Ideology and Politics in the Struggle to Regulate the Talking Therapies: The rise and fall of the HPC plans, 2006-2011

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Ever tried. Ever failed. No matter. Try again. Fail again. Fail better.

Samuel Beckett

I have believed for as long as I can remember in an afterlife within my own life – a calm, stable state to be reached after time of troubles. When I was a child, that afterlife was Being Grown Up. As I have grown older, its content has become more nebulous, but the image of it stubbornly persists.

Donald A Schon (1971)

ABSTRACT

This thesis offers a discourse analytic account, informed by Lacanian psychoanalysis, of the 2006-2011 struggle over plans to make the Health Professions Council (HPC) statutory regulator of the field of counselling and psychotherapy in the UK. I contextualise the plans in relation to the Government's parallel Improving Access to Psychological Therapies (IAPT) programme and the Skills for Health (SfH) project to map competencies within the field. These projects, along with HPC regulation, promised to render practice safe and effective. However, the HPC plans were seen by some as a threat to diversity within the field and were met with resistance from the (especially formed) Alliance for Counselling and Psychotherapy Against State Regulation. I assess these competing evaluations and argue that the HPC plans would have advanced a 'transactional' orientated regime, in which the field would have been assimilated to a more consumerist mould, and that in contrast, the Alliance were seeking to defend a more 'contextual' and 'relational' conceptualisation of practice in which expertise tends to be seen as co-created between client and practitioner. The HPC adopted a series of bald strategies to marginalise opposition voices, conditioned in part by structural features of the policy making process and supported by a 'problem minority' narrative in which inherent uncertainties about what counts as good and effective talking therapy are eclipsed from view. The Alliance, for its part, I argue, tended at times to espouse a position close to talking therapy exceptionalism, thus eclipsing similarities with more contextual healthcare imaginaries. I examine how fantasy provided these positions with affective 'grip.' Policy implications for regulation and policy making process are drawn out. More broadly, my account contributes to literature that questions the often-supposed democratising nature and inevitability of highly calculative forms of regulation and audit within arenas of indeterminate professional work, where enhancing practitioner responsivity to unique elements within each context they find themselves is arguably more efficacious and democratic in character.

CONTENTS

LIST OF ABBREVIATIONS

- **BABCP:** British Association for Behavioural and Cognitive Psychotherapies.
- **BACP:** British Association for Counselling and Psychotherapy.
- **BPC:** British Psychoanalytic Council.
- **CFAR**: Centre for Freudian Analysis and Research.
- **HPC:** Health Professions Council (Now the HCPC: Health Care Professions Council).
- **IAPT:** The Improving Access to Psychological Therapies.
- **NICE:** The National Institute for Health and Care Excellence.
- **PLG:** Professional Liaison Group.
- **PPAG:** Psychological Professions Association Group.
- **SFH:** Skills for Health.
- **UKCP:** UK Council for Psychotherapy

CHAPTER ONE

INTRODUCTION

> The plot comes straight from a campus novel: splenetic academics; a government hell-bent on reforming their discipline; sexual impropriety, whispering campaigns and litigation threats. The narrative practically writes itself. But this is not a David Lodge tour de force; this is the bitter, increasingly public, war ripping through the UK's "talking therapies". If psychotherapy were on the couch right now, it would not be short of issues. (Doward and Flyn, 2010).
>
> The field we know as counselling and psychotherapy is so diverse, so rooted in relationships and places, so firmly fixed amongst ordinary people that the wish to legislate it into a neat standardised package should rather be written into [the] next DSM as a sectional mental illness' (Low, 2008).
>
> New rules don't 'enslave' therapists or make types of practice illegal – they're an acknowledgement of the reality of abuse (Coe, 2009).

This thesis provides an account of the 2006-20011 struggle over plans to make the `Health Professions Council (HPC) the statutory regulator of the field of counselling and psychotherapy. I extensively contextualise this struggle in relation to the broader healthcare regulatory reforms in which the HPC plans were embedded, as well as the Skills for Health project (SfH) to map the competencies - the so called National Occupational Standards (NOS) - of counselling and psychotherapy, and the Government's Improving Access to Psychological Therapies programme (IAPT). The Chief Executive Director of the British Psychoanalytic Council (BPC), Malcolm Allen, described the HPC plans, together with the SfH and IAPT projects as

constituting a ‘new zeitgeist’ for the field of counselling and psychotherapy.[1] By mid-2006, once the possibility of HPC regulation of the field became seen as a serious possibility, a group of mainstream professional associations within the field, including the two biggest - the UK Council for Psychotherapy (UKCP), and the British Association for Counselling and Psychotherapy (BACP), spearheaded by the British Psychological Society (BPS), put together an alternative proposal for a specialist regulator called the ‘Psychological Professions Council’ (British Psychological Society, 2006). They were chiefly concerned that the HPC, as a multiple-professional regulator, focussed on the health professions, would lack adequate specialist knowledge of the field. The BPC and the British Association for Behavioural and Cognitive Psychotherapies (BABCP), however, positioned themselves in favour of the HPC plans from the outset.

The Government rejected the alternative proposal, and in February 2007, tucked within the Government White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* (Department of Health, 2007a), was the Labour Government’s announcement that it intended to push ahead with HPC regulation of psychologists, psychotherapists and counsellors ‘following [the HPC’s] rigorous process of assessing their regulatory needs and ensuring that its system is capable of accommodating them’ (Department of Health, 2007a:85).

Perceiving the plans to be the only politically viable possibility for statutory regulation, the UKCP and BACP did an about turn and joined the BABCP and

[1] Malcolm Allen (Chief Executive Officer of the BPC), interview by author, October 2014. See Appendix A transcript p.457.

the BPC in broadly committing themselves to supporting the development of the HPC plans. In December 2008 the HPC held the first meeting of its Professional Liaison Group ('Liaison Group' as shorthand) for counselling and psychotherapy and included representatives from all the main professional associations within the field, and was given the remit to develop the 'nuts and bolts' of the plans, as Michael Guthrie, the HPC's Director of Policy and Standards, put it.[2] ; as opposed to a wider remit of considering the more fundamental policy parameters of whether statutory regulation of the field is desirable, and, if so, by what kind of regulator. The HPC also conducted wider consultations within the field, beginning In July 2008 with its 'Call for Ideas', followed by a fractious 'stakeholder meeting' held in Manchester in March 2009, and another written consultation on the draft recommendations, made by the HPC's Liaison Group to the HPC's Executive, on the 'proposed statutory regulation of psychotherapists and counsellors'.

Two key frontiers within the struggle over the HPC plans emerged. The first was within the HPC's Liaison Group itself; that is to say there was a division among supporters of the HPC plans. This was a strong cleavage within the group over the 'nuts and bolts' of the plans, namely on the issue of 'differentiation': whether or not the register should distinguish between counselling and psychotherapy, each with its own distinct entry levels and standards of proficiency. The HPC plans had become the latest locus of a pre-existent 'turf war' within the field, and the HPC plans intensified anxieties over how this turf war might be settled. Most parties within the Liaison Group supported differentiation. However, the BACP, by far the largest organisation

[2] Michael Guthrie (Director of Policy and Standards, HPC), interview by author, June 2014.

within the field, was resolutely opposed to differentiation, and each side of the division accused the other of abandoning the public interest in pursuit of their own organisational interests. A key feature of the struggle over the 'nuts and bolts' of the plans was the tendency for the 'differentiation' camp to push (somewhat to their own discomfort) the characterisation of psychotherapy in a psychiatric orientated direction in order to secure a distinction from counselling. [3]

The second frontier is that between the HPC and its proponents on the one hand, and those opposed to the HPC plans in their totality on the other. The HPC's wider consultations, including a fractious 'stakeholder meeting' held in Manchester in March 2009, failed to produce any palpable rapprochement between the HPC and its opponents. Whilst the HPC firmly pushed forward an agenda which focussed on developing the 'nuts and bolts', many within the field attending the meeting pushed for a resolute and total rejection of the HPC as prospective regulator of the field, demanding that the HPC address the fundamental 'whether and by whom' questions (Low, 2008), (Postle, 2012).

In frustration of the character and direction of the consultation and policy-making processes, a group of practitioners from a diverse range of schools within the field formed the Alliance for Counselling and Psychotherapy Against State Regulation. One of its key founders, the Jungian Analyst, Andrew Samuels, characterised the Alliance as 'not the great and good of the

[3] James Antrican (Chair of UKCP 2007-2009), interview by author, October 2014.

psychotherapy world, but [the] troublesome bolshie of the psychotherapy world'[4]. Other founding and key members included the Lacanian psychoanalyst, Darian Leader, the humanistic counsellor, and long term campaigner against 'the professionalisation' of counselling and psychotherapy, Denis Postle, and the Jungian analyst, Paul Atkinson. I have interviewed all of these actors as part of this research.[5]

The HPC and the Alliance made radically different interpretative and narrative accounts of the HPC plans. Proponents claimed that the plans were a 'neutral' or 'light touch' way of dealing with a 'problem minority' of practitioners within the field, and that therefore the plans were not a threat to the diversity of practice, or to the vast majority of practitioners. Enthusiasts, conversely, saw the projects were seen by many as together helping to ensure that practice and services were safe and cost-effective, as well as more widely available. IAPT for instance was set to create an army of new therapists to deal with what the Depression Report called an 'epidemic of depression' (Layard et al, 2006). The projects were, in short, seen by policy makers as a long overdue move to improve the quality and availability of psychological services, and as a means of protecting the public from unscrupulous practitioners in a hitherto inadequately regulated and governed field.

However, for many within the field the emergent character of the SfH and IAPT projects heightened their concerns about the HPC plans. The SfH project was initiated with the express intention of informing the development of standards within the HPC regulatory plans, and was predominantly led by a

[4] Andrew Samuels (Chair of UKCP 2009-2011), interview by author, June 2014
[5] Darian Leader(Lacanian psychoanalyst, Alliance co-founder), interview by author, June 2014

relatively narrow faction within the field, namely academics and practitioners from the Department of Health Psychology at the University College, London, and practitioners associated within the BPC (Arbours Association et al, 2009). The project adopted the contentious 'experimentalist' research paradigm, valorised by the National Institution for Clinical Excellence (NICE) [6] and the so called evidence based practice movement, as the foundation upon which to develop the NOS for four modalities of talking therapy, namely cognitive behaviour therapy, psychodynamic psychotherapy, systemic family therapy, and humanistic psychotherapy and counselling. Despite strong assurances from SfH that it was inclusive, the project quickly ran into deep controversy, most psychoanalysts, for instance, viewing the NOS developed for psychoanalysis as unrecognisable, and as incommensurable with their practice, and with all psychoanalytic literature, with the exception of mentalisation based therapy (MBT) developed by the psychoanalyst Peter Fonagy at the UCL (Arbours Association et al, 2009).

Similarly the IAPT programme was contentious within the field, largely as it was restricted to therapy packages 'proven' to be cost-effective through experimentalist controlled trials. This tended to favour cognitive and behavioural based therapies (for a range of reasons), and many practitioners from other schools regarded the research evidence as flawed, with some holding that the experimentalist paradigm is incommensurable with many forms of counselling and psychotherapy, contending that talking therapy cannot be standardised in the way required by such research. SfH and IAPT therefore raised the temperature within the field and fuelled suspicion that the

[6] In 2013 NICE was renamed the National Institute for Health and Care Excellence.

HPC plans were part of a bid of certain factions within the field, drawing on both the strength and demands of the state, to ‘take over’, or radically restructure, the terrain of the counselling and psychotherapy field (Arbours Association et al, 2009), (Postle, 2012).

In short the Alliance saw the HPC plans, along with the SfH and IAPT projects, as a threat to diversity within the field and to the freedom to practice particular forms of talking therapy. The Alliance characterised the projects as a medical and consumerist encroachment upon a field in which many practitioners foreground the importance of the contextual and emergent, and therefore the unique, character of each therapeutic relationship. To attempt to delineate and guarantee the qualities or outcomes of therapy in advance of the therapeutic relationship, whether through medical rationalisation of the process, or through a consumer contract, is, the Alliance contended, to destroy the process before it has even began. Closely related to this was the Alliance’s characterisation of the plans as a threat to therapies which seek to provide a space in which alternatives to dominant values within society can be freely explored (Arbours Association et al, 2009).

Despite consultations which were a standard part of the HPC’s procedures for taking on board new professions as well as additional meetings between HPC personnel and members of the Alliance, the gap between the parties remained stubbornly unbridged. Opponents sought to stall and derail the implementation of the HPC plans through attacks on three key fronts. In October 2009 several psychoanalytic organisations launched legal action against the HPC, challenging the legality of the both the content of the HPC plans and how the HPC had conducted the policy process. Simultaneously,

with the 2010 General Election and a possible change of Government was on the horizon, members of the Alliance lobbied the Conservative Party, the then Official Opposition within the House of Commons. In the third key front, there was mounting vocal opposition to the HPC plans among many members of the main professional associations within the field, especially the UKCP and BACP, and a pivotal point within the struggle was the surprise election of Andrew Samuels to the Chair of the UKCP on an 'anti-HPC ticket' in late 2009.

In the meantime the HPC sought to resolve the differentiation issue through a second wave of Professional Liaison Group meetings; ones not originally scheduled. Additionally the Psychological Professions Association Group (PPAG) was established, comprised of the professional associations around the HPC's Liaison Group table, in an attempt to make headway on the issue and thrash out a position acceptable to all. It came up with a more nuanced position on differentiation as far as minimum levels of qualification and training required was concerned, which acknowledged that some counselling trainings are as advanced, or as in-depth, as psychotherapy trainings. But differentiation between counselling and psychotherapy within the structure of the register, in its totality, still remained unacceptable to the BACP; a fact that was reflected within its members' responses to the HPC's consultation, in autumn 2009, on the Liaison Group's proposed recommendations to the HPC Executive regarding the 'nuts and bolts' of the planned regulation.

In December 2010 the High Court gave the go ahead for a full Judicial Hearing, and the HPC was ordered, unusually, to pay some of the legal costs of the plaintiffs. In 2011, following the 2010 General Election and the

formation of the Coalition Government, the Government published a Command Paper 'Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care workers' (Department of Health, 2011) in which it indicated its intention to shelve the HPC plans, along with a number of other regulatory projects. Government Minister, Anne Milton, told Andrew Samuels that the Alliance 'had won the argument'.[7] The full Judicial Review therefore did not go ahead. The Government announced plans for the Assured Voluntary Regulation for counselling and psychotherapy, in which the Professional Standards Authority accredits voluntary registers within the field. In response to unofficial communications from Government, the Alliance said that it would not campaign against the assured voluntary scheme. [8]

The HPC, however, still submitted its recommendation to Government that HPC regulation of the field of counselling and psychotherapy was feasible. This was despite the fact that the Professional Liaison Group had not been able to reach a consensus on the 'nuts and bolts' of the plans, and in fact remained deeply divided on the issue of differentiation and how this might impact the structure the field and the main competing organisational players within it (Health Professions Council, 2011c).

This is the basic synopsis of what happened. But in what ways does it deserve our detailed attention?

[7] [7] Andrew Samuels (Chair of UKCP 2009-2011), interview by author, June 2014

[8] *Ibid.*

Why the HPC struggle matters: One might contend that the HPC struggle, as a feature of the past, is 'water under the bridge', and that the counselling and psychotherapy field is a minor, even obscure, part of the economy and regulatory field, and so not worthy of detailed attention. There are four main points I want to forward in defence of the struggle as warranting careful scrutiny. The first is that the HPC plans could potentially be revived. A government paper, Promoting professionalism, reforming regulation', published in October 2017, looks towards the reform of the system under which registers for counselling and psychotherapy are currently accredited (Postle, 2018). Some within the field of counselling and psychotherapy are reportedly enthusiastically pushing for it (*ibid*). But even if there were not any moves to revive the plans, there is nonetheless– and this is my second point – the basic tenant of doing history, consonant, in a sense with many forms of talking therapy, that understanding our past helps us to better shape our present and future. As Foucault states, the aim of doing research critically is 'to separate out, from the contingency that has made us what we are, the possibility of no longer being, doing or thinking what we are' (Griggs and Howarth, 2013:50)*.* So understanding the recent past of regulatory struggle within the field has an important contribution to make in our understanding of the present, and any possible future steps for the field within the regulatory arena.

My third point is that the HPC struggle is a significant event in the 'life and times' of the field of counselling and psychotherapy in the UK, and that the field plays a significant role within society, constituting a significant element of what many refer to as the 'psy-complex' (Miller and Rose, 1988). Questions

and concerns about the extent to which talking therapies embody dominant, and perhaps dominating, forms of practice within society, and to what extent they are, conversely, avenues of counter-cultural practice which contest forms of domination, are largely what make the question of regulation both an interesting and difficult one. How this field is (re)shaped or influenced by the introduction of new forms of regulation, whether through force, nudging, seduction, or persuasion, therefore matters. But the significance of this case study arguably also goes beyond the shores of the talking therapies. This is my fourth point. It may help us to further understand the so called rise of the regulatory state and its accompanying forms of (de)professionalization more generally, especially, though not exclusively, within the healthcare professions. By the 'regulatory state' I mean the rapid growth of regulatory practices, namely audit, within the professions, and the increased forms of marketization which often accompany it, as explored by researchers with a diverse range of takes on it, including Moran (2003) and Power (1999) . Professional 'shelter' from the market and independence from government agencies have both been eroded in recent decades, hence why some writers characterise the process as 'deprofessionalisation'. Simultaneously, there has been a proliferation of occupations becoming 'professions', in accordance with more regulatory and market orientated norms of organisation and practice. In this sense there can be said to have been a wave of professionalization across many sectors of the economy.

