to treat. (MAS, 1989, p. 5)

Psychology has a significant contribution to make to the health and wellbeing of the population....It is in the activities of preventing people from becoming ill through their own behaviour or psychological state and in the development of effective complementary and alternative therapies to medical strategies that healthcare psychology is likely to make its biggest impact.

(MAS, 1989, p. 175)

Caplan (1964) argued that preventative interventions can take three forms. Primary prevention aims to reduce the incidence of new cases of mental disorder by focusing on the environment and strengthening people’s capacity to cope with situations. Secondary prevention aims to shorten the duration of cases of mental disorder and, therefore, might be seen as a form of treatment. Tertiary prevention tries to ensure that people who are recovered from, or coping with, severe forms of mental distress can participate in community life if they desire. Radden (2017) has argued that the distinction between different

types of prevention can become blurred because of the difficulty in conclusively identifying the onset of mental disorders from so called states of normality. These challenges are reflected in the lack of clarity in this report. The first extract maintains that prevention is about treating the worried well. Although it is not outlined specifically in the review, this type of prevention would fall under the heading of secondary intervention. It involves selecting a particular group in society, the “worried well”, for intervention aimed at preventing them from becoming chronically unwell, dependent on health services and, therefore, costing the state money. Alleviating human suffering is justified by economic rationality. Such arguments position our relationships with those diagnosed with mental health problems in terms of burden rather than care and solidarity (Rose, 2019).

The second extract is more focused towards primary prevention by using phrases like “the wellbeing of the population” and “preventing people from becoming ill”. However, this change to population-level strategies is not acknowledged in the review. Universal strategies of this kind are distinct because they do not select particular populations for intervention. Instead they aim at what is good for everyone and, therefore, universal strategies may be less susceptible to ethically problematic issues around consent, stigmatisation and medicalisation (Radden, 2017). However, the report plays down the relationship between the socioeconomic determinants of health and prevention. It was written at a time following the Whitehall Study of British civil servants (Reid et al., 1974), the Black Report (Gray, 1982) and during the second The Whitehall study (Marmot et al., 1991). While the Black Report was buried under the new conservative government (Bartley, Blane & Davey Smith, 1998), all these studies emphasised the importance of long-term, cross-cutting government policies to tackle the social and economic determinants of health inequalities. However, the MAS review continually emphasises health behaviours and the responsibility for health is placed firmly with the individual. The vision of prevention aimed at behavioural science still influences government strategies (Cromby & Willis, 2014). This exclusive focus on the individual risks ignoring the impact of human rights violations and obscuring the social and political conditions in which distress occurs.

4. DISCUSSION

The first three sections of this chapter address each research question in detail and explore the extent to which they were answered. The research questions are restated here for clarity:

- What is the nature of the relationship between clinical psychology and human rights?
- What were the historical conditions that could explain the relationship between clinical psychology and human rights?
- What are the implications of engaging more with human rights for the theory, research and practice of clinical psychology?

The concluding section is a critical review which analyses the strengths and limitations of the research project, considers alternative ways that the questions could have been approached and outlines what I have learnt from the process.

4.1. The Relationship between Clinical Psychology and Human Rights

The overarching aim of the research was to explore the moral and legal dimensions of clinical psychology through the lens of human rights. The initial research question focused on the nature of that relationship and will be explored more fully in this section.

4.1.1. Changing Focus

This research could be considered in opposition to the sanctioned histories of the psychological sciences (Rose, 1998). Rose (1998) argued that a critical history of psychology seeks to “question the certainties of the present by paying attention to the margins and the processes of their marginalisation” (p. 43). The analysis demonstrated that human rights were vaguely referenced in the codes of conduct that guided clinical psychology as it was shaped during the latter half of the 20th century. There was a clear statement of human rights in the guidelines for professional practice in 1983. Clinical psychology did not develop as sophisticated and complex an appreciation for morality as it did for science.

The history of human rights in UK clinical psychology is one of marginalisation. These include the tendency of human rights to be thinly theorised in the profession, for them to come more sharply into focus at different periods and for a certain subsection of rights to be more fully elaborated. However, the claim that human rights have been marginalised in the profession of clinical psychology needs to be elaborated further.

Clinical psychology is a heterogeneous discipline comprising broad models of practice, client groups and health settings (Llewelyn, Beinart & Kennedy, 2009). Therefore, in keeping with a critical realist philosophy, claims about the whole profession standing in relation to a body of thought need to be made cautiously. It has been discussed that at times the professional practice of clinical psychology used the language of human rights. The most significant example of this tendency was the passage concerning the political implications of psychological knowledge and practice from the 1983 guidelines. This discussion of professional standards represents the most sustained reference to human rights throughout any of the division's documents on professional practice. However, these pockets are exceptions and even contradict other passages in the same document. For example, the 1983 guidelines also contain a discussion about "weighing scientific and human values" (pp. 14). This was described earlier as inviting the type of utilitarian calculations that human rights morality specifically guards against. Therefore, a linear history of progression or regression concerning human rights in clinical psychology should be rejected. Rather the documents that were analysed in relation to human rights demonstrate a lapsed history characterised by "false paths, of errors and illusions, of prejudice and mystification" (Rose, 1998, p. 42). Had these paths been taken, or more fully trodden, the profession might look very different today.

Another challenge with defining the relationship of clinical psychology with respect to human rights concerns the status of the documents analysed. Harry Brierley, who chaired the sub-committee that drew together the first professional guidelines in 1973 acknowledged that the guidelines would not solve all the problems of the profession (DCP, 1973). Commenting on the 1974 guidelines, the chair who convened the working part of the 1983 guidelines, Miles Mandelson (DCP, 1983) said that it was unclear the extent to which the

previous guidelines had been disseminated to members of DCP and whether they had been helpful. Therefore, it is important to question the extent to which guidance is reflective of practice and whether the guidelines provide a meaningful window on the profession's relationship with human rights. Newnes (1996) has questioned whether the values expressed in the professional documents relating to clinical psychology are driving forces for change or merely expressions of what it deemed good. In response to this, it is possible to contend that the documents still capture a consensus about how professionals should be practising clinical psychology. Newnes (2014) later argued that guidelines have an undeniable authority in promoting clinical psychology. Therefore, the documents not only reflect what professionals should be doing but also what the profession should be seen to be concerned about. These documents developed over time and gained a certain authority via a historical consensus. It is possible to conclude that, while the documents do not represent an eternal truth about the profession, it is possible to discern continuities in the way that people understood their practice, or wanted to present it to others. These processes offer a meaningful insight into some of the preoccupations and challenges that the profession has sought to resolve.