It is perhaps two interrelated exceptional elements which make the HPC struggle, as a case study, most interesting to the general regulatory picture. The first is that talking therapy, or at least many forms of it, could be regarded

as ‘contextual’ and ‘relational’ practice par excellence, in which the relatively open ended relationship is regarded as the means of the therapeutic ‘treatment’ itself. This exceptional character of the talking therapies could throw the contextual characteristics of other professional practices, including healthcare ones, into sharper relief. The second exceptional element is the fact that it is relatively rare for a wide-cross section of a field, with nascent and some established professional elements, to both vociferously, and in a highly organised fashion, resist the increased status and power that becoming a statutory profession is often argued to afford. Added to this, in many senses the Alliance could be said to have been somewhat unusual in its degree of success in achieving its aims in engendering considerable opposition within the field to the HPC plans, as well in its dogged optimism about the capacity of practitioners to resist and change government policy. The HPC saga also arguably has some of the hallmarks, even if it is not a clear cut case, of what King and Crewe (2013) refer to as a ‘policy fiasco’, by which they mean instances in which policy has failed predominantly because of failure of policy makers to achieve adequate foresight of likely problems. Because of this there are possible lessons to learn from the case study about the policy making process. This still stands, incidentally, even if one were to take the view that the fall of the HPC plans was more to do with broader tectonic shifts in the political landscape than with the specific interventions of the Alliance.

Let me now say a bit more about the specific aims and the approach of this research.

Aims and approach: Overall this case study seeks to contribute to our understanding of regulatory issues within the field of counselling and psychotherapy, as well as also contribute to our understanding of the policy making culture and structures involved within the HPC struggle. This may also help illuminate regulatory issues and policy making cultures and structures within wider fields, especially, though not exclusively, the healthcare and social professions.

I have adopted the innovative 'logics' research approach developed by Glynos and Howarth (2007), built partially upon the post-structuralist work of Laclau and Moufe (1985). As Howarth (2005) puts it, the 'kernel of this research programme centres on the idea that all objects and practices are meaningful, and that social meanings are contextual, relational, and contingent' (317). This approach is therefore significantly 'contextual' in orientation – a qualitative, as distinct from quantitative, form of research – and seeks to incorporate and foreground both the importance of the self-interpretations and values of the participants as well as the 'situated judgement' and values of the researcher in the construction of an account of the phenomenon under investigation. The approach I have adopted therefore has strong affinities with what I refer to as the more 'contextual' conceptualisations of talking therapies forwarded by the Alliance in which the character of a therapy is seen as emergent within the practitioner-client relationship. There is also strong affinity between a Lacanian psychoanalytic element within the 'logics approach' and some psychoanalytic actors and their framing of the HCP struggle. There is a shared notion of the subject as constitutively 'fractured' (as suggested within the Maresfield Report) (Arbours

Association et al, 2009) and incomplete (a ‘subject of lack’ as characterised by Laclau) and predisposed to seek ‘fullness’ (Glynos and Howarth, 2007). The subject is therefore seen as predisposed to idealise particular objects as inhering the promise of a ‘fullness’ to come once they have been acquisitioned. In pursuit of maximum market success, consumer and market logics are seen as particularly prone to appeal to the subject’s tendency towards the idealisation of some objects, and simultaneous denigration of others which are thought to be obstructing the subject’s path to ‘fullness’. However, contra a tendency within the Alliance towards a position near to a talking therapy ‘exceptionalism’ (where the association of talking therapy with healthcare tends to evoke strong reactions) the logics approach, given its view that all practices are discursively mediated, arguably has affinity with a scepticism towards any strong demarcations between the talking therapies and other forms of professional practice, including healthcare ones, as well as strong demarcations between professional and non-professional/community based ways of organising talking therapy services. Rather, the logics approach lends itself, so to speak, to an emphasis upon both continuities and discontinuities between contextual and acontexutal/transactional practices and norms across both the healthcare and talking therapy fields.

These predispositions within the approach, and its affinities with different elements and ‘sides’ within the struggle, obviously raises significant concerns about the objectivity and impartiality of this research. Indeed, rather than adopt the pretence of a God’s eye view of the research problem – a claim to absolute objectivity – I foreground this thesis as an ‘intervention’, of a sort, within the HPC struggle, in the form of an account of it, which is not (and

could not possibly be) entirely above the political ‘fray’. Social scientific research, whatever its design, is always necessarily an interpretative activity, and therefore always contestable. I take the view that attempts to entirely banish the subjective judgement of the researcher from the research (a practice often evident within more positivistic forms of research) only serves to mask the subjective judgement, and, therefore, make it less available to robust scrutiny. In such instances research tends to be rather more ‘objectifying’ than objective. Acknowledging and foregrounding subjective judgement and values of the researcher and their centrality to the research process avails them more easily to scrutiny, and therefore, arguably, facilitates the production of more robust and properly objective research accounts, which seek to contribute to democratic deliberation in the definition and addressing of problems, rather than ‘settle’ or foreclose a matter through false or misleading claims to complete objectivity or neutrality.

I produce a narrative account of the HPC struggle, encompassing a critical understanding of the competing ‘stories` that constituted and shaped the campaign stalls of the pro and anti-HPC camps. I have sought to produce a representative account by drawing on a rich and diverse range of sources, including extensive HPC documents, government policy papers, blogs, newspaper articles, online commentary, letters of exchange, solicitor letters, court submissions, as well as over fifteen hours of material from interviews I carried out with over fifteen key actors within the struggle and prominent members of the field.

My narrative account has two key facets and aims. The first is a descriptive and critical analysis of the character of the policy proposals and of the

competing characterisations made of them by the pro and anti-HPC camps. The second is an analysis of the political dynamics of the struggle; how the pro and anti-HPC camps sought respectively to implement and derail the HPC plans. Additionally I contextualise my account in relation to existing literature, both on the HPC struggle and broader literature on the professions, seeking to scrutinize and build upon existing accounts. There is a tendency within much of the literature on the professions towards a polarisation between public and private interest accounts in which the professions often tend to be seen as either embodying the successful pursuit of the truth and of the public interest through the exercise of science and reason, or, conversely, as the pursuit of private interests (either their own or those of the capitalist elite) through the exercise of ideology and power. Whereas public interest accounts tend to characterise the professions as ameliorant and progressive, private interest accounts tend to emphasise the problem of 'professional dominance', where government and clients are seen as getting a 'bad deal' out of the professions. Ivan Illich (1975) for example, back in the 1970s, in his private interest-based account, described the profession of medicine as the most serious modern threat to health.

In decades since the 1970s, the rise of the regulatory state, the marketization of the professions, encompassing the 'evidence based practice movement', are the central ways in which government and the professions have sought to address the dangers posed by professions. I explore and draw on both celebratory and critical accounts of these ways of seeking to address this so called problem of professional dominance. I also (largely in the concluding chapter) seek to draw out the implications of my account for policy advice,

namely on how the talking therapies should be regulated, as well as recommendations on the policy-making process itself. I also draw out the broad implications of my account relating to how these policy aims might best be strategically achieved. I also suggest that this case study illuminates aspects of broader health and social care regulatory regimes that are in need of urgent reform, chiefly (though not exclusively) concerning regulatory failure to address problems relating to the dominance of healthcare by the pharmaceutical industry and the prominent role played by the profit motive within the latter. I draw on the work of Healy (2013) and others in this analysis.

Before briefly outlining the main research questions and my overarching thesis let me first say something briefly about the motivation behind the research.

Motivation for the research: I began the research in 2010 whilst the regulatory struggle over the HPC plans was still in progress. Regulation can perhaps, to appropriate Wittgenstein's comment on the relation of rationality to passion, seem, when compared to talking therapy itself, like 'cold grey ash covering the burning embers'. Regulation is not, self-evidently, the heart of professional practice. This is perhaps one reason why so many people within the field were relatively disinterested in the HPC struggle as reported, for example, by the then Chair of UKCP James Antrican. [9] Conversely, however,

[9] James Antrican (Chair of UKCP 2007-2009), interview by author, October 2014.

opponents of the HPC plans felt that there was a real danger that HPC regulation, if implemented would not be easily kept at a distance in daily practice, but would in fact insidiously implant itself *as* the heart of talking therapy.

My personal motivation has partially stemmed from my experience of regulation within my work as a support worker within a range of social care institutions, including a therapeutic community. There is a tendency, in my experience, towards accountability as audit, in which, to put it in a slightly pejorative fashion, the regulator places an emphasis on imposing upon an institution a complex of audits and 'paper trails', which the institution then checks itself again, rather than holding institutions to account in more direct, contextual, and relational ways. I have, along with many colleagues, often had the sense that regulatory demands and the interests of clients, though often converging, too often do not do so adequately, and that audit and regulatory practices too often become the primary focus of an organisation, excessively distorting practice and wastefully draining work-force resources. It is perhaps due to my interest partially arising out of a social care context that I have been alert to and interested in the broader significance of regulatory struggle within the talking therapies for other arenas of professional regulation, especially within health and social care. Given, as noted above, talking therapy is a highly relational and contextual practice, an examination of the HPC struggle holds the attraction of throwing into sharp relief issues within the regulation of other occupations and practices with less, but still significant social, indeterminate and relational elements. By this I mean each new situation within such professional work presents significant unique

elements (it is contextually very variant), and that consequently, in keeping with the views of Power (1999, 2004) and Schon (1983), such work cannot be heavily proceduralised without detracting substantially from the quality and effectiveness of the work. These motivations have to an extent informed my research questions and how I have delimited the research, especially in regards to the broader contextualisation of the HPC struggle in relation to healthcare reforms, as well as in relation to a wider body of literature on the social professions more broadly, and the rise of the regulatory state. Let me now briefly set out the key research questions which helped frame and which also partially emerged in the course of the research.

KEY RESEARCH QUESTIONS

I have approached the HPC struggle with two overarching questions. First, what are the characteristics, norms and values of the competing policy and policy-making imaginaries that were at play? And second, what political and rhetorical strategies were used by the pro and anti-HPC camps in their respective attempts to install and derail the HPC plans? These questions have been partially shaped by the prism of the 'logics approach' (Glynos and Howarth, 2007) I have adopted (more on this below). The first question steers towards a 'thick description' of the HPC plans and of the associated IAPT and SfH projects, and towards a value-critique of their key characteristics and potential (and sometimes actual) impacts on the field of counselling and psychotherapy. I adapt a comparative analytic 'nodal' framework developed by Glynos and Speed (2012) and Glynos et al (2014) to help identity, across

different nodes of the field, the assemblage of norms embodied within the HPC plans, the IAPT and SfH projects, as well as the broader healthcare reforms in which these were situated. The key nodes I delineate are governance and regulation, education and training, provision and distribution, and delivery. I also compare and contrast these with the assemblage of norms embodied within the counter-policy imaginary of the Alliance. In this analysis I seek to assess competing characterisations by the pro and anti-HPC camps of the HPC plans and the associated SfH and IAPT projects. This task entails, among others, addressing the following key questions. What did the HPC regulatory plans presuppose about the nature of talking therapy practice, and how does this compare to the myriad of conceptualisations of talking therapy existing within the field? To what extent was there some incongruence between the HPC plans and existing forms of talking therapy, and, if so, was this, as the Alliance contended, a legitimate cause for concern? Or, conversely, as the HPC contended, did the HPC and the Alliance in fact essentially share the same values and aims – the apparent differences a consequence a mere misunderstanding of the facts?

This brings us to the second overarching question, which relates to the political dynamics of the struggle; a dimension of the critique that I refer to as ethico-ideological. A key aim of this analysis is to highlight ways in which what I take (drawing on the work of Laclau and Mouffe) to be the fundamentally and radically contingent nature of the HPC plans, was, to an extent, hidden from view by the pro-HPC lobby, partially rendering (or seeking to render) the plans an ‘inevitability,’ or as part of an apparently inexorable policy trend.

The focus on the more political and rhetorical dimension of the struggle also entails the following key question: how did the pro and anti-HPC discourse acquire ‘affective grip’? In other words I seek to account for the role played by fantasy within the regulatory and policy discourses. In the context of this case study my analysis of the ‘fantasmatic’ narratives at play tends to focus on seeking to account, at least in part, for the persuasive ‘force’ of the HPC plans, despite what I contend to be the relatively threadbare political discourses and analysis forwarded by the HPC seeking to legitimate them (more on this in a moment). Here significant presuppositions within the theoretical approach I have adopted, namely an emphasis upon the fundamental contestability of knowledge claims, and the fundamental vulnerability of the subject/individual, come together with key empirical material of the case to produce this account.

Ultimately, in the political and rhetorical dimension of my analysis, I seek to account for how the policy terrain was initially shaped in favour of the emergence, and near-implementation, of the HPC plans, and how the policy terrain later changed, leading to the shelving of the plans.

By approaching and scrutinising a wide range of sources and empirical material with these questions, I craft an account of the struggle which identifies the role played by competing organisational interests - the ‘turf war’ at play - and the competing policy imaginaries, encompassing rival values and norms, which, at least in part, constituted these organisational interests.

Let me now forward a sketch of my account.

THE OVERARCHING THESIS

The HPC plans were understood by the HPC to be an ‘approach neutral’ (my phrase) attempt to regulate the field, as highly distinct from the SfH and IAPT projects, and as more than capable of regulating non-healthcare practices. Conversely, the Alliance tended to construe the HPC plans as an attempt, along with IAPT, SfH, and NICE, to assimilate the field of the talking therapies to a consumer ethos, and to the broader healthcare regime, which the Alliance contended are sharply incongruent with most talking therapies.

Whilst for the HPC the policy dispute was based on a misunderstanding (the HPC and the Alliance in fact shared the same values and aims), for the Alliance it was a struggle over practice and regulatory values, and HPC style regulation was seen by them as an existential threat to many forms of talking therapy.

In my account I seek simultaneously to critically assess the veracity of these contrasting accounts, as well as delineate and identity the rhetorical and political strategies used by each camp to forward their respective positions. Overall, I characterise the HPC policy dispute and the broader professional reforms in which it was situated as a struggle between what I refer to as a ‘transaction’-based regime of practice and regulation on the one hand, and a more ‘contextual’-based regime of practice and regulation on the other. In a normative description and critique, I argue that the contemporary ‘transactional’/’acontextual’ orientated practices of governance and regulation predominant across the healthcare professions - which were consolidated and deepened within healthcare and psychological services by the 2006 and

2007 White Papers, ‘Our health, our care, our say: A new direction for community services’ (DoE: Feb 2006c) and ‘Trust, assurance and safety – The regulation of Health Professionals in the 21st Century’ (DoE: 2007a) – and the transactional/acontextual norms within the SfH and IAPT projects, all embody an emphasis upon the exercise of a calculative rationality in which there are quite ‘fixed notions’, to borrow from Fook’s work (2000) in the field of social work - ‘of desirable outcomes’ derived from the legitimacy of professional knowledge’ (Fook, 2000). In short, expertise is seen in relatively simple terms as something preformed and applied to a client. In contrast, the more contextual orientated regime and policy imaginary places an emphasis upon pluralism within ‘services’ and the processual and relational qualities of talking therapy, healthcare and regulatory practices. To borrow again from Fook’s (2000) analysis of social work, ‘practitioners often engage in a mutual process of discovery with service users, in which, together they create and experience the conditions which assist the person, and at the same time, engage in their own process of self-discovery’ (2000:115). Whilst in the transactional regime there is a pronounced hierarchy between the production of expertise and its delivery, within a more contextual regime, the site of ‘delivery’ – the practitioner-client relationship – is itself a central site in which expert-knowledge is produced.

As regards counselling and psychotherapy, therapeutic expertise or knowledge, and the ‘outcome’ of the therapy, are seen as a ‘product’ of the relationship between the practitioner and client. The difference between transactional/acontextual and contextual practice, when formulated in terms of evidence paradigms, concerns a tension between what is referred to as

‘evidence based practice’, in which a highly quantitative and predictive approach to knowledge production /expertise is valorised, and what is often referred to as ‘practice based evidence’, in which knowledge/expertise is seen as produced in each new practice context.

I argue that the HPC plans were less intensely transactional/acontextual in character than IAPT, SfH and NICE, and that there was a considerable lack of clarity about the character of HPC regulation, especially regarding the kind of evidence the HPC requires an applicant profession (or one under its jurisdiction) to have in relation to the requirement for it to demonstrate the safety and effectiveness of its practice (see Chapter Six). The HPC does not require professions to demonstrate the efficacy of their practice through experimental trials, but they do expect quantitative ways of measure and demonstrating efficacy, such as through client questionnaires before and after treatment. I find that the HPC plans were broadly ‘transactional’ in character and dovetailed with IAPT and SfH in their attempts to assimilate the field of the talking therapies to a more transactional mould already strongly established across the healthcare professions.

As regards the character of the policy making process itself is concerned, I argue that a similar norm of transactionality was at play. In short, the policy structure of a sharp institutional demarcation between the government and the HPC (between policy maker and administrator/low level policy maker) served to increase, rather than decrease, the ‘top-down’ determination of the policy parameters, radically diminishing the possibility for policy makers to learn from the experience of people *on the ground*, namely HPC administrators and practitioners within the field.

As regards the political dynamics of the struggle (i.e. the more ideological dimension), drawing on existing accounts and discourses within the struggle, I argue that the HPC plans were advanced an extensive way along the policy path to implementation, despite widespread opposition within the field (most of the main professional associations within the field were opposed to the HPC plans when they were first seen down the pipeline), through a complex of strategies which marginalised opposition voices. These were mainly forms of aggressive agenda setting and 'stonewalling' within the policy making process, including the plans being 'swept along' within wider healthcare regulatory reforms (see Chapter Five). I argue that the HPC's central strategy (reinforcing its more bald strategies of marginalisation) was its assertion of its 'approach neutrality', coupled with a 'problem minority' narrative, in which risk to the public tends to be exclusively individualised (the threat of the incompetent or 'rouge' practitioner) and the contours of the 'transactional' regime left outside the scope of critical and regulatory scrutiny. Additionally, for those unconvinced by the virtues of the plans, the pro-HPC camp tended to see and project them as nonetheless 'inevitable', or as part of an inexorable policy trend towards multi-professional regulators (see Chapter Six).

Opponents of the HPC plans, I argue, advanced their resistance to the plans by construing the HPC plans as an existential threat (often overegged) to many forms of talking therapy, i.e. essentially by identifying a clash of values and norms. I say often overegged because, although there was, in my view, a strong clash of values, HPC regulation would have been by 'title' rather than 'function', and therefore (as Alliance members often acknowledged) any form

of talking therapist would have been able to continue to practice legally outside of the jurisdiction of the HPC, even if nominally restricted in terms of what they might have been able to call themselves. The Alliance also tended to contest the 'inevitability' of the plans in positioning them as a metonym of a broader contingent political 'settlement' - namely neo-liberalism – or of the consumerism of late capitalism, or bureaucratisation.

Drawing on Lacanian psychoanalysis (Glynos and Howarth, 2007), I also seek to address how the HPC's regulatory discourse, with its key motif of public protection, and the Alliance discourse, with its key motif of a 'space' free from the dominant norms of society, inhere an affective appeal for both their purveyors and some of their audience. I argue that the 'affective grip' of the HPC's discourse stems largely from a tacit promise to eradicate anxiety about what I take to be the fundamentally uncertain, interpretative, contestable, and emergent nature of psychological expertise. In other words I argue that the HPC tended to deny these fundamental characteristics of counselling and psychotherapy (many of which are also shared by health and social care professions) and therefore seeks to quell anxiety related to uncertainty by offering, to borrow a phrase that Power (1999) applies to audit culture more broadly, 'false assurance'. The Alliance, for its part, I argue, tended at times towards a tacit fantasy or promise of a therapeutic position outside of history and society, so to speak, where 'therapy' is seen as speaking truth to power from a position entirely free of power. In the case of the Alliance this discourse is far from clear cut and much less evenly present across different documents and members than the 'fantasmatic' discourse within the HPC camp. It is partially for this reason, and that the HPC plans

themselves are the focus of attention, in addition to reasons of scarcity of space, that the analysis and critique of the fantasmatic dimension of HPC position is more developed within this thesis than the fantasmatic dimension within the Alliance.

Broadly, my account of the HPC struggle challenges two key elements within existing literature on both the HPC struggle and on professional and regulatory struggles more broadly. The first is the tendency, within both broader literature on the regulatory state (e.g. Moran, 2013, Maltby, 2008) and some existing literature on the HPC struggle and the SfH and IAPT projects (Waller and Guthrie, 2012), to see the rise of the regulatory state and the projects as a form of democratisation: as a triumph of reason, science and the public interest over dogma, tradition, professional oligarchy and private interests. My account draws upon and has greater consonance with accounts of the so called rise of the regulatory state (Power, 1999, 2004), (Mol, 2008) which see it, and the marketization of public and professional services which often accompanies it, as, in fact, broadly detrimental to the capacity of public services and professionals/practitioners to engage with and respond effectively, in more context-sensitive ways, to problems facing their clients and the broader communities in which they live I argue that this HPC case study supports a view that the regulatory state (as currently configured) tends to supplant professional dominance with regulatory dominance (arguably another kind of professional dominance), rather than, as regulatory rhetoric and ideology would have it, truly eradicating the problem of professional dominance.

My account of the HPC struggle suggests that the regulatory state, contrary to being above the political 'fray', tends to help constitute, and then serve, particular interests within the broader 'neo-liberal' political settlement. This is broadly consonant with the analysis made by the Alliance. The two professional associations in favour of the HPC plans from the outset – the BABCP and BPC – both embraced, to varying degrees, the 'evidence based practice movement', thereby arguably making themselves more attractive to the current policy regime, and in turn more likely to benefit from government contracts. Drawing on the work of others, which I review in Chapter Two, I argue that the kind of experimental and quantitative based research which underpinned IAPT and SfH are not above the 'political fray', but are in fact often shaped, and sometimes crudely distorted, by institutional interests. In this case both the Government and factions within the field of the talking therapies seem to have consolidated and deepened the 'sway' of the evidence based practice movement within the field through a feedback loop: the government and policy makers' predisposition towards experimentalist trial evidence, as established through NICE, and factions within field, namely (though not exclusively) CBT, lobbied the government for recognition of the effectiveness of their practice (in contradiction to other factions within the field) by subjecting and, to an extent, reshaping their practice through the framework of the evidence based practice movement. This is often despite considerable, and even deep scepticism, about the effectiveness of the evidence based practice movement.

As regards the HPC plans, my thesis contests the main academic account put forward in support of the plans by Waller and Guthrie (2012). I contest the

tendency of their account to eclipse the transactional-orientated norms within the HPC plans - which exaggerate the difference of the HPC plans from the IAPT and SfH projects – and I thereby foreground the particularism, as opposed to the supposed universalism or neutrality, of the plans. My account also seeks to counter what is arguably Waller's and Guthrie's tendency to assume that the HPC plans were, and are, despite the shelving of the plans, part of an inexorable policy trend. In short their account seems to imply that the implementation of the plans is inevitable, and that ultimately there is no viable alternative.

Another key critique forwarded within this thesis, albeit less developed, is the tendency of the Alliance, I argue, to espouse a position close to a talking therapy 'exceptionalism', in which similarities between counselling and psychotherapy and more contextual healthcare imaginaries tend to be eclipsed. In short, the central argument often forcefully forwarded against the HPC plans by the Alliance was that counselling and psychotherapy is fundamentally incommensurable with healthcare practices. In the light of critiques of highly 'acontextual' approaches to medicine I am neither convinced that such a strong demarcation is normatively credible nor that it is strategically desirable.

Finally, I seek to explore the more general implications of the substantive and critical analysis offered within this thesis for regulatory policy, the policy making process, and politico-hegemonic strategy. Broadly speaking I advocate that more 'contextual' (in counter-distinction to transactional/ acontextual) approaches and norms should be adopted in the practices and structures of regulation and governance across the different nodes of the field

of counselling and psychotherapy as well as the policy-making processes and structures in which these practices are developed. More specifically, I argue that the so called ‘practitioner full disclosure list system of statutory regulation (Postle, 2003), (Arbours Association et al, 2009), forwarded as an alternative to the HPC by the Alliance, meets many of the demands of the different constituencies and stakeholders within the struggle, and should be given serious consideration by policy makers. As regards the policy making process, my account echoes concerns made by others, namely King and Crewe (2013) and Du Gay (2000), that the sharp institutional demarcation between higher level policy making i.e. Government Department and lower level policy making/ administration (e.g. the HPC) is problematic in that it diminishes the ability to learn lessons in the process. In other words the policy structure (compounded by other aspects in the HPC case) is calibrated too much towards getting a policy to statute come what may. As regards implications for politico-hegemonic strategy, my analysis, given that it tends to foreground the frontier between acontextual and contextual practice (e.g. between evidence based practice and practice based evidence) across both the talking therapies and healthcare practices, is suggestive of a hegemonic strategy whereby strategic collaboration is sought by counsellors and psychotherapists with healthcare and other professionals (such as social workers) who wish to see a radical or significant shift towards conditions which support deeper contextual regimes of practice. This is to an extent contra the position taken by some institutions within the field of the talking therapies that have started to remould practice and services in accordance with the principles of the evidence based practice movement and its

valorisation of efficacy trials. It is also contra the position of Postle (2012) and House (2003) who tend to foreground, and in my view exaggerate, the differences between the 'professional' expert and the supposed 'non-expert' within the community – thereby underestimating the possibility of radical improvement within the sphere of state sponsored provision of talking therapies (as well as healthcare and other professional services).

Let me now look provide a brief sketch of the structure of the thesis.

STRUCTURE OF THESIS

In Chapter Two I critically explore a diverse range of literature on the HPC struggle, as well as on the regulation of the professions, and the so called 'rise of the regulatory state' more broadly. I examine a range of literature from a rich array of research and theoretical traditions, including structural functionalism, neo-weberianism, Marxism, political science, and post-structuralism. The chapter is structured into three main sections. First, there is an examination of key existing accounts, namely those offered by Waller and Gurthrie (2012), and Postle (2012). Given that these authors were central antagonists within the struggle, it is unsurprising that their contributions not only contribute important insights into the struggle, but that they also bear significant resemblances to the discourses at play within the struggle In fact Postle's book is an anthology of material published during the course of the struggle. An examination of this literature therefore gives a significant flavour of both the key discourses at play within the struggle, and what I regard to be the relative strengths and weaknesses of these discourses.

In the second and third main sections of the chapter, I seek to contextualise and deepen the understanding of these accounts by reviewing wider literature on the professions and on the so called rise of the regulatory state. This helps to intellectually contextualise the HPC struggle in relation to a broad set of theoretical and empirical problems and questions raised and addressed within the literature. This includes normative-orientated questions about the desirability of both archetypal professionalism and of the regulatory state: can either or both, for instance, be said to act in the public interest? Does the new regulatory state, including the closely allied 'evidence based practice' movement, constitute an Enlightenment revolution proper, supplanting privilege, dogma, and private interests supposed to be endemic within professions, with reason, merit, and the public interest? Or does the new regulatory state, in the name of particular styles of reasoning, science, and practices, in fact promote particular factional values and interests? I also examine literature which addresses pressing questions about what kind of norms of practice are best adopted by organisations and individual professionals, as well as clients, when approaching the professional-client relationship. In this chapter I also seek to elucidate literature which addresses questions that are focussed more on the political dynamics (what I refer to as the ethico-ideological dimension) of professional and regulatory struggles: for example, what strategies are used to promote different professional, organisational and regulatory forms?

Overall, my critical review of existing literature partially orientates my approach to the HPC struggle in two significant ways: first, towards scepticism of celebratory accounts of the regulatory state, and the evidence

based practice movement, and a concomitant positive regard for more reflective and open ended ways of framing professional practice; and, second, it orientates my research towards scepticism of any strong demarcations between 'community' and professional forms of organisation.

In Chapter Three I go onto set out the broad ontological coordinates – the basic assumptions made about reality – of the post-structuralist logics approach I have adopted, and how this helps address some of the explanatory deficits of other accounts and approaches explored within Chapter Two. Whilst elucidating the broad contours of the approach I seek to address questions of the objectivity of my research (already mentioned above) which are raised by affinities between this 'qualitative' research approach and the emphasis placed by the Alliance on the importance of 'relationality' and 'contextuality' within the practice of the talking therapies, as well as affinities between the Lacanian conceptualisation of the subject within the logics approach and with some Lacanian conceptualisations of the subject by Alliance members in contesting the HPC plans. In the second main part of Chapter Three I seek to provide an exposition of the research process: how I 'applied' the logics approach to the case of the HPC struggle. I set out what methodologies, or norms of research, guided how I went about both gathering and analysing the data, including the sourcing of material, and I address the issue of the balance of material, why I chose a semi-structured technique of interviewing, as well as address how I went about identifying within the data what are, to use the terminology of the logics approach, the key 'social', 'political', and 'fantasmatic' logics at play within the struggle. Overall, in Chapter Three I seek to spell out how the logics approach helps provide a

‘problem driven’ account which avoids two (often interrelated) explanatory weaknesses; namely excess idealism or theoreticism, in which the account is too far abstracted from the ‘real’ world to seem to be of much use; and an excess descriptivism and/or fatalism, in which the ‘performative’ aspects of a research intervention-cum explanation are eclipsed from view. Following the work of Glynos and Howarth (2007) I elucidate the approach I have taken to the HPC struggle in counter-distinction to a critical understanding of more positivist ways of framing social phenomenon, such as the postulation of ‘laws’, which are seen as independent of human interpretation, discourse and the act of representation.

In Chapter Four I provide a historical contextualisation of the HCP struggle. In other words it outlines the key historical antecedents of the HPC struggle, including ones that are internal and external to the field of the talking therapies. This helps us to identify the rich tapestry of historical struggles and contestations that were interwoven within different facets of the HPC struggle. In the first main section of the Chapter we chart the emergence of psychoanalysis and its key concepts, and the proliferation of different forms of talking therapy throughout the twentieth century within the ‘psy-complex’, paying particular attention to issues relating to concerns about the role and the governance of the talking therapies within society. In the second main section I examine the context in which the first Government linked calls for statutory regulation of psychotherapy were made in the UK, following concerns about the cult and practice of Scientology, and chart the various developments and responses within the field to these calls, including failed attempts to introduce statutory regulation of the field, and, more crucially, the

changing landscape of the professional associations, as well as counter-professional movements, within the field, which were important conditions of the terrain in which the HPC struggle was played out. The first two sections also seek to furnish my account - through an exposition (albeit limited) of some key talking therapy ideas and concepts - with an historical understanding of why a healthcare/medical association with the talking therapies jarred so strongly for many within the field. In the final main section of Chapter Four I focus on the more external antecedents of the HPC plans, which helps to understand what led to the Government's novel interest in strongly pursuing the statutory regulation of counselling and psychotherapy, as well as understand the broader historical context of the healthcare reforms in which the HPC plans were embedded, including New Labour's enthusiasm for the 'science' of the evidence based practice movement, and how this fitted in with the Government's broad political frontier between anti-modernisers and modernisers.

Chapters Five, Six, and Seven present the main empirical case study, covering the period between 2006 and 2011. Each chapter follows the same broad structure, beginning with an 'overview of events', which includes a summary of the key 'problematisations' of the struggle made by the central actors within it. I then go on in each chapter, under the heading of 'competing policy imaginaries' to dig deeper into these problematisations, describing and critiquing the key assemblage of norms at play within the competing policy imaginaries forwarded by the pro and anti-HPC camps. These sections largely pertain to the normative dimension of my analysis. In the third main sections of these chapters, under the heading of 'political and rhetorical

strategy', I focus on the political dynamics of the struggle – essentially foregrounding the political contingency of the HPC plans – and seek to carve out an understanding of the key strategies adopted by the pro and anti-HPC camps in their respective attempts to install and derail the plans. In each chapter this section includes an examination, drawing on Lacanian psychoanalysis, of the 'fantasmatic' narratives which arguably gave the pro and anti-HPC discourses 'affective grip'.

In Chapter Five we examine the period between mid-2006 and February 2007, focusing on the immediate context in which the HPC plans emerged, namely reforms to the regulation of healthcare, and, within the field of the talking therapies, the emergence and fruition of the IAPT and Skills for Health projects, as well as initial responses, in the form of the proposal of a 'Psychological Professional Council', within the field of the talking therapies, to strong indications that the HPC plans were in the pipeline. An examination of the key norms of practice at play within the healthcare regulatory reform signalled within the 2007Trust and Assurance White Paper**,** indicates a consolidation and deepening, of what I refer to as a 'transactional' regime within healthcare, encompassing greater hierarchy between a research and managerial elite on the one hand, and 'rank and file' practitioners on the other, as well as an enhanced delivery of healthcare in accordance with 'guidelines' and protocol. I identify this as being contra to a deeper 'contextual' imaginary of healthcare, as set out, for example, by Mol (2008) and Healy (2013)**.** A close examination of IAPT and SfH indicates that they significantly sought to assimilate aspects of the field of counselling and psychotherapy (IAPT successfully, and SfH much less so) to the strongly

‘transactional’ orientated regime of healthcare. I go onto examine the key political ‘logics’ though which the regulatory reforms and the IAPT and SfH projects were implemented. These include bald strategies of marginalisation or exclusion of deep ‘contextual’ imaginaries of practice, supported by a tendency to focus on a ‘problem minority’ of abjectly unethical or incompetent practitioners, rather than on concerns about the very practices of governance and regulation – including so called evidence based medicine and practice – supposed to render practice safe and effective. Overall, Chapter Five serves to give us a clear characterisation of the IAPT and SfH projects, and therefore forms an important part of the jigsaw in my assessment of the HPC plans and their relationship to these projects.