4.1.2. Engagement

Clinical psychology's engagement with human rights has a particular character. The ethical principles described in the professional practice guidelines, some of which are aligned with human rights, have been discussed in circumscribed and superficial ways. Particular human rights were more in focus than others and the complexity of human rights in the practice of clinical psychologists have not been engaged with in sufficient depth.

Human rights are seen as being indivisible, interdependent and interrelated (World Conference on Human Rights, 1993). There is much scholarly debate about the precise meaning and implications of this phrase (De Beco, 2019), but one promising approach emphasises that indivisibility emphasises that human rights are strongly interdependent (Nickel, 2008). Clinical psychology's ambivalent relationship with human rights has meant that concerns about consent, privacy and discrimination have been focused on and developed in ways that are meaningful and relevant to the profession. However, this current

state of affairs, which gives priority to certain categories of human rights, can be ineffective because it hinders the fulfilment of other rights (De Beco, 2019). Patel (2010), for example, has shown that diversity agendas in clinical psychology tend towards this myopia because they often do not aim to address institutional racism or the wider socio-political structures that sustain discrimination. This narrow focus in clinical psychology invites particular ethical dilemmas while precluding others. It is perhaps this picture that accounts for clinical psychology's avoidance of social context (Boyle, 2011), narrow scope of intervention (Harper, 2017b), and reinforcement of inequalities associated with human rights violations (Patel, 2003).

Another important oversight has been the depth of engagement with the substantive issues of human rights morality and law. It is claimed that "clinical psychologists will adhere to and be guided by explicit and public statements of the ethical principles that underpin their work" (DCP, 2010, p. 2). However, while the professional guidance uses words relating to human rights instruments, any meaningful integration of clinical psychology with human rights has not been sufficiently theorised. Therefore, it is important to question the extent to which the profession has elaborated on these principles and whether it is possible to discern the implicit ethical assumptions that shape the guidelines for practice. A number of searching questions that might be asked in this regard:

- What does it mean that we all have a human right to mental health?
- Is clinical psychology as it is currently practised the best way to realise the human right to mental health?
- How does the profession of clinical psychology, with respect to its theories and practices, contribute to the realisation of this human right?
- What is the scope of clinical psychologists' obligations under human rights law and morality?
- How does clinical psychology address aspects of human life that are not usually considered the domain of health professionals but that have a bearing on people realising their human right to mental health?

The formal documents of clinical psychology have intermittently and occasionally used the congenial language of human rights without engaging

with the far harder intellectual and practical labour of specifying the correlative obligations, practices and training necessary to promote and protect these rights. What do the professional proclamations of respect, dignity and equality mean to people working and living in contexts of disadvantage, injustice, coercion and compulsion? Clinical psychology's aim is to "reduce distress and enhance and promote psychological well-being (DCP, 2001, pp. 2), but without a more developed engagement with these challenges it may only be able to realise this goal for a privileged section of society.

The history of clinical psychology's ambivalence and false starts in relation to human rights undermine any possibility of recounting a linear narrative of progression or regression. The profession of clinical psychology has fallen short of its ethical and legal responsibilities in relation to human rights. However, there have also been pockets of ethical awareness in professional guidance and practice. There continue to be principled actions of individuals and groups of clinical psychologists seemingly working against the guidance of their profession. It is vital to recognise both the ethical shortcomings in the profession and the examples of practice that open up avenues for a more ethically oriented future. Seeing clinical psychology from both perspectives can guard against the perils of disillusionment and idealism common to both human rights and clinical psychology.

4.2. Explaining the Relationship

The second research question sought to outline possible mechanisms that could explain this ambivalent relationship between human rights and clinical psychology. Retroduction is the distinctive form of inference associated with critical realism which posits that events can be explained through hypothesising about causal powers (Hu, 2018). In keeping with the principle of judgemental rationality, this discussion will seek to establish a rationally plausible account for the relationships discussed in the analysis at three levels of conceptualisation (Mohan, 1996; Pilgrim & Rogers, 1999). These conclusions were discussed in the analysis but they are presented here in a more systematic way. The macro-level account will suggest that the relationship between human rights and clinical psychology was shaped by global and transcultural forces beyond the

control of individual nations. The meso-level accounts for how particular ideological, political and policy contexts contributed to the discipline's engagement with human rights at a national level. The micro-level interpretations emphasise how the internal characteristics of clinical psychology in the UK shaped its engagement with human rights.

4.2.1. Macro-Level

Inconsistencies in international human rights law (IHRL) have contributed to the ambivalent way that clinical psychology has incorporated human rights into professional practice. Tasioulas (in press) has argued that two particular internal pressures have led to a corrosion of the idea of human rights in IHRL. Firstly, he notes the tendency, already discussed, for human rights law to identify human rights with human values or interests. This lack of clarity in IHRL might have caused the confusion between interests and human rights that have been reproduced in clinical psychology. A second way in which IHRL strays from its formative aim to give rigorous effect to a background of human rights morality is the overenthusiasm towards legalisation and judicialisation. Tasioulas (in press) reminds us that IHRL is only one among various mechanisms, legal and non-legal, for realising human rights morality. This tendency towards the institutional embodiment of human rights norms may account for the movement's lack of sustained engagement with a mobilised citizenship that is crucial for realising human rights (Younis, 2018), and the notion that it is an alien ideology imposed on non-western societies (Matua, 2002). This may have had the effect that human rights are considered the domain of legal and political process, divorced from the everyday practice of clinical psychology.

Another aspect of clinical psychology that has influenced its adoption of human rights has been the influence of science. The triumphal progress of the natural sciences led to a scientism that promoted a belief that "their methods were the *only* methods for securing useful or reliable knowledge about anything" (Danziger, 1990, p. 41). However, the disciplinary arrangements in American universities set the conditions for the emergence of a scientific psychology. Danziger (1990) has demonstrated that science had taken over from religious authority in American universities during the late 19th century. Wundt's

conception of psychology, connected with philosophy, linguistics and anthropology, slowly gave way to the practice of psychology that was more aligned with the natural sciences (Danziger, 1990). The extent to which developments in American clinical psychology directly influenced the profession of British clinical psychology is unclear (Hall et al., 2015). However, the Boulder conference established the scientist-practitioner model of training that had a profound influence on how the profession understands its fundamental orientation (Pilgrim & Treacher, 1992). Eysenck (1949), whose views influenced the training of clinical psychologists in the UK, disagreed about many of the methods in the American programmes except for the belief that it should be predicated on science. The challenge for a profession that defines itself in relation to scientific methodology is about its purpose. Earp (2011) has argued that science cannot determine human values. Drawing on David Hume's argument for the gap between facts and values, Earp (2011) noted that science can describe nature and explain these descriptions by reference to general laws and patterns. However, it cannot determine questions that necessitate moral reasoning such as determining the best way to live or whether an action is good or bad. These normative questions fall outside the domain of objective empirical research and practice. Therefore, the morality of human rights may always occupy an uneasy position in clinical psychology so long as the scientific self-image of the discipline continues to dominate.