In Chapter Six we move to the heart of the HPC struggle, covering much of the year 2007, through to late 2009, charting responses to the announcement of the HPC plans in the White Paper, namely the HPC setting forth with the establishment of the ‘Professional Liaison Group’ to develop the detail of the HPC plans, and the formation of the Alliance for Counselling and Psychotherapy Against State Regulation. I focus on the two main frontiers within the struggle: the struggle between the HPC and the Alliance over the totality of the plans, and the struggle within the HPC’s Liaison Group over the ‘nuts and bolts’ of the plans, namely the structure of the register as regards differentiation between counselling and psychotherapy. In this Chapter I conduct a forensic examination of the HPC plans, drawing on critiques made by the Alliance, allowing a critical assessment of the level of ‘family resemblance’ between the HPC plans and IAPT and SfH projects. I go onto explore the key political logics deployed by the pro and anti-HPC camps.

Extensive focus is given to the HPC's bald strategies to marginalise opponents within the process, namely attempts to restrict the policy consultations to a narrow 'nuts and bolts' agenda, and a construal of the plans as a 'neutral' intervention, supported by a fantasmatic narrative of a 'problem minority' of practitioners.

In Chapter Seven we cover the period from late 2009, when the legal action against the HPC was initiated; when the 'leadership' stance in favour of the HPC plans within the UKCP and BACP was transformed or placed under increased pressure by members; and when the Conservative Party was wooed by the Alliance. It is in Chapter Seven that I pay particular attention to the competing legal interpretations of the policy process through which the HPC plans were advanced, as well as the competing imaginaries of the policy making process allied with these interpretations: I explore symmetries between the transactional policy content of the HPC plans and a transactionality within the policy making process, on the one hand, and symmetries between the Alliance conceptualisation of talking therapy and policy process in more contextual terms.

In Chapter Eight I bring together the various strands of the thesis, providing a synopsis of the broader regulatory policy contours and dilemmas which the HPC struggle both embodied and speaks to, namely what form(s) of democratisation of practice and services are the most effective way to address the problem of 'professional dominance'. I go onto summarise my account of the HPC struggle, drawing out and together the key normative, political, and economic strands of my account which led to the rise and fall of the HPC plans. Then, explicitly revisiting the literature review, I draw out more

explicitly what my account contributes to the existing body of literature, both on the HPC struggle and on the rise of the regulatory state more broadly. `I then go on to explicitly to draw out some of the policy implications of my account, namely the regulation of the talking therapies, as well as how this is suggestive of policy issues that need to be addressed as regards the regulation of other professions.

Finally, I would like to cover a few terminological and 'delimitation' issues, which hopefully will help clarify what the thesis is trying to do, and what is peripheral within it or outside of its scope.

TERMINOLOGY AND OTHER ISSUES

The 2007 Trust and Assurance White Paper (Department of Health, 2007a), and the HPC, both refer to the HPC as planning to regulate the field of 'counselling and psychotherapy'. Other government papers and the IATP programme tend to refer to 'psychological therapies'. Generally, though not always, I have opted for the term 'talking therapies' as an all-inclusive term that refers to all forms of counselling and psychotherapy. This is partially as short hand, but also because the meaning of the distinction between counselling and psychotherapy is variably contested across the field. I do not wish to imply a strong commitment to differentiation between counselling and psychotherapy and a view of the structure of the field that this may imply. My use of the term 'talking therapies' is not without its problems however. The term emerged initially in relation to psychoanalysis being dubbed the 'talking cure' (Milton et al, 2014). Some practitioners and theorist therefore tend to

see the term as referring exclusively to those therapies that involve the unravelling of psychological or psychosomatic symptoms through the revelation of their unconscious meaning to the patient. My use of the term as 'all-inclusive' is partially driven by the Foucauldian tendency to view all forms of therapy as 'technologies of the self' (Rose, 2003). All modalities of counselling and psychotherapy are, at least partially, in my view, forms of discursive practice which to an extent 'perform' or construct the realities they reveal, and encompass 'talking' as central to practice. This tends to be a challenging proposition for 'depth' talking therapies given that there is an emphasis upon revealing 'underlying' personal truths. The status of the concepts and phenomena of the unconscious and of transference in relation to the notion of reality as discursive is a fascinating one, but is outside the scope of this research.

This thesis is not primarily an assessment of the relative merits and strengths of different modalities of therapy – between for example psychodynamic and cognitive behavioural therapies – or between diagnostic and non-diagnostic approaches to 'mental health' difficulties. Rather, the primary focus is on issues of regulation and governance, and what particular forms of regulation and governance presuppose about the nature of therapy. In the case of the HPC struggle, to repeat one of my key research questions: were the presuppositions the HPC plans made about therapy congruent with those made by the talking therapies themselves? And if incongruent, what is the significance of this? However, my thesis is not simply a taxonomic exercise, setting out a typology of therapies and regulatory systems. Rather, I seek simultaneously to describe and critique competing policy imaginaries. This

thesis is in part motivated by a concern and sense, shared by many, that the government driven attempts to increase the accountability of professionals and practitioners, across many occupational sectors, through a combination of audit and consumer logics, are weighted excessively in favour of conditions conducive to fostering acontextual/transactional forms of practice and regulation, which arguably diminish the 'dialogic', democratic, and creative character of practice, and which ultimately undermine its effectiveness. Given that my focus is on the projected influence of the HPC plans – as opposed to a focus on an existing regulatory regime – this case study does not afford the opportunity to explore how a regulatory system functions when actually already in place, and how such a regulatory regime is or can to an extent be resisted or subverted by practitioners (either to the benefit or the detriment of client and public interests) in everyday practice. As regards the IAPT programme and the SfH project to map the National Occupational Standards for counselling and psychotherapy my primary aim is not to conduct a detailed assessment of their effectiveness, though it is interesting to note that SfH were unable to direct me to any places where the NOS for counselling and psychotherapy have been used since the completion of the project, and when I asked Malcolm Allen, who was involved within the project, in what way NOS for counselling and psychotherapy had been put to use, he responded emphatically: 'no [..] I might be wrong, but I'd be amazed if more than ten people have looked at those Skills for Health competencies in the last six, seven, eight years'.[10] My primary aim at looking at the IAPT and SfH projects is to furnish an understanding of the immediate context of the HPC plans.

[10] Malcolm Allen (Chief Executive Officer of the BPC), interview by author, October 2014. See

The more ethico-ideological dimension of my analysis, concerning the political dynamics, is motivated in part by a sense of frustration by the fact that across many professions and occupations, especially social and healthcare ones, more context sensitive ways of working – such as 'practice based evidence – and of regulating, are often side-lined, not only on the basis of the perceived superiority of transactional ways of working, but also, sometimes even exclusively, on the basis of perceived political and economic inevitability of 'progression' to more acontextual ways of working – *that there is no viable alternative.*

Now let us turn to the existing literature.

Appendix A transcript p.457.

CHAPTER TWO

THE REGULATION OF PROFESSIONS AND TALKING THERAPIES: A CRITICAL REVIEW OF THE LITERATURE

The primary aim within this chapter is to review and critically assess existing accounts of the HPC struggle, as well as wider literature on the sociology of the professions, and literature on the rise of the regulatory state, including audit practices and 'market logics', and the 'evidence based practice' movement. I also look at very selective aspects of the body of literature on the policy-making machinery, which will help illuminate in further chapters aspects of the policy-making process within the HPC policy dispute. I aim to identify the key strengths and weaknesses within current explanatory accounts of both the HPC saga and regulatory struggles more broadly. This paves the way for identifying, namely in Chapter Three, how the 'logics approach' can help address some of the explanatory deficits of accounts addressed here. Not only will this literature thereby help further illuminate the HPC struggle but also provide key grounds upon which this case study can illuminate the broader body of work on the regulation of the professions. The latter is drawn out within the concluding chapter. To put it in a slightly different way, in this chapter I seek to place the existing literature on the HPC struggle within an overarching intellectual narrative of the broader literature. To an extent this touches upon the history of the regulation of the professions given that theoretical and research approaches are enmeshed within the same socio-historical conditions as the shifting terrain of professions they seek to

understand. I draw on intellectual approaches to the professions broadly, but pay particular attention to medicine, for two main reasons. First, it is heavily researched, and second, there is a strong intersection between the HPC plans, the IAPT and SfH projects, and the healthcare professions. In other words, engagement with the debates on the regulation of healthcare professions will help to illuminate the context and character of the HPC plans and the allied SfH and IAPT projects.

I present two overarching arguments in this chapter. First, 'interest-based' accounts (namely structural functionalism, neo-Weberianism, Marxism, and 'political science' approaches) of the professions and of the rise of the regulatory state tend to see interests and identity as overly 'fixed' and do not offer sufficiently nuanced and contextualised accounts of regulatory struggles. They tend tacitly towards an historical determinism, as well as excessively polarised views of the professions and/or regulator as either uniformly 'good' or 'bad' as regards the 'public interest', which itself tends to be seen as a given. Discourse orientated approaches tend to provide more nuanced accounts, the socio-political character of professions and regulation seen as variable in accordance with the contexts in which they are articulated. They also tend to illuminate the political and rhetorical strategies which build, install and defend professional and regulatory regimes, rather than a tendency towards a tacit historical determinism. However, I argue that the discourse orientated literature tends not to set out clearly different facets of their analysis and that they also tend to fail to account for why particular professional and regulatory discourses have 'affective grip'.

The chapter takes a ‘pyramid structure’ – going from the particularity of the HPC struggle out towards broader considerations – and is split into three main sections. Examination of the broader literature is split into two main sections. First I focus on literature on ‘archetypal’ professions (i.e. those ‘sheltered’ from both the market and external regulatory control), and, second, I focus on accounts of the deregulation/regulation of the professions, namely increased external regulation and the introduction of logics of the market. This structure helps to bring into focus a delineation that was at least tacit within the Alliance during the HPC struggle, between those that tended to see professionalization of the talking therapies as a problem as such and those that did not see professionalization as necessarily a problem as such but saw the HPC as bringing a specifically problematic form of professionalization.

ACCOUNTS OF THE HPC STRUGGLE

Let me begin with Waller and Guthrie (2013). This is the main academic text in favour of the HPC plans, and was written by the two principle leaders of the HPC project to develop the ‘nuts and bolts’[11] of the HCP plans to regulate counselling and psychotherapy. I therefore look at this relatively short paper in considerable detail. Waller and Guthrie seek to make sense of the HPC struggle, including why the field of counselling and psychotherapy resisted what Guthrie and Waller describe as the benefits conferred by statutory regulation, namely ‘enhanced status and increased recognition’ in exchange

[11] Michael Guthrie (Director of Policy and Standards, HPC), interview by author, June 2014.

for ‘a pledge that the profession must put protection of the public above narrow professional interest, through adherence to agreed standards and increased accountability’ (*ibid:*12). Their main target is the research approach of structural functionalism and its assumption that professions are, or must be, entirely homogeneous, and they ague that this false assumption pervaded the struggle, leading to the misunderstanding that the HPC plans were a threat to diversity within the field. Drawing on the ‘process model’ of Bucher and Strauss (1961), Waller and Guthrie quote them as saying professions are ‘loose amalgamations of segments’ (Waller and Guthrie, 2013:5) which are ‘more or less held together under a common name for a period of time’ (*ibid*:5). Segment here can be understood as ‘faction’ or ‘section’. In short, professions are comprised of a competing number of factions or segments. Waller and Guthrie describe ‘segments’ as “‘jockeying for position’ in a battle for prominence, in this case [the HPC struggle], motivated by a perceived threat that the standards or other arrangement for regulation would favour one segment over another’ (*ibid*:10). They continue, ‘this is mirrored in those areas of conflict between the professional bodies during the PLG [Professional Liaison Group] process, particularly the question of a distinction between psychotherapists and counsellors, with the positions adopted by each group necessarily reflecting the approaches of those organisations’ (*ibid*:10). Holding the statutory regulation of the Arts Therapists up as a success story, they suggest that, given time, the professional bodies within the talking therapies (around the HPC Professional Liaison Group table) would have reached a compromise position.

Another key target in Waller and Guthrie's paper is what they argue is the overegged sense of collective professional autonomy and identity embodied within Larson's (1977) view of the professional 'project'. Waller and Guthrie write: 'a "project" suggests a discrete set of activities with clear objectives in a predetermined direction and infers a defined lifespan - for example, that the professional project ends with the achievement of regulation and that the profession (as a whole) are willing and active participants in this endeavour' (Waller and Guthrie, 2013:6). Perhaps the key target here is the perception within the HPC struggle of some organisations (e.g. the BACP prior to its considerable change of heart) that HPC-style regulation is unattractive because it would diminish the field's collective control and autonomy over its future direction (see also Chapters Four and Five).

Waller and Guthrie raise a number of pertinent and difficult issues and themes. Their observations about a tendency within structural functionalism, as well as within Larson's more 'conflict based' approach, to overestimate the autonomy and 'discreteness' of professions seems to me to be broadly an important and accurate one (more on this in relation to discourse approaches to the professions below). But I think the conclusions they draw are considerably off kilter. There are in my view a number of problems within the paper. First, the 'success' of the HPC regulation of Art Therapists seems rather more asserted than demonstrated. As far I can tell there is to date scant, if any, academic literature which addresses HPC regulation of Art Therapy.

Perhaps more importantly, Waller and Guthrie tend to overly conflate the fact that professions are made up of competing segments of expertise with conditions of possibility that are conducive to the thriving of pluralism within a field. Early in the paper they acknowledge that the HPC's criteria for 'aspirant groups' to join the HPC were influenced by the Benson regulatory principles (named after Lord Benson) and the concept of a 'mature profession', in which it is seen that there is and must be homogeneity across a profession (*ibid*:5). Waller and Guthrie later go onto to critique the concept of the 'mature profession' for misleadingly implying that regulators like the HPC could not accommodate diversity. Perhaps the question that should be formulated, arising from Waller and Guthrie's 'segment'/conflict based approach, more explicitly, is what degree of erosion of autonomy and influence and control any particular segment or segments within a field are willing to cede, in return for what degree of broader gains made through statutory regulation (such as increased status, being part of a field more firmly constituted as a collective 'power'). The 'process model' and 'segment' approach adopted by Waller and Guthrie seems to me to be a strong contender for not only explaining, but also perhaps legitimating, the resistance to the HPC plans. Related to this is the fact that Waller and Guthrie do not address the degree to which the HPC plans, along with the IAPT and Skills for Health Projects (SfH) were perceived to be (and to a significant extent were) dominated by particular segments and 'political groupings', as the Maresfield Report put it (Arbours Association et al, 2009:33), within the field, namely those centred around the BPC and BABCP (this is explored in Chapters Five and Six). The degree to which the HPC

plans became unfairly assumed to favour these political groupings by mere association with IAPT and SfH is also explored within Chapters Five and Six. Another key problem is what is arguably Waller's and Guthrie's tendency to take what might be referred to as the ideology of the regulatory state, namely as guarantor of the public interest and safety (more on this below) at face value. They state that regulatory policy 'in recent years indicates a shift in the dominant model, away from a focus on the claims of an individual group to be regulated, with all the associated inference of self-interest this entails, towards a focus on what is necessary to ensure the protection of clients' (Waller and Guthrie, 2013:11). This is arguably a false dichotomy, and an assertion, through a sleight of hand, that the 'new' regulatory state is unambiguously conducive to public protection. They are arguably rather too quick in their tacit dismissal of what they refer to earlier in their paper, citing Friedson (2001), to be professions responsibility to the 'larger public good' (Waller and Guthrie, 2013:6). Waller and Guthrie do not even mention the contention that Government has a broader set of interests (in addition to the one of public protection) in pursuing statutory regulation. They do refer to the HPC as 'multiple' and 'non-hierarchical' regulation, but they do not say what they mean by the latter. It may pertain to the view that the statutory regulation of healthcare professions traditionally supplementary to medicine helps 'level the playing field' between healthcare professions, helping to further diminish the profession of medicine as an alternative source of power and authority to that of the Government. This may have been a key motivation of the government's pursuit of statutory regulation, but these potential political interests are left unacknowledged. My final criticism is that Waller and Guthrie

in the paper do not seem to properly register that the HPC plans were shelved. For example, they concluded that:

> The shift away from the instigation of the regulatory process by a group itself indicates a new paradigm in which the 'maturity' of a group, and the benefits it forsees in its own regulation, is very much a second order consideration to the primary objective of statutory regulation – public protection (*ibid:*12).

This statement reads as if HCP regulation had been introduced. It does not take into account the fact that the plans were 'shelved': that the newly formed Coalition Government claimed that the Alliance 'had won the argument':[12] or that the attempt to impose HPC regulation (initially against the will of the majority of the major professional associations) was legally strongly contested. There is arguably a tacit prescriptive judgement in this statement masquerading as a descriptive claim about policy trends; that the abandonment of the HPC plans was a policy mistake, and that the plans should be reintroduced at a later date.