4.2.2. Meso-Level

Also relevant to understanding clinical psychology's troubled relationship with human rights are the tensions within domestic law. Before the introduction of community care in the 1950s, clinical psychologists often worked in mental institutions with residents under the control of the 1907 Mental Deficiency Act and the 1930 Mental Treatment Act (Rogers & Pilgrim, 2003). However, not until the 1959 Mental Health Act was it possible to discern rights in the form of voluntary admission (Kelly, 2015). The powers afforded to psychiatry under the 1959 Mental Health Act can be understood in terms of the medicalisation of social control rather than the promotion of human rights (Rose, 1985b). Rose (1985b) has argued that the Mental Health Act 1983 was the culmination of a reforming campaign which was couched in terms of human rights. He argued that MIND, led by its Legal Director Larry Gostin, produced voluminous

publications, and evidence to official committees and the courts, arguing that the treatment of those diagnosed as mentally ill were an abuse or denial of their human rights. This may have been one reason for the specific reference to human rights in the professional guidelines in 1983. The fact that these references were not developed is perhaps indicative of the paucity of discussion relating to human rights in public discourse prior to the Human Rights Act 1998. Although reforms to the Mental Health Act in 1983 and 2007 often mentioned human rights there remained concerns that legally enforceable coercion undermined key human rights principles of liberty, autonomy and self-determination (May, Hartley & Knight, 2003). Bindman, Maingay and Szmukler (2003) have argued that mental health legislation specifically discriminates against people with mental health difficulties. In particular, Kelly (2014) has argued that the legal framework for coercion contravenes the core principles of the CRPD. There are no easy answers and others maintain that interpreting the CRPD as precluding any involuntary intervention for people with disabilities would not offer sufficient protection for patients (Appelbaum, 2019).

As statutory employees, under the 1998 HRA, all NHS staff have a legal duty to uphold the rights of everyone in their care. What does this mean when our domestic laws may not uphold the human rights of those with mental health difficulties? The contradictions and complex relationship between domestic and international law can leave professions regulated by those laws in a difficult position. Clinical psychology has grown as a profession alongside possibly irresolvable conflicts about the scope of choice, protection and coercion in mental health. It is perhaps no wonder than in the midst of this ethical controversy and political difference that the profession has also neglected core concerns of human rights.

In this context the Beveridge Report of 1942 and the NHS Act of 1946 established the world's largest publicly funded healthcare system (Weait, 2013). The NHS both constrained and facilitated the development of clinical psychology (Pilgrim & Treacher, 1992), and the same can be said about the impact it may have had on human rights in the profession. In many ways the right to health, enshrined in Articles 25 of the UDHR and 12 of the ICESCR, is largely fulfilled by the NHS because of the provision of free health care (Weait,

2013). However, this research has questioned the particular model of mental healthcare promoted in the NHS. Firstly, there has been a relative neglect of psychosocial and public mental health intervention in the NHS (Kinderman, 2014). As the profession was still developing, the occupational priorities for the majority of clinical psychologists related to the assessment of individual differences in the tradition of Francis Galton and the application of the scientific method to the practice of psychiatry (Dabbs, 1972). There were a number of calls for a more socially-oriented profession (Durndell, 1977; Michie; 1981, Smail, 1982), but possibly the lack of evidence of efficacy combined with the institutional structures of the NHS have precluded their realisation.

The relationship between economic policy also influenced the development of clinical psychology in the UK. Rapid economic growth after the economic shocks from the world wars began to stagnate in the early 1970s (Piketty, 2014). This period in the UK was notable for a stalled economy and rising prices which cleared the way for a new government (Chang, 2014). Margaret Thatcher came to power in 1979 and key policies in her government led to an unprecedented rise in inequality (Atkinson, 2015). While caution should be used when positing neoliberalism as an all-encompassing explanation and critique (Rose, 2019), the policies of that period are often distinguished by their neoliberal ideology (Atkinson, 2015). Progressive income taxes were lowered, the welfare state was reduced and the power of trade unions was undermined. It is unsurprising in this context why reports that stressed the socially determined dimension of health difficulties, like the Black Report, were suppressed. Instead, value was increasingly given to the enterprising individual who related to themselves against markers of autonomy, fulfilment, responsibility and individual choice (Rose, 1999). Increasingly competitive and insecure workplaces caused people to feel fearful and isolated leading people to blame themselves for perceived shortcomings (Smail, 1993). However, clinical encounters focused on the individual and intrapsychic sphere, avoiding any exploration of the impress of ideological and economic power (Smail, 2005). Clinical psychology avoided the social context as this was the prevailing ideology at a crucial period in its development. The shift from the focus on states protecting their citizens to increasing hostility towards welfare and

dependency laid a framework for the erosion of human rights in society that was mirrored in clinical psychology.

4.2.3. Micro-Level

This section explores how internal pressures in the profession of clinical psychology have potentially contributed to the marginalisation of human rights in theory and practice. The first aspect concerns the aspirations of the emerging profession. Pilgrim and Treacher (1992) argued that clinical psychology has always sought legitimacy by being useful to society through the application of science. Hall (2007) has shown how effectively the CPP (MH) organised around the emerging structures of the NHS and actively sought a role for the new profession. One of the challenges centres around the profession's primary mode of legitimacy being through the state and its institutions. It remains possible that the profession's proximity with state-sanctioned institutions has meant that it has not been able to challenge the laws, policies and practices of the state. In addition, Smail (2005) argued that although clinical psychology has often been at pains to promote itself as objective and disinterested that its science is thoroughly bound up with interests. He maintained that the interests of the clinician in maintaining their livelihood meant that certain questions were asked in research, and particular conclusions highlighted, at the expense of alternative hypotheses. Under these conditions moral argument and praxis can become co-opted in the interests of power and maintaining the status quo (Smail, 2005). He went further and argued that clinical psychology maintained itself largely through its resolute refusal to countenance the socio-political dimension of distress. These processes can be seen to play out in some of the ethical guidance. The first code of conduct for psychologists stated that "criticism of the profession conduct of a Member of the British Psychological Society should never be made publicly, but through the Council of the Society" (BPS, 1955, p. 18). Such institutional processes can actually serve to protect perpetrators of abuse (Pilgrim, 2011), which reflects the wider tendency towards the protection of its membership rather than the public.