Moving now to key literature which argued against the HPC plans, Denis Postle (2012) provides an extensive 'narrative account' of the HPC struggle in an anthology of his articles he wrote during the struggle; consequently forming a significant part of the empirical scene, so to speak, and I return to them as a rich resource throughout the thesis. My main aim here is to provide a critical overview of the approach taken by Postle (2012), as well as others writing in the same humanistic tradition (House, 2008, 2003; Mowbray,1995), rather than in detail to their accounts. Postle's account is within a tradition against statutory regulation and professionalization of the field to emerge

[12] Andrew Samuels (Chair of UKCP 2009-2011), interview by author, June 2014

following the Sieghart Report's (1978) recommendation that psychotherapy should be regulated and tends to see counselling as a social movement working towards an emancipatory transformation of society (more on this in Chapter Four). Postle's work has both distinctly normative and ideological dimensions. The former is focussed upon how the HPC plans were incongruent with the field of talking therapies, both in terms of the interests of the individual client and the wider public interest as envisaged by the Human Potential Movement. Postle also reiterates an articulation of a counter-regulatory regime – the full practitioner disclosure list system – a system of regulation promoted as non-hierarchical, non-bureaucratic, and as de-centralised (Postle, 2012, 2003). I explore this further in Chapter Six as it became an important focal point of agreement between a diverse range of members of the Alliance for counselling and psychotherapy against state regulation. The ideological dimension is focussed on the strategies used by the pro and anti-HPC camps in their respective attempts to install and derail the plans. Postle tends to frame the HPC saga as a David and Goliath style struggle between an oppressive and stultifying state sponsored bureau-profession on the one hand, and a creative and benign community/'psy-commons' on the other. Diametrically contra the view of Waller and Guthrie, the HPC plans are seen as an overwhelming threat, namely in the form of medical and bureaucratic domination, to the diversity of the field of the talking therapies (Postle, 2012). The motif of public protection is seen by Postle, following on from the seminal work of Mowbray (1995) – 'the case against psychotherapy registration' - as a political ruse for state sponsored bureaucracies to gain control of the talking therapies. He tends to see the

HPC plans, and professionalization more generally, as driven by the interests of the big professional associations (e.g. the UKCP and BACP), which have embraced what Postle (2012) drawing on the work of Scott (1998) calls the state's tendency towards 'techne' rather than 'metis'. Whilst techne involves government, 'top-down', centralised policy programmes, which force contextual diversity (the particular) into abstract and general administrative systems, and in so doing enacting much violence or distortion, metis, refers to systems and ways of life constructed from the 'ground up' which respect diversity and particularity (Postle, 2012:180, 2007:226). Professions, Postle argues, create 'scarcity' of psychological knowledge within the community or 'psy-commons', keeping it within the 'walls' of the professions, fostering a learned collective helplessness among the public, as well as creating a sharp divide between 'ordinary wisdom' which gets us through the ups and downs of daily life and 'mental illness' (ibid:31-39). Postle's work is within the tradition of the work of Ivan Illich within the sociology of the professions (more on this below) in which there is a tendency to make sharp demarcations between professions and community knowledge. The distinction between contextually sensitive and insensitive approaches to organising social life and services (metis versus teche) is, in my view, a very useful and insightful one, but Postle arguably maps with excessive neatness this binary of techne and metis onto a binary between bureau-professional and community forms of organisation. A tendency to dichotomise the professions/community into a bad/good binary seems evident for example within his claim that 'copious amounts of deference' within the pursuit of PhD's and within training institutions supports professional dominance (2012:135). Postle has strong

confidence, however, in the capacity of community organisation and non-professional forms of talking therapy to avoid, as he puts it, 'power over', as distinct from than 'power with', communities and clients (*ibid*) (more on this below). Postle also importantly seems to suggest, through his concept of 'trance induction' that affect played a significant role within the HPC struggle. Trance induction is described as a type of hypnotic phenomenon which 'short-circuits discrimination and closes down thinking' (*ibid*:308). Postle suggests that it is due to a 'trance induction based on the claim of 'client protection' and that state regulation was "inevitable"'. The notion of trance induction as used by Postle appears to be more of a persuasive and descriptive metaphor than an explanatory concept, attesting that people were lulled into a state of 'false consciousness', but not theorising, beyond noting the material interests of professional associations served by statutory regulation, how this state of false consciousness is constituted. In short it does not address how or why many people within the field were 'hood-winked', as Postle seems to claim, into believing that the HPC would be beneficial for the field or the public interest. Whilst the concept of 'trance induction' seems to attest to what we might, following Glynos and Howarth (2007), refer to as the 'affective *grip*' of HPC regulation discourse (more on this in the next chapter), it does not offer an explanatory account of how the HPC plans, or 'techne' more generally, did or can acquire 'force' or 'affective 'grip'.

There are other significant and interesting reflective and exploratory accounts of the HPC plans which were presented either just prior or during the course of the struggle, most notably within chapters by a number of authors within a

booked edited by Ian Parker and Simona Revelli (2008), which offers a diverse range of accounts. Whilst many present psychoanalysis as a marginal practice under threat, Chris Oakley (2008) in contrast offers a different angle in his suggestion that the embracement of the HPC plans by many psychoanalysts and others may have been driven by a self-sabotaging attack on a broader cultural hegemonic status of psychoanalytic ways of framing and viewing and experiencing the world. Adopting a Foucauldian slant Oakley links psychoanalysis to Western individualism and the demand that we come to know the secret of who we are, via the myth of interiority, and that psychoanalysis has in this sense become a super-power – 'it saturates our world and we are kidnapped by it', he states, and 'no one can avoid having destructive fantasies towards any power that has become hegemonic to such a degree' (Oakley, 2008:43). This is a useful reminder that the marginal status and the emancipatory potential of psychoanalysis, or of any form of talking therapy, should not be assumed, and that there are no easy delineations between practice that is social control/socialisation and that which is emancipatory, or even any easy delineation between that which is marginal and that which is dominant. Whilst I think this is a very interesting dimension, it is not one that I focus on in this thesis as it did not become a central discourse within the struggle. The general principle or observation of the difficulty of making such distinctions – however important they are to make – does, however, inform my broad thesis analysis.

Let us now look at the broader literature.

CONTEXTUALISING LITERATURE

I have structured the examination of this literature into two main sections, 'archetypal' professions and the rise of the regulatory state. This helps to delineate two key sets of themes, processes and historical junctures, at play within the HPC struggle. The first pertains to the character and desirability of 'archetypal' professions and significant levels of professional autonomy, whilst the second pertains to an argument over the desirability of the rise of the regulatory state and the concomitant erosion of collective and individual professional autonomy (though, as we see below, the degree of this erosion is contested).

'ARCHETYPAL' PROFESSIONS

Interest based approaches

The descriptor 'interest-based' approaches encompass diametrically opposed views on the professions. Baldly put these are as an engine of societal progress and purveyor of the public interest, versus the view of professions as driven by private interests and as detrimental to the public good. Let us start with structural functionalism, a 'public interest' account, followed by neo-Weberian and Marxist approaches, which are 'private interest' accounts.

Structural functionalism

Structural functionalism (SF) was the predominant approach to the professions within sociology during the 1940s, 50s and 60s, arguably the heyday of the professions. Structural functionalism is close to the professions own ideology (Saks, 2012).Baldy put structural functionalism tends to contribute to the legitimation of professions as self-regulating and statutorily protected forms of organisation which serve the public good (Evetts, 2003). Structural functionalist accounts tend to see and welcome professions as engines of modernity and social progress,[13] and the capacity of professions to act in the public good seen as resting on their capacity and autonomy, namely by virtue of its 'shelter' from the market and independence from government, to act in accordance with scientific truth. A system of self-regulation and set of statutory protections, which protect professions from market competition and 'failure' are seen as securing the public interest. Parsons claims that within medicine 'commercialism [is seen to be] the most serious and insidious evil with which it has to contend' (Parsons, 1951:43). Additionally, Parsons contends that individual professionals are no more or less altruistic than other workers, but the emphasis upon cultural rather than monetary indices of success lead to more altruistic outcomes (Macdonald, 1995). This seems to me to be an insightful observation given a current backdrop tendency at times to idealise healthcare professionals (more on this in Chapter Five).

[13] Parsons (1951) argued that people's behaviour is governed by five underlying set of 'pattern variables' relating to role definitions. Professions, Parson's argues, emphasise the values of affective neutrality, self-orientation, universalism, achievement, and specificity, whilst tending to disfavour each of their contrasting norms, namely affectivity, collective-orientation, ascription, and diffuseness (Parsons,1951:43).

From the SF's consensus-driven perspective professional expertise tends to seen as an 'organic' outcome of scientific progress, which tacitly tends to be assumed to be uniform and linear in its development, hence partially why a profession tends to be seen as internally homogeneous. Partially because of this, the asymmetrical nature of the doctor-patient relationship (one in which the doctor is dominant) is regarded as benign. Parsons wrote that the sick persons' 'combination of helplessness, lack of technical competence [relative to the doctor's], emotional disturbance, as well as a degree of medical uncertainty (of diagnosis and prognosis) make him a peculiarly vulnerable object for exploitation' (Parsons, 1951:300) . This means that a patient cannot choose the best between two doctors 'if he were fully rational he would have to rely on professional authority, on the advice of the professionally qualified or on institutional validation' (*Ibid*:297). This view of the profession as a relatively benign normative system of values seem tacitly held by some members of the Alliance who framed the prospect of HPC regulation as the latest political thread that began with 'Thatcher's attack on the professions'[14] Similarly Janet Low talked of 'running' from audit culture within the university (Low, 2008), and of it now catching up with her within the field of the talking therapies. These comments imply archetypal professionalism is not so much a problem as the rise of the regulatory state and audit culture (more on this below).

Let us now look at Marxist and strong versions of neo-Weberian approaches, often referred to as 'conflict-based' approaches. The neo-Weberian approach

[14] Thorne (2009) Key note speech, Inaugural Conference of the Alliance for Counselling and Psychotherapy Against State Regulation.

of Ivan Illich (Macdonald, 1995) is particularly relevant given similarities to Postle's account (2012) explored briefly above. These approaches take an antithetical view of the professions as driven by private interests.

Professions as driven by private interests: Neo-Weberian and Marxist approaches

If for SF professions supplant power with truth, then for some Marxist and Neo-Weberian approaches, professions do the inverse, they supplant truth with power: in short professions are seen as anti-Enlightenment. Weberian, neo-Weberian and Marxist theories in sociology emerged during the 1960s and 70s, and are 'conflict theories' in so far as they characterise societies as divided, socially stratified and structured by relations of power, dominance and inequalities. Some Marxist and neo-Weberian approaches both contend that professions act in accordance with private interests. For neo-Weberian's this is mainly professions acting in their own interests, and for Marxists acting in accordance with the interests of their capitalist masters (Macdonald, 1995). In both cases the public and clients are seen as harmed. In medicine a tendency towards an individualist aetiology of illness is seen as problematic. For Strong (1979), for example, it strips 'problem' behaviours and phenomenon of their social meaning, which Illich refers to as cultural iatrogenesis i.e. the medicalization of social and political problems. For Illich medical intervention tends to radically diminish 'personal responses to pain, disability, impairment, anguish and death' (Busfield, 1986:117). Cultural

iatrogenesis is encouraged by the form of medical knowledge - what Brante (1988) refers to as the 'myth of technology' - whereby 'professionals tend to comprehend their social role through the philosophy of technological reductionism [in which] other factors, such as political relations, and ideological currents, are reduced to epiphenomena' (*ibid*:130).

In Marxist approaches, medicine and psychiatry are seen as serving the ruling class by legitimating the view that what are in fact politically, socially and/or environmentally caused problems are simply an innate physical or mental illness within an individual (*ibid*). Cohen (2016) notes, for example, that an inordinate number of black men were diagnosed with schizophrenia and were 'institutionalised for violent behaviour' during the civil rights protests during the 1960s and 1970s (72). As another example, the rapid proliferation in the number of conditions defined by the DSM (Diagnostic and Statistical Manual of Mental Disorders) such as Attention Deficit Hyperactivity Disorder (ADHD) and Social Anxiety Disorder is analysed as a means of cultivating, through institutional and professional intervention, particular personality characteristics suitable for the demands and needs of advanced capitalism. Social anxiety disorder for example is interpreted as a medicalization of shyness; the latter seen as at odds with an increasing need for 'workers to be conversive, outgoing and assertive' (*ibid*:73). The Marxist, Navarro (1980, 1983), similarly argues that medical science within capitalism eschews the real causes i.e. social relations, that produce illness. He claims that the industrial revolution and the emergence of capitalism gave rise to a form of medicine that viewed disease as a consequence of oppressive social relations, but once capitalism had 'won its hegemony' another form of

medicine was adopted, one 'that would not threaten the power relations in which it [capitalism] was dominant' (Navarro, 1980:539). In this reductive and positivist medicine, disease was seen 'not as an outcome of specific power relations, but rather a biological individual phenomenon where the cause of disease was the immediately observable factor, i.e. bacteria' (*ibid*:540). However, a central problem with a Marxist orientated approach, given its view of the economic 'base' as determining, is its difficulty providing a convincing account for actions within the superstructure that seem out of step with the interests of the capitalist elite. For example, the creation of the NHS and welfare state in the UK following the Second World War was 'hard won' by the working classes; it was not handed over by the capitalist elite on a plate. The Marxist approach is therefore arguably an unconvincing way of addressing the agency-structure dichotomy (more on this below)**.**

Hegemonic/discourse approaches both highlight and address some of these weaknesses within interest-based accounts. Let us now briefly look at how hegemonic approaches frame archetypal professionalism.

Hegemonic approaches to the professions

The Foucauldian approach: professionalism as government 'at a distance'

The Foucauldian 'governmental approach' (Rose, 1988) is a significant approach within the sociology of the professions literature and has been

largely developed through an analysis of the so called ‘psy-complex’. Fournier (1999), drawing on the work of Foucault, argues that the professions were central to the emergence of liberal government and society. Liberalism is of course critical of sovereign power (as for example in a police state) and therefore seeks to ‘reconcile freedom with social control’ (283). Fournier puts it succinctly: ‘the main rationale of liberalism (in its various forms) is to govern through freedom’ (*ibid*:283). Expertise is a key way in which liberal government acts on subjects to make them act appropriately as ‘free’ citizens and free ‘workers’. Professions are both the ‘governor and the governed’ (*Ibid*:283). That is to say professions are a means of working ‘at a distance’ on both individual citizens, whole populations, and the worker, and are a central means by which expertise gains authority and legitimacy. Crucially, the autonomy of the individual citizen is seen as something constituted and shaped by forms of expertise. Subjects are incited to think about themselves and act in accordance with the view of themselves as autonomous. For Foucault ‘autonomy’ is not a ‘first cause’; the subject is not ‘naturally’ and ‘wholly’ autonomous, but rather autonomy is constituted through a ‘repertoire of discursive practices’ *(ibid*:1999). As a form of occupational control, professions produce ‘professional subject positions’, shaping how professionals should conduct themselves, and so professionalism in this instance tends to be seen as a means of governing workers in roles where there is a high indeterminate to technicality ratio; in short where it is difficult for an employer to monitor or directly police employee behaviour. Fournier (2000) and Evetts (2003) tend also to critique the tendency of consensus and conflict-driven approaches to overegg the professions as highly ‘discreet’

projects. Rather, the collective 'autonomy' of the profession (including archetypal professions like medicine, even during the 'heyday' of self-regulation) is dependent upon professions seeking legitimation and approval from other actors in the 'liberal network', including the state, clients and other sponsoring elites, which are themselves heterogeneous entities. This helps resolve the explanatory polarisation between public and private interest accounts, essentially by regarding professions as sites of contestation, intersected and constituted by competing discourses, demands and interests. Tensions and contradictions in theory (between public and private interest accounts) are relocated, so to speak, within the terrain of social reality itself. Fournier (2000) also stresses that professions do not simply engage in 'turf wars' over pre-existing fields of expertise and 'objects' of concern, they actually actively constitute them. For example, subjectivity is shaped and produced by professional interventions, not simply liberated, 'crushed', or distorted. Fournier's view is also consistent with Brante's (2011) 'ontological model' approach to the professions which places an emphasis upon how professions, through particular models of truth construct the 'objects' upon which they act.[15] The 'process model' used by Bucher and Strauss (1961),

[15] The way in which in which an object is constructed by science and a profession partially depends upon their shared 'ontological model' (or what Foucault calls 'archaeology'). The ontological model is the basic, often implicit, template of a discipline or sub discipline – what are assumed to be the basic elements and relations of reality. They are the presuppositions that make theory and practice possible. There are often different explanatory theories of the same constructed object based on different ontological models. In the constructed object of 'madness' for example there are different explanatory theories based on different ontological models, including sociological, psychoanalytic, psychological, biomedical and neuro-psychiatric. Brante writes: 'These ontological models, indicating that the field is multi-paradigmatic and characterised by struggles over truth priorities, make entirely dissimilar types of observational evidence "significant"; introspection and dreams, cultural factors and social environments, rational and irrational choices, physiological properties. Each model is supported by its own paradigm and its own theories, and is match with its own facts' (Brante, 2011:858).

which Waller and Guthrie (2013), to recall from above, base their defence of the HPC plans upon, is consistent with Brante's (2011) emphasis upon pluralism within professions. A pluralism of 'ontological models' essentially means that science does not operate outside of socio-political and cultural relations, or above the political 'fray', and therefore cannot be used to definitively settle policy disputes: values are always at play within any deployment, scientific or otherwise, of facts. It also essentially means that professions, as Fournier puts it, do not simply involve a process of 'divisions of labour', but a 'labour of division' (thus contesting the SF sense that professions are simply a 'natural' outgrowth of linear technological and scientific development). As regards the psychological therapies, Rose (2003), adopting a 'governmental' approach, argues that all talking therapies are forms of 'technologies of the self', which incite people to experience themselves in particular ways, broadly in tune with the needs of liberal society. This is consonant to an extent with claims that the psychoanalytic way of viewing the world deeply structures our cultural outlook (Parker, 2009c). Overall, the Foucauldian approach tends to soften and complicate the demarcation between 'social control' and 'emancipation', which should perhaps (as I have already noted above) make us cautions about strong demarcations between talking therapies which 'speak truth to power' and those that are seen as bald instruments of social control. The Alliance arguably had a tendency to do this in its sharp demarcation between psychological therapies within the so called 'mental hygiene movement' and those talking therapies seeking to provide a space free from the dominant norms within society (see Chapter Six), (Arbours Association, 2009:12). This

reflects the tendency of Foucauldian and poststructuralist approaches more generally to see power and truth as a nexus. For this approach truth and power are closely intertwined and one can never supplant the other (Bacchi, 2012): power is always implicated in the constitution of a 'regime' of truth. It is worth noting, however, that Rose (2003) acknowledges that there are probably significant political differences between different forms of talking therapy. Additionally, Schon (1983) questions the sharp demarcation made by theorists, like Illich, between community and professional/bureaucratic organisations, and highlights that the former as forms of expertise often carry many of the hallmarks of their 'professional' counterparts. He writes: 'there is something inconsistent about a demystification of professional expertise which leads to the establishment of a breed of counter-professional experts' (Schon,1983:342). In a liberalist defence of bureaucracy, Du Gay (2005) warns against the hasty dismissal of the value of bureaucracy. Claiming that it has its own distinct moral ethos, and has been a hard fought for achievement within liberal democracies, he critiques what is a tendency within many critiques of bureaucracy to overly valorise the unified rational subject, where personal affect and the thought of the subject must be united in her or his action. The bureaucrat is seen as a lesser, incomplete moral form of person. But Du Gay argues that in fact it a distinct moral form of comportment which seeks, in a pluralist society, to ensure some fairness in government and the meeting of competing demands.[16]. Du Gay's approach encompasses a pluralist view of organisational forms, as well as different forms of personhood, which have distinct qualities and different sets of achievements

[16] The 'banality of evil' thesis is often the strongest one levelled against bureaucracy, but Du Gay argues that the first thing that Hitler did was to dismantle the German civil service.

in different contexts, each with distinct demands and problematics. Another important, closely related angle on the professions is the question of the authenticity of expertise. To recall from above, structural functionalist approaches tend to presuppose that expertise is the product of rationally grounded scientific research, whereas private interest accounts of the professions tend to see expertise as an ideological way of forwarding the interests of powerful elites to the detriment of the public good. There are mixed positions within discourse analytic research on this. Let me briefly spell out two of these now.

On the question of the 'indeterminate-tech' ratio and the basis of the legitimation of professions

The first view is, forwarded, for example by Fournier (1999), claims that professional work is not genuinely indeterminate and could in fact be more fully codified and routinized. Professions use concepts such as 'talent' to obscure the fact that it could be rationally codified, and to obscure the concomitant possibility that others could do the work with minimal training and for less remuneration. This view is consistent, for example, with the IAPT programme's 'protocolisation' of practice, and its training of non-experienced therapists in the skills for particular tasks, diminishing the requirement to employ more experienced and qualified counsellors and psychotherapists (see Chapter Five). This claim, however, seems inconsistent with the general temper of the 'government at a distance' approach, which rests on the

contention that professionalism is a means of exerting some control over work that has significant indeterminate qualities i.e. is so contextually variable and complex as to bar complete routinisation. There is of course the possibility, however, that professional discourse, even if dealing with indeterminate objects (i.e. high contextual variability), may conjure a misleading belief that so called 'lay' people cannot respond just as adequately, or even better, than professionals to a situation at hand. In other words, taking the view that much professional work is inherently indeterminate and cannot be routinized, does not by itself settle questions regarding the authenticity and use-value of professional practice vis a vis so called amateur or paraprofessional practice.

Schon (1983), in contrast to Fournier, and more in keeping with the theory of professionalism as a meaning of governing indeterminate work 'at a distance', claims that 'technical rationality', namely the application of general scientific laws to specific cases (within the professional's case load), tends to side-line 'artistry' and 'craft' in the process of professional practice. For Schon (1983) and Fook (2000) professions are (at least traditionally) legitimated on the basis of a 'scientistic paradigm', where highly rationalist, technical, and objective conceptualisations of knowledge dominate. This model of legitimation produces a strong hierarchy: 'the role of the researcher/academic/theoretician becomes privileged over that of the practitioner and service user, since it is assumed that only knowledge generated and used in this way is valid' (Fook, 2000:110). Furthermore, 'professional expertise is thus defined as that which is generalizable (acontextual), developed by scientific method by researchers, and applied by

practitioners to service users' (*ibid*:110). This is arguably similar to Postle's (2012) position (as described above) and his characterisation of government programmes as 'techne', which subsumes diversity and particularity. However, contra Postle, Fook tacitly contends that the 'acontextual' framing of practice is not a necessary feature of professions when she juxtaposes the top-down, dominating forms of social work with the work of some experienced social workers within her research. She writes:

> Rather than entering situations with superior and fixed notions of desirable outcomes, derived from the legitimacy of professional knowledge, practitioners often engage in a mutual process of discovery with service users, in which, together they create and experience the conditions which assist the person, and at the same time, engage in their own process of self-discovery (Fook, 2000:115).

Contra the view of House (2003) and Illich (1975), Fook contends that the professional does not necessarily 'use specialised knowledge or expertise to legitimate a powerful position, but rather to create a situation for mutual benefit' (2000:116). Schon (1983) is similarly critical of technical rationality and proposes an alternative epistemology of practice, and therefore, like Fook, leans forwards a relatively optimistic view of the emancipatory potential of professions. He delineates a 'knowing-in-action': a 'know-how', which is an intuitive ability to do something, especially after repeat performances. He states that there 'is nothing in common sense to make us say that 'know-how' consists in rules or plans which we entertain in the mind prior to action' (1983:51). When a professional encounters similar 'cases' over and over, his 'knowing in practice tends to become increasingly tacit, spontaneous, and automatic, thereby conferring upon him and his clients the benefits of specialisation' (*ibid*:60). Specialisation, however, can lead to two key problems Schon argues. First, 'subspecialities [..] can break apart an earlier

wholeness of experience and understanding'; within medicine, for example, where the patient is treated for 'particular illnesses in isolation from the rest of the patient's life experience (*ibid*:61). Second, the practice of the professional can become overly spontaneous and over-learned, so that they become 'selectively inattentive to phenomena that do not fit the categories of his knowing-in-action' (*ibid*:61). Schon contrasts this to what he calls 'reflection-in-action', where the professional seeks to think more consciously about what she is doing. Similarly to Fook (2000), Schon argues that the reflective practitioner is context sensitive and responsive: 'when someone reflects in-action, he becomes a researcher in the practice context. He is not dependent on the categories of established theory and technique, but constructs a new theory of the unique case' (Schon, 1983:68). Schon claims that, whereas for the professional that sees themselves as a technical expert, 'uncertainty is a threat; its admission is a sign of weakness', for the reflective practitioner, uncertainty is seen as an important part of practice, linked to 'the scientist's art of research' (*ibid*:69). Fook's and Schon's accounts of professional practice do raise questions about both the suitability and accuracy of what we might refer to as a 'scientistic' base for the legitimacy of the professions. This perhaps helps to explain the apparent anomaly between the paradigm of technical rationality often thought of as the basis for professional practice and the lamentation by Thorne (2009b) and others within the field of talking therapies of the 'Thathertite attack' on the professions, suggesting that there was something laudable about professions being attacked. Fook's contextual/acontextual binary is very useful for our purposes here as it helps (in further chapters) to avoid what I argue can be the misleading binaries

between healthcare and talking therapy practice, as well as between ‘community’ and ‘professional’ social organisation (more on this below). This also raises questions about changes to the way that professions have been legitimated in recent years.

So far I have bracketed off the rise of the regulatory state from consideration, which has been useful because it helps to be clear on different perspectives on the professions prior to the so called regulatory state – perspectives which are still at play within research on professions, and within professional life itself, and within various stakeholder responses to it. I want now to focus on the ways in which the regulation of professions has changed in recent years and decades, as a result of ‘the rise of the regulatory state’ (Levi-Faur and Gilad, 2004), the ‘audit society’ (Power,1999), or, more simply, the erosion of professional autonomy and the increase in external control of professions. The rise of the regulatory state has in some senses changed *the* ‘animal’ of the profession.

THE RISE OF THE REGUALTORY STATE AND SUPPOSED EROSION OF PROFESSIONA AUTONOMY

Literature on the rise of the regulatory state is obviously relevant because the HPC plans were an aspect of the rise of the regulatory state. Also, some of the discourses within the struggle bear some family resemblance to the academic discourses on the rise of the regulatory state, so it follows that an

analysis of the academic literature will inform the analysis of the discourses 'at the scene'. For example, Malcolm Allen's critique of the professions during the 1950s and 1960s as abusive and unaccountable[17], and of psychoanalytic associations 'closing ranks' against complaints of poor or abusive practice, has strong affinity with the legitimation of the rise of the regulatory state (more on this in the concluding chapter). Let us first look at Moran's (2003) political science account of the regulatory state, followed by neo-Weberian and discourse analytic accounts.

Celebratory accounts of regulation/de-regulation

Some academics from political science (e.g. Moran, 2001, 2003) have quite strongly and broadly welcomed the 'rise of the regulatory state', which began in the 1980s and 'took off' during the 1990s, and which has been consolidated and developed further more recently. The so called 'audit explosion' (Power, 1999) occurred in conjunction, following the emergence of the New Right, with 'de-regulation' / economic liberalisation across most sectors of the economy, including the introduction of quasi-market competition within pubic services. For the New Right, and for 'public choice' theory within academia, state intervention was 'criticised for undermining economic efficiency and investments as well as debilitating the enterprise culture through promoting welfare dependency' (Exworthy and Halford, 1999:19). This 'new managerialism' was continued under New Labour in the guise of 'modernisation' (*ibid:19*).

[17] Malcolm Allen (Chief Executive Officer of the BPC), interview by author, October 2014.

The New Right's characterisation of professions as 'producer monopolies' - given their 'shelter' from the market and relative freedom from government control - and its rhetoric of rolling back the frontiers of the state (*ibid*:19) has considerable commonality with Illich's critique of the professions. However, a key insight of Moran's is his critique of the claim that under successive neo-liberal governments there has been a 'hollowing out' of the state i.e. that the state has been in retreat. Moran (2003) and Levi-Faur and Gilad (2004), on the contrary, argue that the 'deregulation' (i.e. privatisation) of aspects of services has entailed, through the rise of the regulatory state, the inauguration of a period 'high modernism' in which the state, albeit 'at a distance', has extended and deepened its reach. The regulatory state is seen essentially as a means of dealing with market failure within services such as the utilities of gas and water that are too important to risk failure. Moran (2003) and Levi-Faur and Gilad (2004) highlight how liberalisation and managerial reforms that are often supposed to 'hollow out the state' are in fact 'intimately coupled with the rise of multi-layered regulatory institutions and formalisation of codes of behaviour at the corporate, state, and international levels' (2004:106). Moran argues that 'far from being a reaction against utopian projects of large-scale interventionism, it [the new regulatory state] has its own utopian ambitions, and these ambitions are entirely congruent with Enlightenment modernism' (Moran,2003:7). For Moran (2003) the rise of the regulatory state is primarily driven by the need for public protection in response to adverse events within the public services, ensuing lack of public trust, as well as fiscal crisis. In relation to the professions the

new regulatory state is seen as the true social revolution, enabling the proper fruition of the modernist values identified by Parsons (as identified above). With the dawn of the new regulatory state professions are now kept on the 'straight and narrow', guided and forced to act in the client and public interest. Descriptive aspects of Moran's historical analysis are very helpful. He draws a broad historical distinction between a system of 'self-regulation' (dubbed 'club government'), dominant across all economic sectors of society throughout much of the 19th century up until the 1980s, and the 'regulatory state', gaining dominance since the 1980s. Moran's evaluation is, in my view, rather more problematic. He draws a stark contrast between the two regulatory systems. Opacity, informality and cronyism are seen by Moran to be characteristic of self-regulation, whereas codification, transparency and meritocracy are positively seen to be characteristic of the (new) regulatory state. Quantification, standardization and formalisation are closely intertwined with democratisation, according to Moran, transforming 'tacit knowledge of insiders into public knowledge available to all' (Moran, 2003:7). Moran tends to see the regulatory state as an unalloyed form of democratisation, and resistance and objection to it as essentially 'old' elites – professionals of the welfare state, academic elites and elites in the civil service – seeking to preserve their vested interests: 'the club system privileged precisely these elites—and its replacement by something more open and modern threatens their independence from popular control' (*ibid:*8). So those that were once 'quintessentially modern' – the professionals and state elites that wrestled power from the aristocracy- themselves are seen as having become the privileged resistors of modernisation. Maltby (2008), in her critique of Michael

Power's scepticism towards the regulatory state forwarded in his book 'The Audit Society' (1999) (more on this below), similarly expresses:

> *The audit society* and its progeny, Power's own papers and wails of unhappy academics and doctors and civil servants, are ultimately not a protest about the creation of an iron cage round society. They are a stifled chorus of fury at being made accountable (Maltby, 2008:397).

Moran's and Maltby's position therefore shares with structural functionalist perspectives a confidence in expertise, only the placeholder of the values of neutrality and objectivity have shifted from the profession towards the regulator (or at least towards professions that are strongly overseen by regulators). As far as Moran is concerned the regulatory state attempts to restore public confidence in professions are substantive, genuine, and do succeed.

Whilst Moran and Maltby in effect apply a sceptical neo-Weberian-style analysis to the professions, they seem to apply a 'rose-tinted', structural functionalist-style analysis to the regulator. In the light of critiques (see below) of aspects of the regulatory state, Moran and Maltby do not, in my view, adequately justify this stark demarcation between the profession and the regulator (see below). Rather, they tend to displace the problem of polarisation present between public and private interest accounts i.e. the tendency to see professions broadly, almost a-priori, as either 'good' or 'bad' when it comes to serving public and client interests. In Moran's account, the polarised positions, rather than present within two theories, are displaced into a single poorly integrated theory. The regulator in effect becomes seen as the

‘good other’ of the profession. In further Chapters I argue that the HPC case study helps illuminate the motivations for such idealisations of the regulator.

Other accounts of the apparent erosion of individual and collective professional autonomy in recent decades are either less celebratory in tone, or are stridently critical. Those which tend to fall in the former camp are the deprofessionalisation and proletarianisation theses, and, for our purposes, the more pertinent restratification thesis. More strident critiques I consider are by Michael Power (1999) and Mol (2008). Let us look at each in turn.

The deprofessionalisation and proletarianisation theses

In 1973 Haug developed the deprofessionalisation thesis of medicine**,** claiming that medical autonomy was being increasingly eroded by the codification and standardisation of medical knowledge and practice (Chamberlain, 2010:77). An increasingly educated public was also narrowing the knowledge gap between patients and doctors, which along with increasing public concern about medical malpractice, contributed to the diminishment of public trust in and deference towards doctors (Hewitt and Thomas, 2007:5). In the same year Oppenheimer inaugurated the proletarianisation thesis and similarly argued that scientific medicine was becoming routinized i.e. medical practice was becoming more reducible to a set of rules and procedures: complex processes could be broken down into a succession of simple tasks. The division of the profession into increasing medical specialism reduced the

autonomy of medics, Oppenheimer argued, and reduced the distance of the medic from the end 'product'; medics increasingly resembling workers on a factory line Oppenheimer claimed (Chamberlain, 2010:78). As the indeterminacy of work turned increasingly into technicality, medical work would increasingly be able to be carried out by less qualified workers, driving down costs. In 1985 McKinlay and Arches developed this further by claiming that doctors, like factory workers, suffered from false consciousness: contending that the true nature of doctors' employment relations are hidden from them by the rhetoric of their supposed elite status (Hewitt and Thomas, 2007:7). A strong objection to these theses is the fact that the number of occupations undergoing some kind of professionalization in recent decades has proliferated. However, such professionalisation could be regarded as mere rhetoric, suggests Evetts (2003), hiding the opposite state of affairs; essentially keeping professionals in a condition of false consciousness (see below). Freidson (1984), who tended to seek a middle path between celebratory and sceptical accounts of the professions, was not, however, convinced by the deprofessionalisation and proletarianisation theses (Hewitt and Thomas, 2007).