A salient feature of clinical psychology has not only been its ambivalence in relation to human rights morality but also an uncertainty about its purpose and aims. Barry Richards argued in 1977 that "clinical psychology is a range of

heterogenous and often conflicting tendencies, reflecting, as it must, conflicts within psychology and ultimately within society as a whole” (as cited in Pilgrim & Treacher, 1992, p. 99). He continues to question whether there is dominant ideology in the profession beyond attempts to minimise dissensus. This seeming resolution, or compromise, led to the eclecticism that is common to clinical psychology practice. Pilgrim and Patel (2015) argued that these divergences of opinion are almost inevitable given that clinical psychology exists in ambiguous spaces between a range of disciplines with differing epistemology and ontological assumptions. This ambiguity also reflects clinical psychology’s rightful roles with respect to direct and indirect modes of intervention: “Some practitioners are of the view that the professional should focus on direct patient care, whilst others are convinced that maximum effect is to be achieved by seeking to influence the environment, organisation and management of health services” (MAS, p. 95). These professional tensions between treating the individual and the environment will not be resolved easily because, of course, both are needed. Human rights should be seen as an integral part of both direct patient care and efforts to influence the environment around people.

4.3. Implications of Engaging with Human Rights

It has been established earlier that clinical psychology’s avowed purpose of alleviating distress and promoting wellbeing is consistent with the aims of human rights to secure liberty, freedom and equality (Patel, 2007). For clinical psychology to engage more fully with the promotion and protection of human rights it must connect with other professions, agencies, networks and survivors towards these aims (Patel, 2011). This section outlines possible strategies and challenges of human rights-based approaches to clinical psychology.

4.3.1. Training

An immediate concern in relation to clinical psychology training and human rights is the continued lack of ethnic and socioeconomic diversity of clinical psychology training candidates (Daiches, 2010; Newnes, 2014). An important consequence of this lack of ‘representation’ in the profession is the continued perception that the psy-disciplines cannot work towards equality and non-

discrimination (Patel & Keval, 2018). Training courses should recognise that inequalities in access to the profession relate to the denial of human rights in relation ethnicity, gender, age and other marginalised social locations that people occupy. This necessitates understanding the complex interaction between ethnicity and social disadvantage such as employment, poverty and socio-economic status and coordinated efforts to address these issues.

There a small number of training clinical psychology training courses in the UK that have sustained teaching on human rights (Greenhill & Golding, 2018; Wood & Patel, 2017). The University of Liverpool have incorporated human rights into training. The elements include value-based selection procedures, the co-production of content and delivery of teaching through experts by experience and sessions that encourage trainees to take a critical stance towards the history of the profession (Greenhill & Golding, 2018). The course also includes sessions on the history, core concepts, instruments and institutions relating to human rights. UEL have teaching on human rights and address the impact of inequalities in relation to race, culture and ethnicity (Patel et al., 2000). However, courses also need to consider how to move beyond the professions' tendency to pay lip service to progressive social ideas (Patel, 2007). For example, critical teaching does not necessarily lead to students being less discriminated against (Adetimole, Afuape & Vara, 2005). Therefore, it is necessary to question and challenge the impact that teaching and training has on the experiences of other trainees and service users.

Patel (2003) has also argued that the professional tendency towards understanding client's lives and appreciating the impact of social inequality without demanding that psychologists critically look at how their own practice contributes towards further marginalisation. Therefore, training programmes could also invite trainees to move beyond vague appeals to dignity, human rights and equality and critically analyse the scope of their own obligations, as professionals and citizens, towards realising those human rights. Such a critical analysis may involve questioning the role of justice in mental health which is often spoken about in clinical psychology but can have a number of different meanings (Patel, 2011). Such an approach would interrogate the moral underpinnings of the profession more deeply and question the normative

assumptions of clinical psychology and the underlying theories of morality, mind and personhood that they imply.

4.3.2. Practice

The clinical psychology guidance documents emphasise the importance of recognising the context of distress but provide few insights into the role of clinical psychology in addressing that social context. Patel (2011) argues that taking our responsibilities seriously, in this regard, would necessitate redefining the role of mental health professionals as having both individual and social responsibilities. At the level of individual practice, psychologists have an ethical obligation to remain up to date with practice and developments in broader social and political contexts (BPS, 2017). Such an approach acknowledges the importance of confidentiality, consent and capacity but also questions what ethical and legal considerations those narrow parameters exclude. It might also entail an acknowledgment of the violations of people's human rights in areas such as poverty, employment, housing or violence. Patel and Pilgrim (2018) provide a useful framework for clinical psychologists to work with individuals who report human rights violations. Drawing on this work, a critical realist approach to assessment and formulation might recognise the ontological dimension of what happened and the epistemic dimension of how those events are recollected and made sense of by individuals. This framework recognises that human beings are both determined and determining and that the experience of adversity relates to both inner and outer realities (Pilgrim, 2014a).

Butchard and Greenhill (2015) maintain that human rights frameworks not only establish legal and ethical obligations towards individuals and their immediate systems but could also guide the development of more ethically oriented institutions. Patel (in press) has argued that psychologists should provide mechanisms to address the social determinants of health, monitor discrimination and disparities in access to healthcare and identify the most marginalised in society. Services should be more visible and establish partnerships with diverse communities to improve accessibility. This could improve knowledge about local communities' cultural frameworks and lived experiences (Weatherhead & Daiches, 2010), break unhelpful stereotypes (Keating & Robertson, 2004) and provide opportunities for co-production in

services (Roberts, Greenhill, Talbot & Cuzak, 2012). It may also involve promoting an understanding of how human rights may be at risk in particular services, adopting a service-level stance of non-neutrality against human rights violations and understanding how best to promote best practice around human rights in complex systems (Patel, in press).

It would also require a shift from addressing individuals' psychological health in institutions to a focus on social justice and broader socioeconomic conditions. This broader perspective is consistent with recent arguments to adopt a public health approach in clinical psychology (Harper, 2016; 2017b). However, social change risks becoming unsustainable if development is not facilitated at the structural level of policy and legislation (Afuape, Hughes & Patel, 2016). Therefore, the role of a clinical psychologist should also involve contributing to service, local, national and international policy to address their potential psychological impact on individuals. Although there is evidence to support mental health promotion and prevention (Knapp, McDaid & Parsonage, 2011; Newton, 2013), a great deal of prevention work takes place in zones of uncertainty (Radden, 2017). Given that psychology's impact on influencing policy is often overstated (Walker, Speed & Taggart, 2018), clinical psychologists need to critically reflect on how best to achieve any ambitions in this domain. There are finite public resources and, therefore, there should be ongoing discussions about the proportion of a clinical psychologist's time directed towards policy, with all the aims of primary prevention, compared with relieving the symptoms of those already experiencing mental distress. These are all necessary avenues to explore in the future as the profession continues to develop and adapt to the various dilemmas and challenges of society.

4.3.3. Research

Patel (in press) argues that the principles of human rights and the standard ethical procedures in psychological research are complementary and need integration throughout the research process. A human-rights based approach to research may involve looking beyond the sanctioned ethical parameters of research to consider genuine co-production and the wider effects of the knowledge produced from research (Brinkmann & Kvale, 2017). This may involve recognising the limitations of evidence-based practice (Harper, Gannon,

Kenneth & Robinson, 2013), overcoming the idea of scientists as neutral observers of phenomena (Patel, 2007), and treating the outcomes of research with care (Rose, 2019). Monitoring and accountability measures could help ensure the protection of human rights in all aspects of psychological research whether or not the research outcomes may benefit society (Patel, in press).

The relationship between mental health and human rights is complex and demands more scientific scrutiny (Mann, Bradley & Sahakian, 2016). It is important for clinical psychologists to research the causal mechanisms in relation to human rights and mental health. One of the challenges with research is that there is significant disagreement about the constructs under investigation, and how best to investigate mental health and justice. One proposal is that clinical psychologists could develop methods of detailing the social patterning of distress that improves the questionable validity and reliability of psychiatric constructs (Harper, 2016). However, Pilgrim (2014a) points out the psychiatric hegemony remains because of its institutional status rather than the scientific credibility of its knowledge claims. It is unclear the extent to which acknowledging the importance of social context might help clinical psychology challenge, rather than further reinforce, the research agenda of psychiatric epidemiology in the future. Therefore, clinical psychologists trying to promote human rights should critically reflect on their relationship to diagnostic language, and whether they adopt, or distance themselves, from psychiatric categories.

Human rights research and practice could be an area that unites the human sciences. What might a genuinely interdisciplinary approach to human rights look like that encourages collaborative research between academics from psychology, sociology, economics, political science and human geography? There are very real challenges to working across disciplines but also opportunities for a revitalised approach to articulating a sustained and enduring critique of the unjust distribution of resources in our society. Patel (2007) has argued that embedding human rights in clinical psychology raises tensions and dilemmas that cannot be resolved in language but in action. Clinical psychologists could lend their research skills to community organisations or carry out action research with those who have survived and endured human

rights violations (Patel, 2007). This is an area that clinical psychologists could support and campaign around. Working with colleagues from other disciplines, alongside service users and survivors, to promote human rights may also challenge ideas that academia is increasingly disengaged from people's concerns.

4.3.4. Challenges

One key challenge of human rights-based approaches to clinical psychology might be that practitioners engage with the moral and ethical demands of human rights solely at a rhetorical or procedural level (Rose 1985b; 2019). As discussed previously, this is one of the dangers of approaches to human rights that could be characterised as overly legalistic. Rose (1985b) has argued that the dominance of rights discourse in contemporary liberal democracy sidesteps important ethical issues, by smuggling in an unquestioned morality about our obligations towards one another and just behaviour. This could be addressed by ensuring that human rights are subject to continued scrutiny and reflection. Therefore, it is important that human rights, and the moral dimensions of clinical practice more generally, provide the basis for critical engagement through the same mechanisms of training and supervision that support the development of all clinical psychologists. Rather than viewing human rights-based practice as a competency that is either established or consolidated, supervisory and academic contexts provide an opportunity for the continued development of moral imagination (Arpaly, 2005). In the context of human rights, this moral impulse would involve the acknowledgment, recognition and engagement with the painful reality that human rights violations have for people. Developing this sensitivity would require continued support from others, but is essential in order for professional engagement with human rights to move beyond formal measures and policies.

A human rights-based approach to clinical psychology places mental health in the context of security, social justice, equity and non-discrimination (Patel, in press). It would highlight important ethical and legal questions that have been ignored in the profession for too long. However, the domains of goodness and justice are not exhausted by human rights (Donnelly, 2013). There are moral considerations beyond the scope of human rights that also have an important

bearing on the practice of clinical psychology. These may include important moral considerations such as charity, mercy or compassion (Tasioulas, 2012). A consequence of this argument is that even if all human rights were fulfilled serious deficits in health may still persist and, therefore, human rights should not be the sole consideration in promoting health (Tasioulas & Vayena, 2016). One of the dangers, then, of a human-rights based approach is that other considerations relevant to mental health get ignored or become incorrectly characterised as human-rights issues.

Western models of psychopathology have increasingly organised responses to terrorist attacks, natural disasters and war (Summerfield, 2000). Another concern is that the theories and research of clinical psychologists can psychologise the political dimensions of human rights violations (Patel, 2011). Papadopoulos (2002) has argued that confusing moral and psychological discourses can mean that in order to express justified condemnation of moral atrocities professionals sometimes offer as proof the fact that people have been left traumatised, broken and damaged. This trauma discourse can position survivors of tragic events as victims in need of medical treatment (Fassin & Rechtman, 2009). These practices might reinforce a moral economy of trauma, such that our systems of support and advocacy only support those in medical need rather than addressing the socio-political causes of violations (Fassin & Rechtman, 2009). Papadopoulos (2007) has discussed that when people are exposed to adversity there is a tendency for professionals to become polarised, viewing them as either being resilient or psychologically damaged. While it is important not to neglect or underestimate human suffering, responses to adversity often entail resilience or even positive response (Papadopoulos, 2007). These traumatised conceptualisations of people's response to adversity neglect the systemic complexities of the way that events impact families, communities and professionals.