The restratification thesis

Freidson (1984) argued that even with advances in technology and a more educated public, there was still a very significant knowledge gap between doctors and patients, and that doctors are still gatekeepers of information and the main interpreters of it (Hewitt and Thomas, 2007:7). Elston (1991) differentiated between economic, political, clinical and technical medical

autonomy, drawing a more uneven and differentiated picture of trends in autonomy. For example, whilst doctors in the UK since the inauguration of the NHS, in becoming salaried employees, have less economic autonomy (no autonomy over their own pay), Elston claimed that their political and clinical autonomy has increased. She also distinguished within 'medical dominance' between 'social authority', relating to 'medical control over the actions of others', and 'cultural authority', relating to 'the acceptance of medical definitions of reality and therefore medical judgments being accepted as valid and true' (Chamberlain, 2010:81). Friedson's restratificaiton thesis (1984) contends, however, that the retention of a degree of collective clinical and political autonomy comes at a significant price, namely that professions are reborn in a more hierarchical form, in which there is greater cleavage between the elite of profession and their rank and file members (*ibid*). This analysis seems very pertinent to the HPC struggle, given that, although initially most of the field opposed the HPC as regulator to be, once the government had more strongly asserted its will, the field became more differentiated on the issue: significant divisions for example opened up within the main professional associations of the BACP, UKCP and to a lesser extent the BPC, between the leaderships and many of their rank and file members. Although the latter pertains to the restratification of the field within the struggle over policy development, this would likely have solidified into a more permanent state of affairs had the HPC plans been installed. According to the restratification thesis, the profession retains, through the co-optation of elite members, overall autonomy (Chamberlain, 2010). Gray and Harrison (2004) point out that government ambition to simultaneously cut costs and

raise standards requires the professions to cooperate (Chamberlain, 2010:83). However, the restratification thesis is suggestive of a degree of ambiguity to what extent professionals are successfully co-opted. The co-optation by the government and regulators of an elite within professions to exert greater control over rank and file members might suggest that the overall autonomy retained is rather more symbolic than substantive, perhaps invoking the charge of those individual professionals joining the research and regulatory elites as 'selling out'. However, Friedson (1985) also suggests that co-opted doctors do sustain more loyalty to their clinical colleagues than their 'corporate masters' (Chamberlain, 2010:83). Similarly, within the field of social work, White (2009), points to ways in which social workers often in effect resist and subvert government policy 'on the ground' by covertly refusing to fully or 'properly' administrate it where they see policy to be contrary to the client and public interest. The failure of regulatory directives and governance to always 'work all the way through' - that regulation and governance meet resistance in everyday practice – is an interesting area, but, as noted in the introductory chapter, given that my focus is on the political dynamics of attempts to install and derail the HPC policy initiative, rather than on how an already existing system of regulation and governance 'runs', it is largely outside the scope of this thesis[18]. I point this research out, however, as it is important not to equate formal policy and procedures entirely with what happens 'on the ground'. It is perhaps this potential for resistance which may have been one reason why some counsellors and psychotherapists were inclined to accept the HPC plans despite their own significant reservations.

[18] I am, however, to a significant extent focussed upon how the projections of how the HPC regulation would likely have impacted the field/'worked' had it been installed.

Julian Lousada, Chair of the BPC, for example, was regarded as having taken the view that HPC regulation would bring benefits to the field (such as an increased role within the NHS), and that practitioners would be able to ignore or circumvent any aspects which would otherwise prevent them from, as they see it, working in the best interests of clients and the broader public (Musgrave, 2009d).

Before looking at discourse approaches to the rise of the regulatory state, I would first like to briefly examine literature on the evidence based practice movement. This is because it plays a central role, implicitly within the healthcare regulatory reforms, and more explicitly within the IAPT and SfH projects within the field of psychological therapies, in which the HPC plans were embedded (see Chapter Five). The rhetoric of evidence based practice also played a direct role, if a rather obscured one, within the HPC policy dispute (see Chapter Six).

The evidence based practice movement

Pro-evidence based practice literature

As we shall see in Chapter Four, the evidence based practice movement has played a central role in the policy reforms of the public services since the initial emergence of ‘evidence based medicine’ in the 1990s. The latter has been a significant feature of ‘clinical governance’. Basically it is set of criteria

of subjecting literature and sources of evidence on a topic to ‘systematic review’ (Hjorland, 2011).The National Institute of Clinical Excellence (NICE) has been instrumental in establishing its widespread use within medicine. There is some disagreement among proponents, however, over the exact nature of ‘evidence based medicine’. Sackett et al (1996) for example emphasise that it is an integration of ‘individual clinical expertise and the best external evidence from systematic research’ (71). They argue that neither individual clinical judgement nor external evidence are alone enough: ‘without clinical expertise, practice risks becoming tyrannised by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient’ (*Ibid*:71). They expressly argue against evidence based practice being an assault on individual clinical judgement, or as a manualisation of practice: ‘clinicians who fear top down cook books will find the advocates of evidence based medicine joining them at the barricades’ Sackett et al state (*ibid*:71). Other researchers tend to equate evidence based medicine with what Sachet refer to as ‘external evidence’, but similarly argue that evidence based medicine/external evidence cannot adjudicate between, or entirely ‘trump’ other sources of evidence (Hammersley, 2005). In contrast, others, such as Chalmers (2003), tend to have stronger ambitions for evidence based medicine, regarding it as having the capacity to adjudicate between different sources of evidence and definitively signal or determine what is best practice (Hammersley, 2005). Evidence based medicine is defined as practice based on the evidence procured from a systematic review of different studies. It is based on the premise that individual doctors sometimes cause harm to patients because their practice is not based on the

most up to date research, and therefore seeks to radically diminish subjective error by ensuring that doctors act in accordance with the evidence of the efficacy of treatments. Chalmers also claims that it helps prevent 'human and financial costs arising from failure to perform systematic, up-to-date reviews of randomised controlled trials of healthcare" (Hammersley, 2005:94). The latter speaks to the hierarchy of evidence established by the Cochrane Centre – a network of researchers - and adopted by NICE, in which the conclusions of random control studies are given greatest weight in a systematic review, and conclusions garnered from qualitative research less weight, and practitioner observations within clinical practice are given the least weight (*ibid*). Chalmers' (2003) view that evidence based practice can adjudicate between different sources of evidence, accords with Schon's (1994) description of what he describes as the 'policy science' approach to policy making. He draws a distinction between 'policy disagreements' and 'policy disputes'. A policy disagreement is relatively superficial in the sense that it is a disagreement about facts: the disagreement is essentially resolvable through an appeal to facts because there is broad agreement about the terms that constitute the relevant facts. The evidence based medicine and practice movements tend to assume that all policy controversies are, to use Schon's terminology, policy 'disagreements'. The sharp delineation of evidence based medicine as the pursuit of science, reason and best practice, from the dogmatic and ideologically prone subjective judgement of doctors, is arguably consonant with what Wells (2007) refers to as the 'expert driven' model of evidence based policy making - the view that expertise actually does, or at least should, lead the policy-making process. A tendency towards a

technocratic ideal of expertise delivering policy above the 'fray' or 'muck' of politics is arguably present within this model. The technocratic ideal, or what Schon (1983) refers to as technocratic rationality, was also arguably present within New Labour's emphasis upon 'what counts is what works' (Wells quote of Tony Blair, 1997) as sharply distinguished from 'dogma' and 'outdated ideology' (Wells, 2007:22). It is not clear, however, to what extent 'evidence based policy making' simply means the adoption of findings from systematic reviews of evidence based practice, and to what extent it is at times also much more loosely meant, with a more ad-hoc criteria of what counts as good evidence. Because of the strong confidence in levels of objectivity of evidence based medicine as being 'above the political fray', Chalmers (2003) and other proponents tend to dismiss critiques of the movement as merely 'polemical', 'ideological', and as 'ignoring evidence', or as 'failing to confront reality' (Hammersley, 2005:93). Let me now briefly examine the kind of critiques, both of evidence based medicine and evidence based practice more broadly, and of the use of empiricist controlled trials within the field of counselling and psychotherapy, which Chalmers is quick to dismiss.

Critiques of the evidence based practice movement

Within the literature there are four main interrelated critiques of the evidence based medicine and practice movement. The first relates to the claim that evidence based practice removes practitioner error by eradicating the need for subjective judgement. Hammersley (2005) claims that subjective

judgement is not, and cannot be, eradicated.at both the level of professional practice and research. Let us look briefly at each in turn. At the level of practice the professional must evaluate a diverse range of sources of evidence, which are often incommensurable in kind:

> Knowledge from personal experience and from new research evidence must each be evaluated in its own terms, and then combined some way that takes account of their distinctive characteristics as sources of knowledge (*ibid*:88).

Where evidence based practice is dominated by, and sometimes even equated with, RCT/experimental research, and is coupled with a tendency to believe that it can adjudicate between different forms of evidence, e.g. that it trumps practitioner experience, or what the practitioner sees in front of their eyes, significant problems arise. The literature points to significant limitations of random control trials/experimental research. Hammersley for example states that there are 'problems concerning how one applies research evidence about aggregates to particular cases' (*ibid*:88). Contextual variables are simply too great to be able to predict precisely the impact of a treatment applied to a particular patient or client. Samples studied may not for example be representative of the relevant population and therefore it is not possible 'to tell what works for whom, or about the incidence of side effects' (2005:90). Additionally, Healey (2013) points out that RCT's often establish a significant percentage incidence of strong harmful side effects, such as increased risk of suicide in the case of some antidepressants. The guideline industry within medicine does not enable practitioners to adequately contextually assess the needs of a particular patient, and instead strongly protocolises the prescription of particular drugs in particular broad types of cases. He argues for example that the manner in which anti-depressants are prescribed is akin

to a game of Russian roulette, where a drug has a devastating impact upon a percentage of patients (*ibid*). Although it is within the power of the individual doctor not to adhere to clinical guidelines, there are powerful institutional incentives for him or her not to stray from them e.g. financial rewards and being fired. Healey states that 'clinicians worldwide are increasingly faced with managers enquiring about their compliance with guidelines and more and more are getting the sack' (*ibid*:153-4). So the advisory status of guidelines is close to being in name only.

Hammersley also points out that researchers exercise judgement during the establishment and course of RCT/experimental research:

> It is important to recognise that like all other forms of human practice, research itself necessarily relies on judgement and interpretation: It can never be governed, but only guided, by methodological rules (Hammersley, 2005:89).

Hammersley is in effect pointing towards an inherent limitation: they do involve subjective judgement. Another target of much of the research critical of the evidence based practice movement is on the quality of the judgement often exercised in such research. The quality of scientific work is undermined by unthinking or inappropriate judgement within research when it comes to the construction and application of methodological rules. Whilst Hammersley talks of methodological rules being applied 'unthinkingly', other researchers point to all too systematic and deliberate 'misjudgements' in order to over inflate the efficacy of particular treatments. Shedler (2015) critiques a major NIMH (National Institute of Mental Health) study. He claims that the way that subjects are selected to take part does not reflect 'real' clients; the inclusion criteria of the study excluding two thirds of patients with the diagnosis in

question and seeking treatment. They are usually excluded because of co-morbidity (having more than one diagnosis): yet the 'two thirds that get excluded are the patients we treat in real-world practice' (*ibid*:52). Two thirds are excluded before the study has started. Of the remaining one third included, sixteen percent 'show improvement', only eleven per cent overall get well, and only five percent get well and stay well (*ibid*:52). Another key way by which positive results are inflated is through 'sham' control groups (*ibid*). An NIMH 2010 funded study on the efficacy of CBT, for example, used psychodynamic therapy as the control group. The latter was delivered by graduate students (committed to CBT) who had been given two days training in psychodynamic therapy. Those delivering the psychodynamic therapy were forbidden to talk about the trauma that had brought the patient to therapy; 'if anyone practiced like that in the real world it could be considered malpractice', Shedler claims (*ibid*:54)**.** Shedler contends that this is not a local but a widespread problem, referring to Wampold's (2011) systematic review finding that of twenty five thousand studies only fourteen studies "compared evidence based therapy to a control group that received anything approaching real psychotherapy' (Shedler, 2015:54). Another weakness of the RCT/experimental research, closely related to that of the problem of representative sampling, is that some practices lend themselves less to being standardised and therefore subject to trial. Hammersley (2005) for example claims that teaching practice cannot be standardised because a key requirement of effective teaching is responsiveness, as opposed to rote behaviour, to the unique circumstances presented within the classroom.

The same claim is also made of talking therapies, given the uniqueness of each therapeutic encounter. In this sense the RCT or experimental trials are not neutral measurements of practice, but in fact moulds practice, through a process of routinisation and standardisation, in the process of seeking to *merely* measure it.

In addition to such internal weaknesses, the findings of studies are often misleadingly represented. Some studies are presented as providing strong support for the effectiveness of a particular treatment, yet the 'statistical significance' between CBT and a sugar pill in one NIMH study, for example, was 1.2 difference. Shedler (2015) argues that the '1.2 point difference is trivial and clinically meaningless. It does not pass the "so what?" test. It does not pas the "Does it matter?" test. It does not pass the "why should anyone care?" test' (*ibid*:49). Another central way in which the efficacy of a particular treatment is misleadingly presented is through what Shedler calls the 'file drawer effect': that is the suppression i.e. non-publication of studies with negative results. Cuijers et al (2010) found that publication bias has exaggerated the benefits of CBT by 75% (Shedler: 2015). Healey (2013) contends that this practice is also rife within the pharmaceutical industry, and also critiques the practice of the *ghost writing* of research studies where by the study is conducted by 'in-house' researchers within the pharmaceutical company, and then the name of respected academics added. Academics within medical research departments that have challenged such distorting and sham practices have in some cases lost their positions (Healy, 2013).

The overall result of these practices is that treatments are promoted within services as highly effective when in fact they are at best minimally so, and at worst, damaging. Wampold et al (2011) claims that 'currently there is insufficient evidence to suggest that transporting an evidence-based therapy to routine care that already involves psychotherapy will improve the quality of services' (Shedler, 2015:55). For Healey (2013) and for Goldacre (2013), there is not so much an inherent problem with RCT, but a problem with how they are currently conducted and interpreted. Healey (2013) refers to a 'conspiracy of good will' between medicine, the pharmaceutical industry, patients and policy makers as regards the production of supposedly 'wonder' treatments. He identifies a complex of factors within the pharmaceutical industry that have led to its dominance of medicine, namely that a number of regulatory changes in recent decades have led to the emergence of 'billion dollar' markets for single drugs, producing a situation in which the profit motive is little constrained, and a situation in which the marketing departments within pharmaceutical companies have become the main driving force for the creation of new patented (and therefore hugely profitable) drugs, rather than driven by more robust and carefully assessed clinical need. Essentially, the tail, Healy claims, is wagging the dog (Healy, 2013). Dalal (2015) similarly claims that 'many of the great and the good' (23) – governments and policy makers – have been gullible enough' to believe in wonder treatments which have in fact often been fabricated by a complex of 'statistical malpractices' (22). In a critique of the more rhetorical aspects of the evidence based practice movement Shedler (2015) identifies what he defines as a 'master narrative' behind the evidence based practice movement

within the talking therapies: ‘In the dark ages, therapists practiced untested, unscientific therapy. Science shows that evidence-based therapies are superior’ (47). Given that IAPT and SfH are both strongly predicated on knowledge garnered through experimental trials I return, to an extent, to these critiques within Chapter Five. The latter analysis, and some of the more nuanced approaches to evidence based practice considered above, tend to recognise that there are different styles of reasoning and evidence. They tend therefore to be what we could describe as interpretative or discourse analytic in approach. These critiques of the evidence based medicine and practice movement, especially where RTC’s and experimental trials are valorised, in so far as they are important parts of the regulatory state and new forms of governance, undermine celebratory accounts forwarded by Moran (2003) and others, of the regulatory state as weeding out bad practice and bringing almost unalloyed objectivity and effectiveness to professions across many fields.

Let us now consider hegemonic and discourse literature, which further critique the self-justifying ideology of the regulatory state.