4.4. Evaluation

Flick (2009) has argued that the proliferation of quality criteria in qualitative research means that the researcher needs to justify which proposed set of criteria would be most suitable to meet the aims of the evaluation. The

framework that has been chosen to evaluate this research assesses the contribution, credibility and rigour of the research (Spencer & Ritchie, 2012). A final section on reflexivity will be added to the framework to further support the depth of the evaluation. These standards were chosen because they were proposed for assessing the quality of research specifically in mental health and psychotherapy. Secondly, the areas can be applied flexibly as guidelines rather than rigid criteria (Spencer & Ritchie, 2012), which is in keeping with the principles of qualitative research and critical realism.

4.4.1. Contribution

Spencer and Ritchie (2012) underline the importance of considering how research might be relevant to theory, practice, policy and individual's lives. This study has contributed to knowledge in the profession by outlining some mechanisms that can account for clinical psychology's ambivalent engagement with human rights over time. Previous studies have established equivalent values between clinical psychology and human rights (Kinderman, 2007; Butchard & Greenhill, 2015), or noted the challenges and possibilities of clinical psychology's engagement with human rights (Patel, 2007; 2011). By focusing on possible explanatory mechanisms, this study outlines the steps that professionals could take to challenge the areas that undermine clinical psychology's engagement with human rights. The three-tiered analysis affords a basis to address these challenges at different levels depending on people's role in services and policy. A key insight, in this regard, has been the evidence of clinical psychologist's willingness to engage with human rights. It, therefore, demonstrates that human rights have not been completely marginal to the profession. Although their role has not been coherently integrated, those historical precedents highlight their potential to be developed more fully in professional theory and practice. Identifying these moments in time, however narrow and precarious, can support arguments that call for a profession more oriented towards the concerns of morality, justice and human rights.

Price and Martin (2018) have argued that an emerging area of study in critical realism has been an engagement with moral realism. This study has maintained that human rights are relevant to clinical psychologists because they have a moral reality beyond being merely legal conventions (Tasioulas, 2012). It has

been argued that human rights are important beyond being justiciable (Sen, 2006), and that the moral foundations of human rights, grounded in universal human interests, connect to the moral foundations of clinical psychology. However, such an approach will not convince those who are sceptical about the possibility of rights-based approaches to mental health. For example, Rose (2019) is cautious about the potential of human rights, specifically the CRPD, to influence practice. He argues:

that the best way to reduce such use [of involuntary and quasi-voluntary administration of medication] is by instilling best practice, rather than through legal measures that are often 'honored in breach' – that is to say, which may be on the books, but have limited effects in practice (p. 222).

Rose is criticising a purely legalistic interpretation of rights in this passage. Therefore, it is not an argument against human rights but against a particular conception of human rights. There are a number of ongoing projects in mental health trusts to embed human rights best practice on intensive care units and award wards (N. Patel, personal communication, April 30, 2019). Kinderman and Butler (2006) have argued that psychological theory can reduce this gap between practice and legislation. The arguments developed in this study recommend that recovering the moral foundations of human rights would serve as a guide to instilling best practice and developing services.

4.4.2. Credibility

Exploring credibility in qualitative research relates to the plausibility of the claims (Spencer & Ritchie, 2012). Key questions that should be addressed include considering the composition of the raw data and the interpretative accounts generated. Barbour (2018) has argued that qualitative research, although noted for its ability to develop thick descriptions of phenomena, can often appear quite thin. A central challenge at the collection stage of this study resulted in the raw data being less comprehensive than anticipated. Some of the documents in the BPS's archive at the Wellcome Collection had not been catalogued. In developing the research question, histories of the profession had used particular collections that I incorrectly assumed would still be open to the public. This meant that the analysis used fewer primary sources to generate

explanations than initially designed. An initial hope was to include some discussion of the minutes from the meetings of the CPP (MH) at the beginning of the NHS. Having these documents would have added a richness to the discussion of the professional interests of the society. Having said this, the data that was collected spanned a significant time period, from 1950 to 2018, which allowed a detailed analysis to be carried out.

Bowen (2009) has suggested that documentary researchers should also draw on multiple sources of evidence, in the forms of participant interviews or ethnographic work. Forms of triangulation were used in the research to corroborate the findings. The BPS and DCP documents that were used predominantly in the analysis were compared against human rights instruments and mechanisms to understand the convergences and divergences. However, further studies could employ multiple and creative sources of data to further improve the credibility of the findings. An example might include using more specific document collection alongside ethnographic field work and interviews to explore the success of implementing human rights in mental health settings.

The analysis included extracts of raw data to support the findings. The raw data was fully coded and refined to form the themes discussed in the analysis. Flick (2010) has acknowledged that a key challenge for qualitative researchers is that the themes constructed from the data could be subject to a process of selective plausibilisation. He maintains that it is often unclear how researchers manage passages that they believe do not illustrate, or diverge, from the content of themes. One of the key features of the analysis was the tension evident in the themes. The first theme ("The Right Language") did diverge from the other themes because it was the only occasion when there was a sustained exploration of human rights. Although the themes were discussed with my supervisor, the analysis would have been supported by asking another researcher to validate the themes.

4.4.3. Rigour

Spencer and Ritchie (2012) argue that rigour might seem incongruous with the exploratory aims of qualitative research but highlight the importance of having a transparent research process, a defensible design and thorough conduct. To

ensure transparency I have included a sample extract of the raw data (Appendix D), and provided extracts of data to support the analytic findings. The second chapter defended the epistemological, ontological and methodological commitments of the research. An important consideration, in this respect, is that the methods used were the most appropriate way to answer the research questions. My supervisor and I considered the possibility of conducting interviews and focus groups. Although we thought that such a research strategy could answer the research question about the relationship between human rights and clinical psychology, we decided that it would leave the second question about the historical antecedents that could explain such a relationship. Having rich data to answer this second research question was crucial to appreciating the implications for the profession of engaging more with human rights.

Rigorous research also involves giving thorough considerations to ethical issues (Spencer & Ritchie, 2012), and the exploratory nature of qualitative research demands an ongoing ethical sensitivity to what is constructed through the analytic process (Brinkmann & Kvale, 2017). Brinkmann and Kvale (2017) warned of research being co-opted by those with different agendas to the researcher. A key concern is that critical approaches to research can be considered to cast a suspicious interpretation over the relevant research material (Willig, 2017). This research has described the tensions and contradictions in both human rights and clinical psychology and could be used to undermine efforts to achieve the realisation of human rights for all people. However, critique also functions to question professional activity in ways that open up new avenues for exploration and practice. There is always a danger of research being misread and misunderstood and it is hoped that the dissemination of this work will continue a critical conversation about the values and goals of clinical psychology in relation to society.

4.4.4. Reflexivity

I discussed in the second chapter how my values informed the development of the research questions and design of the study. This section will explore how my learning throughout this process might be taken forward in my career. The opportunity to carry out this research has encouraged me to continue exploring

the relationship between justice, equality and human rights. I believe this is important because there is a growing awareness of how these concepts bear on our mental health and life more generally. There appears to be a more sustained discussion about the relationship between various forms of adversity and mental health. I appreciate more deeply than I did at the beginning of this project how these complex moral questions will demand sustained scrutiny over the course of my professional and personal life. I have already spoken about the dangers of psychologising human rights violations, but it is also important to not seek to explain individual psychological phenomena exclusively by reference to social structures (Fryer, 1994). I believe that psychologists can support individuals and organisations to make sense of the complex way that we experience events and phenomena through a complex interaction of intrapsychic, interpersonal, socio-political and epistemological factors. However, I also recognise the dangers of overemphasising how I might be able to contribute towards the preventative work that was outlined earlier in this chapter. Psychology offers a culturally dominant way of understanding this relationship but, again, the danger here is that this approach risks ignoring the intellectual resources from other traditions. It will be important for me to find a role as a clinical psychologist where I continue these conversations with colleagues and continue to develop these ideas in different contexts.

I was also alerted to a bias that I need to be more mindful of during my career. As discussed, human rights and clinical psychology have been criticised for offering a Eurocentric and patriarchal perspective on human relationships. However, I do not think that I have adequately considered my own social identity as a white, middle class man during this research. When reviewing the final draft of my thesis, my supervisor noticed that the literature I used to form the basis of my arguments was dominated by white men (N. Patel, personal communication, May 3, 2019). We discussed how this bias might relate to my identity and that it had created a particular vision of human rights and clinical psychology. Following that conversation, I felt both gratitude that my supervisor had told me about these omissions but also a sense of loss and discomfort. I thought that this blind spot had potentially cut me off from perspectives that could not only have informed this study, but also my professional practice and outlook on life. I wondered how much of my approach to scholarship and

reading has been influenced by this pattern and am determined to change it in future in order to connect with fuller perspectives on human life and relationships. These conversations also made me reflect on the uncomfortable fact that although I had spoken about the importance of non-discriminatory practice my own work reflected and reproduced dominant forms of whiteness and masculinity that operate in society (e.g., Patel & Keval, 2018; Wetherell and Edley, 1999; Wood & Patel, 2017). The doctoral training has made me aware that being a white, middle class male affords me certain epistemic privileges (Fricker, 2007), such that my views may be given an overdue credibility in virtue of my social position. However, these conversations have made me recognise how wide the gap can be between awareness and action, between knowledge and virtue. In my future work I need to ensure that I pay attention to how my identity influences my approach to an area of research or clinical practice and how my opinions might be heard, possibly at the expense of others in society.

4.4.5. Further Research

There are several ways of building on this research that would clarify clinical psychology's relationship with human rights in more detail. One avenue to explore in future work could be to carry out individual interviews and focus groups to explore the profession's relationship with human rights. The research questions could still focus on clinical psychology as a whole and explore the views of those drafting documents for the guidance of clinical psychologists. This process would highlight some of the dilemmas and compromises that inevitably happen when writing guidelines for professional practice with a number of people who might have different philosophical convictions. Research questions that aimed to elucidate particular areas of clinical psychology could focus on particular specialities where perhaps human rights-based thinking and practice is more established. An example of this might be in learning disabilities service where research could explore how clinical psychologists understand their moral responsibilities in light of the scandals at Winterbourne View and, more recently, Whorlton Hall. A final avenue for research could be the way in which particular therapeutic modalities, either Cognitive Behavioural Therapy, Psychoanalysis or Systemic Therapy, have responded to human rights violations and some of the implications that their assumptions about human nature might have for incorporating these issues into therapy.

4.5. Concluding Comment

This study has deepened my ethical awareness with respect to my professional and personal life. I am not sure whether a new clinical psychology oriented towards the moral concerns of human rights is possible. The history of the profession and current trends in our society guard against such untimely optimism. I believe that we should move away from any idealism associated with grand narratives of change (Afuape, 2011), but remain hopeful that practice can be challenged in local contexts in ways that might have wider impacts on people's lives and social practices. I hope that I can find opportunities to continue developing these concerns with colleagues, supervisors and, of course, the people that our profession purports to serve.

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6. APPENDICES

Appendix A

Table A

Dataset of 31 Documents Relating to the Practice of Clinical Psychology for Initial Coding and Development of Themes

Publisher	Date	Title
British Psychological Society, Australian Branch	1950	Sub-Committee on Professional Problems of Psychologists
British Psychological Society	1955	Standards of Professional Conduct of the British Psychological Society
British Psychological Society	1985	A Code of Conduct for Psychologists
British Psychological Society	1993	A Code of Conduct for Psychologists
British Psychological Society	2006	Code of Ethics and Conduct
British Psychological Society	2009	Code of Ethics and Conduct
British Psychological Society	2018	Code of Ethics and Conduct
British Psychological Society	1977	Ethical Principles for Research with Human Subjects
British Psychological Society	1978	Ethical Principles for Research with Human Subjects
British Psychological Society	1990	Revised Ethical Principles for Research with Human Participants
British Psychological Society	1992	Ethical Principles for Conducting Research with Human Participants
British Psychological Society	2010	Code of Human Research Ethics
British Psychological Society	2014	Code of Human Research Ethics

British Psychological Society	2007	Working Psychologically in Teams
British Psychological Society	2016	Guidelines for Psychologists on Disclosures of Historical Sexual Abuse
British Psychological Society	2017	Practice Guidelines, Third Edition
The English Division of Professional Psychologists	1960	Rules of the English Division of Professional Psychologists
The Scottish Division of Professional Psychologists	1960	Rules of the Scottish Division of Professional Psychologists
Division of Clinical Psychology	1973	Interim Guidelines for the Practice of Clinical Psychology
Division of Clinical Psychology	1974	Current Guidelines for the Professional Practice of Clinical Psychologists
Division of Clinical Psychology	1983	The Professional Practice of Clinical Psychology
Division of Clinical Psychology	1990	Guidelines for the Professional Practice of Clinical Psychology
Division of Clinical Psychology	1995	Professional Practice Guidelines
Division of Clinical Psychology	1994	Core Purpose and Philosophy of the Profession
Division of Clinical Psychology	2001	The Core Purpose and Philosophy of the Profession
Division of Clinical Psychology	2010	The Core Purpose and Philosophy of the Profession
Division of Clinical Psychology	2015	Inclusivity Strategy
Management Advisory Service	1989	Review of Clinical Psychology
The Health Professions Council	2003	Your Duties as a Registrant: Standards of Performance, Conduct and Ethics
The Health Professions Council	2008	Standards of Conduct Performance and Ethics
Health and Care Professions Council	2009	Standards of Proficiency: Practitioner Psychologists

Appendix B

Table B

Final Dataset of 15 Documents Relating to the Practice of Clinical Psychology Included in the Analysis

Publisher	Date	Title
British Psychological Society	1955	Standards of Professional Conduct of the British Psychological Society
British Psychological Society	1985	A Code of Conduct for Psychologists
British Psychological Society	1978	Ethical Principles for Research with Human Subjects
British Psychological Society	2007	Working Psychologically in Teams
British Psychological Society	2017	Practice Guidelines, Third Edition
The English Division of Professional Psychologists	1960	Rules of the English Division of Professional Psychologists
The Scottish Division of Professional Psychologists	1960	Rules of the Scottish Division of Professional Psychologists
Division of Clinical Psychology	1974	Current Guidelines for the Professional Practice of Clinical Psychologists
Division of Clinical Psychology	1983	The Professional Practice of Clinical Psychology
Division of Clinical Psychology	1990	Guidelines for the Professional Practice of Clinical Psychology
Division of Clinical Psychology	1995	Professional Practice Guidelines
Division of Clinical Psychology	1994	Core Purpose and Philosophy of the Profession
Division of Clinical Psychology	2001	The Core Purpose and Philosophy of the Profession
Division of Clinical Psychology	2010	The Core Purpose and Philosophy of the Profession
Management Advisory Service	1989	Review of Clinical Psychology

Appendix C

Table C

The Initial Codes that Formed the Basis of the Broader Themes Explored in the Analysis

Initial coding

Clinical psychology and well-being

Elements of well-being

Clinical psychology and distress

Reputation of profession paramount

Clinical psychologists as unique in a competitive market place

Applied psychology to solve human problems

The notion of psychological expertise

Clinical psychology as a science

Psychologists have specialist psychological knowledge

The important of competence

Psychologists responsible for their fitness to practice

Transferable skills

The relationship between qualifications, competence and public trust

Rights discussed more important in the supervisory relationship

Rights more often invoked in terms of trainees and organisations than for patients

The profession of clinical psychology

Secrecy

The importance of being effective

Relationships important for securing rights

Questioning the purpose of clinical psychology

Psychologists as providers a psychological service

Defined roles in healthcare - practitioners, patient, referral, service etc.

Definition of clinical psychologist

Clinical psychology and the individual

Narrow scope of intervention

Clinical psychologists defined in quite limited terms
Definition of clinical psychology – defining the scope of the profession
Intervention and timescales
Prevention discourses still in the remit of identified patient
Clinical psychology and formulation
Vagueness about the use of human rights
Non-discrimination
Monitoring by disaggregation
Privacy
Participation
Right to Autonomy and Self Determination
Security
Effective remedy
Cautious with respect to current knowledge
Towards ethics-based practice
Rapidly changing discipline
Cautious in public pronouncements.
Avoid being sensationalist or superficial
Clinical psychologists as more than therapists
Psychological health is influenced by context
A wider focus
Human rights explicitly mentioned
Clinical psychology and action
Positive duties
Supervision as a mechanism for professional development
Psychologists as leaders
Psychologists responsible for developing mechanisms
Psychologists as teachers and communicators
Language of rights absent when useful
Particular rights in focus more than others
Work within limits of competence

Consulting with colleagues

Decision making

Primary concern is the patient

Balance between the psychologist's commitment to psychological science and human welfare

Ethical dilemmas with respect to confidentiality

Psychologists as responsible for creating environment for people to exercise their rights

Psychologists aware of what might impact on rights being realised

Power and the infringement of rights

Power imbalance and equality

Power and consent

Capacity and consent

The notion of informed consent – can it ever be truly valid?

People under section do not have the rights to withdraw from treatment.

Right to refuse treatment

A history of deception – in experiments, trainee status

Development of ethical norms - right to withdraw only when deception has been substantial?

Recognition of harms in research

Ethical principles as guidance

Enforcement

Clear recognition of legislation

Legal responsibilities to avoid negligence

Often a responsibility to be aware but is this also the case for the authors

Narrow demographics in the profession

Limits of a code

The role of codes of conduct generally

What is the structure and function of the mind?

Economic rationality

Appendix D

DCP_Clinical Psychology Codes.pdf - Adobe Acrobat Pro DC
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Comment

RESPONSIBILITY

The psychologist is committed to the application of his knowledge of psychology to assist in the relief of distress and the promotion of the well-being of the patient. He places high value on objectivity and integrity in his conduct and seeks to attain the highest standard in the services he offers within the limits of his employment.

- In clinical practice he bears responsibilities to humanity as a whole as his work concerns the application of a science and clinical skills to have influence upon the lives of others.
- In scientific work, the psychologist believes that the advancement of psychological knowledge is in the best interests of humanity and he applies skilled judgment in selecting appropriate areas of investigation.
- In teaching, the psychologist recognises that the furtherance of the profession of psychology by assisting others (particularly those within the profession of psychology) to acquire knowledge, skill, and understanding, is in the best interests of humanity as a whole.

Ethical Code 2

COMPETENCE

A psychologist recognises specific professional skills which he is best qualified to exercise in the interest of the public, the individual and the profession. It is incumbent upon the psychologist to protect these interests.

- The psychologist strongly discourages the practice of psychology by unqualified, inadequately qualified or improperly qualified persons, and also assists the public in identifying an appropriate professional psychological service.
- The psychologist recognises that there are boundaries to his competence and does not engage in services or employ techniques outside his expertise and professional experience except in the pursuit of training. The psychologist undertakes to do whatever is in his power to assist the patient to obtain diagnostic and therapeutic help in such relevant problems as are outside the competence of the psychologist, especially where the psychologist has effective overall care of the patient.

441 comments

Christopher Apr 4
How are we protecting interests when there is no legislation?

Christopher 16:47
Reputation of profession paramount

Christopher 16:47
The relationship between qualifications, competence and public trust

Christopher Apr 10
Work within limits of competence

Christopher Apr 10
Clinical psychology and well-being

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Figure B. A screenshot of an extract from the DCP Interim Guidelines for the Professional Practice of Clinical Psychology published in 1973 showing the coded raw data.