Hegemonic and discourse analytic approaches to the rise of the regulatory state

In this section I first examine the literature which tends to focus on the impact of the rise of the regulatory state, namely audit and the market logics, on

professional practice and services. This helps redress a tendency within the re-stratification thesis and other approaches considered above to focus on changes to formal relations, within what Glynos et al (2014) call the node of governance, at the expense of looking at how practice has been impacted, within what Glynos and Speed (2012) and Glynos et al (2014) refer to as the node of delivery. In the second section I examine literature which focuses on understanding the rhetorical manoeuvres which help install and 'naturalise' more market/consumer-inflected regimes. Without an analysis of the political logics – of the contingency of particular regimes of practice – more purely normative critiques of regimes of practice can more easily be dismissed as excessively idealistic or unworldly: *this alternative state of affairs would of course be nice if it were only possible or politically feasible in the real world.*

Critiques of the impact of the rise of the regulatory state on professional practice

To recall from above, some political scientists, for example Moran (2003) and Maltby (2008), claim that the rise of the regulatory state is democratising. This is contested by others. Power (1999), for example, whilst he acknowledges that giving an account of one self to others is a part of everyday life, and that it makes little sense to make any a-apriori objection to audit, he argues that the audit regime as currently constituted becomes more of a substitute than an aid to democracy, in that the fact of being audited 'deters public curiosity' and diminishes the likelihood or conditions for public dialogue and

deliberation (127). Focusing on the impact of audit practices on the behaviour of organisations, Power (1999) argues that audit regimes often have perverse side effects whereby the whole process consumes resources and undermines the motivation of people who could otherwise be engaged in 'real work'. Du Gay (2000) similarly claims that organisations can become at the very least distracted from pursuing their 'preferred objects'. Most audit reports and their related accounting statements function as labels which must be trusted claims Power (1999). He contends that these practices not only tend to deter curiosity by focussing on offering blanket assurance, but in fact much of the time fail to measure what they claim to do so, thereby tending towards, as Power puts it, 'false assurance'. In further chapters I argue that this is a crucial notion in relation to the HPC struggle, effectively capturing the attraction of HPC-style regulation as well as the problem with it. Traynor (1999) similarly explores the negative impacts of managerial practices, such as the setting of organisational targets, within the profession of nursing. Focussed on the 'deregulation' side of the deregulation/regulation coin, Fournier (2000) claims that market criteria impact how professions must behave in order to legitimise themselves. She cites the example of accountancy, in which the emergence of market criteria within the profession has shifted the behaviour of accountants from a focus on ensuring that a company's tax accounts are commensurate with the 'public good', towards a focus on finding ways to keep tax payable by a company as low as legally possible (via legal 'loop-holes'). Sauder and Espeland (2009), in a Foucauldian analysis of the impact of the regulatory practice of the 'ranking' of American law schools, incisively highlight how regulatory technologies can

help create rather arbitrary markets, and in the process, radically diminish substantive differences and qualities between institutions, and therefore diminish, rather than expand, public choice. Law schools are ranked in a hierarchy against formulae that postulates:

> An abstract, ideal law school comprised of discrete, integrated components. By depicting how well and how poorly schools adhere to this abstraction, schools are encouraged to conform to this ideal' (Sauder and Espeland, 2009:74).

The apparently objective 'measuring' activity essentially imposes a particular set of motives, ideals, missions, goals, established by the judgement of those producing the ranking formulae, on all the schools. All schools must take the rankings seriously because other people do. One Dean is reported as saying 'I end up making decisions with an eye toward those ranking rather than – I'm overstating this to make a point – rather than what's best for the school' (*ibid*:70). Deans may be distracted from their preferred objects and attend to others in order to best assure the school's place in the rankings: 'because schools are often separated by miniscule margins, seemingly negligible changes sometimes produce dramatic shifts in overall rank' (*ibid*:74). Given that the audience of the rankings 'are remote from the messiness of their production' the rankings appear to be value-neutral and objective observations, rather than significant interventions (*2009*:72).

Similarly, in his analysis of risk management, Power (2004) argues that it tends to lead to 'defensive practice' within organisations in which the focus is primarily on producing an audit trail acceptable to the regulator, and guarding against litigation, rather than on the needs of a client or the public interest. This was a key concern about the HPC plans expressed by the Alliance; that the plans would discourage both individual therapists and organisations from

taking potentially beneficial risks, or from taking on complex or difficult clients who present a higher risk of litigation (Arbours Association et al, 2009), (see Chapter Six). Power (2004) focusses on how the effectiveness of an individual worker can be impacted by excess proceduralisation, suggesting, for example, that a procedural culture, including high levels of proceduralisation of high level risk and dangerous situations can diminish a worker's confidence and capacity to think responsively in dangerous situations. Given that each dangerous situation is likely to be unique, or at least have unique aspects, the inculcation of worker preoccupation with procedure is a recipe for him or her being blindsided by procedure, rather than facilitated to respond in a discretionary way that s/he judges to be most helpful in the situation (*ibid*). This is similar to Schon's (1983) claim, as outlined above, that excessively routinized practice - as a result at an individual professional level from strong familiarity with particular types of cases - can lead to a professional being 'selectively inattentive to phenomena that do not fit the categories of his knowing-in-action' (Schon, 1983:61).

Mol (2008), in her study on the care of patients with diabetes by doctors draws our attention to how even technical orientated medical practice and treatments often appear more objective than they actually are. Mol's work highlights how inherently 'contextual' and processual medical practice in fact is. Her work can therefore perhaps serve to caution us, in the context of the HPC struggle, against absolute or overly sharp demarcations between healthcare practices as such and the talking therapies and other less technical professional practices. Mol shares with structural functionalists,

contra Ilich, strong confidence in at least some medical expertise: diabetes, she notes, prior to medically produced insulin, simply used to be a death sentence. So medical expertise as such is not her target. For Mol, what she refers to as a 'logic of choice' within healthcare, is understood as a way of challenging patriarchal authority within medicine, as within the logic of choice patients are constructed as active consumers within healthcare. She sums the logic of choice up as 'patient's manage, doctor's implement' (Mol, 2008:63). In this logic the doctor tends to be reduced to the technician – attending to his or her instruments and providing the patient with the information and facts, which the patient then uses to make value-based decisions about what to do. Mol contests the suitability of a market form of democratisation within the clinical setting, rather than contesting the democratisation of expertise as such: 'as patients we are treated as objects and made passive. This is a bad practice that should be stopped' (*ibid*:6). She contends that a market orientated logic of choice within clinical settings is inappropriate at a general level because 'a market requires that the product that changes hands in a transaction be clearly defined' (*ibid:*20). This, however, is not a good fit with the nature of disease: 'diseased bodies are unpredictable. It follows from this unpredictability that care is not a well-delineated product, but an open-ended process. Try, adjust, try again' (*ibid:*20). Whilst a market requires that a product have a 'beginning and an end', in contrast, in what Mol calls the logic of care, 'care is an interactive, open ended process that may be shaped and reshaped depending on its results' (*ibid*:20). More specifically, Mol demonstrates that the logic of choice tends to assume that facts and values are easy to separate out, and that

medical practice is a relatively simple application of medical expertise to particular cases, and that treatment is a linear process. But Mol contends that it is not, but rather considerably contextually variable and non-linear. In the example of diabetes, excessively low and excessively high blood sugar levels acquire their significance from 'their relation to a standard of the normal blood sugar level' (*ibid*:45). But Mol argues that not even this is a simple given, but in fact varies from patient to patient. Medical practice and treatment therefore must proceed as a 'trial and error' experiment in order to meet the particular needs of each patient. Determining the right treatment for a patient requires interaction between the patient and doctor, not the simple application of pre-packaged treatments. Mol also argues that the logic of choice is unsuitable for the clinical setting as it assumes that the patient is nothing more than a rational actor, whereas within the logic of care, our minds are not assumed to be entirely rational, but instead 'full of gaps, contradictions and obsessions' (*ibid*:25). In the logic of choice the doctor does not seek to engage with the patient in relation to these aspects, and the doctor acting in accordance with a 'logic of choice' is less likely to discover from their patient, for example, that he or she refuses to keep regular tabs on their condition (e.g. measure their blood sugar levels or decline certain foods offered) because of embarrassment and anxiety about doing so in public. They are more likely to see the patient as having made a 'rational choice' which is simply to be 'respected'. There is some affinity between Mol's conceptualisation of the patient here as emotionally complex and what many talking therapies tend to presuppose about clients. Like some talking therapies, Mol also questions the Western tendency to valorise independence and disavow our everyday

(inter)dependence. But in foregrounding the vulnerabilities and complexities of the patient, and in highlighting interdependence, Mol is not advocating a return to professional paternalism, but rather a different model of the democratisation of expertise, advocating a kind of practice and doctor-patient relationship which she seeks to capture by the concept of 'doctoring'. This quite simply refers to a process whereby the treatment and decisions about it are regarded as a shared endeavour between doctor and patient, where asymmetries within the relationship are recognised, but where the voice of the patient is heard and is seen as inherent to the process of medical treatment. Neither the doctor nor the patient are presumed to be sovereign or in possession of a definitive or complete knowledge. Mol entreaties:

> Let us, somehow, share the doctoring. Let us experiment, experience and tinker together practically. This is far from easy. Shared doctoring requires that everyone concerned should take each other's contributions seriously and at the same time attune to what bodies, machines, good stuff and other relevant entities are doing (*ibid*:56).

This echoes Schon's (1983), as explored above, stipulation that both the client and the professional need to be willing to engage within reflective practice in which the uncertainty of expertise and of the terrain of practice is foregrounded to a greater extent, as distinct from strong levels of paternalistic assurance, papering over, so to speak, the 'trial and error' and uncertain nature of practice.

Before examining literature which focusses on the political dynamics of how new regimes of practice are installed, I want briefly to examine literature which critiques the institutionalisation, which has occurred over recent decades, of a sharp demarcation between policy making and its administration. In later chapters, as already noted, I argue that this critique is

particularly pertinent to understanding elements of the policy process within the HPC struggle.

A critique of the policy making process: An esxcess demarcation between policy-making and its administration?

The so called ‘next steps’ programme of reform of the civil service during the 1980s created a sharp distinction between policy formulation and administration (Du Gay, 2000), in which the ‘administration’ of some key government responsibilities have been outsourced to quasi-autonomous agencies, such as the Child Support Agency (CSA) and the HPC, with these supposedly independent agencies charged with the task of implementing policy decided by ministers. However, the distinction between policy formulation and administration is not easy to make in practice, Du Gay claims, as policy is significantly developed during the course of its application or administration. This is because, Du Gay, notes, ‘what we have in legislation are statements of greater or lesser generality which become meaningful only in application to particular cases’ (Du Gay, 2000:90). Given that ministers can only deal with a small number of applications, and given the imprecise nature of original policy statements, officials are left with considerable discretion. It is arguably this inherent character of policy making which makes having policy making and its administration seated in entirely separate institutions problematic. It fosters what King and Crewe (2013) refer to as an ‘institutional disconnect’ between policy making and administration, and increases the

likelihood of ‘policy fiascos occurring. King and Crewe define the latter as a policy failure or farce that is universally regarded as having been avoidable. Institutional disconnect means that there is less feedback from administrators of the policy on the ground, so to speak, back up to the higher level policy makers. Something on the ground may suggest that the higher level policy needs modifying, or abandoning altogether, but with the institutional disconnect this is less likely to happen. The line of accountability is also obscured, so that the minister in practice tends not to be held wholly accountable for the whole process as any policy failure can be attributed to the agency in the name of an administrative error. This potential ‘get out clause’ for the minister makes it more likely that he or she will not be attentive to negative appraisals of how the policy might or is evolving on the ground. Du Gay (2000) and King and Crewe (2013) also argue that the cultural tendency towards ‘frank and fearless’ advice (Du Gay:146), which was traditionally the duty of the civil servant to a minister, has been largely replaced with a ‘can do attitude’ (*ibid*:92) in which the civil servant is expected to strongly promote ministerial policy objectives, rather than present any serious concerns about the administrative feasibility of policy plans.

Now let us look at aspects of this literature and other literature which focusses on the political dynamics of how regimes of practice are contested, dismantled, installed, and defended.

Ideological critiques of the rise of the regulatory state

A range of literature identifies how the 'discourse of the market' (Fournier, 2000) and notions of 'globalisation', instability, and increased complexity and intricacy within the organisational environment are used to legitimate a range of institutional reforms across sectors of the economy, including the professions and government. Above, I have already looked at some literature which evaluates the impact of some of these reforms, including the introduction of multi-layers of audit and regulatory practices, on the professions and government, (e.g Moran, 2003), (Power, 1999, 2004), and of the introduction of quasi-markets into the professions (e.g. Mol, 2008). Fournier (2000) identifies three key areas of interrelated reform: (i) The introduction of quasi-markets within the professions: (ii) the making of the client as 'sovereign consumer', as opposed to 'dependent' client; and (iii) The breakdown of professional monopolies of competence, and of barriers both within and between professions. Instead 'integration and flexibility' are celebrated: 'members of different occupational groups are now required to work in multi-functional teams' (78). A key point suggested by a range of literature is that the 'discourse of the market' – defined by Fournier as 'a broad range of discursive and material practices closely aligned with market liberalism and articulated around notions of flexibility, individual freedom and responsibility' (*ibid*:77) – are recurrently presented as forces *over and above* the rest of society, directing and determining society from without. In this respect neo-liberalism has affinities with Marxism. Andrews (1999), for example, claims that New Labour justified 'welfare retrenchment, labour

market deregulation, the privatisations of public services' (Bates, 2008:25) as necessary responses to changes in the global economy, itself characterised as 'a self-regulating, implacable force of nature about which we can do nothing except look out of the window and hope for the best' (*ibid*:21). Watson and Hay (2003) similarly contend that the globalisation thesis that there are profound and ineluctable moves towards a single world market is in fact not a reality, but in fact an 'image of globalisation, [that New Labour appealed to], as a non-negotiable external economic constraint in order to render contingent policy choices appear 'necessary'" (289). The Leitzch Review (2006), which underpinned the Government's Skills for Health project, including the project to map the National Occupational Standards of counselling and psychotherapy, couches the need for reform as regards skills sets in terms of an urgent national need to respond to globalisation. There is no sense in this report that New Labour played a role in shaping a particular form or vision of 'globalisation' (more on this within Chapter Four). Given that the discourse of the market partially underpinned the shift towards multi-functional professional teams within the public services, it is reasonable to surmise that it also to an extent underpinned the shift towards multi-professional regulators, like the HPC.

Williams and Apperley (2009) in their paper on reforms to the field of public relations highlights ways in which New Labour tended to position itself as external to that which it was in fact helping to enact. Williams and Apperley (2009) flag up the following passage in a government paper (1998) on its 'continuous professional development strategy':

> We are in a new age – the age of information and global competition. Familiar certainties and old ways of doing things are disappearing […] We have no choice but to prepare for this new age in which they key to success will be the continuous development of the human mind and imagination.

This policy document, Williams and Apperley claim, treats as extrinsic that which it is helping to enact. In other words the document has 'an ideological function of masking that state of affairs': what are in fact a contingent set of circumstances are presented as inevitable. The document in this respect is covertly prescriptive. Other key rhetorical strategies to render particular policy reforms apparently necessary or 'natural' are identified within the literature. These include what Clarke et al (2007) refer to as a tendency to 'collapse spatial differences into time'**,** creating 'one modernity' assumed uncontrovertibly to constitute progress (12). Williams and Apperley (2009) note that there is a tendency to create a dualism between different forms of organisation or regime, and to rhetorically position a 'new' form of organisation against an 'old staid' form, and attribute the former with overwhelmingly positive attributes and prospects for the future, and the latter with negative consequences, such as company, organisational, or national decline. Modernity is assumed to be spatially Williams and Apperley (2009) note that a sharp logic of inclusion and exclusion was set up by New Labour between the forces of conservativism, including 'staid' bureaucracy, on the one hand, and forces of modernity, 'new' professionalism, on the other: Blair stated that 'what threatens the nation-state today is not change, but a refusal to change' (Williams an Apperley, 2009).[19] This dualism, coupled with what Clarke et al (2007) refer to as 'collapsing spatial difference into time' renders

the policy apparently on the side of the tide of history (12), and ideologically seeks to temporalize the heterogeneity within organisations i.e. competing values and forms of practice within an organisation are divided into those that are deemed to be on the side of progressive history and those that are antiquated, thereby attempting to make contingent and contestable policy decisions about what counts as 'progress' seem uncontroversial and un-contestable (*ibid*). Similarly, Du Gay (2000) claims that contemporary management theory and practice are shot through with a quasi-religious ethos; a religious and romantic narrative in which enterprise will bring collective and individual salvation in the wake of the degradation wreaked by bureaucracy.

Fournier's (2000) argues that the client as 'sovereign consumer' has to an extent eroded the boundary or division between the professional and client (and therefore the dominance of the professional). But this does not take into account what is an apparent increase in the shoring-up of professional authority through highly contestable approaches to and representations of research, namely the 'evidence based practice' movement. I argue in Chapter Five that the 'sovereign consumer', or consumer choice within healthcare, are in fact strongly delimited by professional knowledge, or at least by the expertise produced by a managerial and research elite within professions (as explored above).

Finally, another strategy to promote institutional reform of occupations is quite simply to promise professional autonomy and prestige, but actually deliver a

more controlling form of professionalism. Workers are attracted to what is a 'myth or an ideology of professionalism which includes aspects such as exclusive ownership of an area of expertise, autonomy and discretion in work practices and occupational control of work' (Evetts, 2003:406). This ideal image better fits archetypal professionalism (our main focus in the first half of this chapter) as a normative system of values. The ideal image is used, the theory goes, to acquire consent for organisational change, but what workers often get is in fact very different from what they were promised. They get 'bureaucratic, hierarchical and managerial controls […] and budgetary restrictions and rationalizations: performance targets, accountability and increased political control' rather than collegiate relations and increased collective and individual autonomy (*ibid*:407). For our purposes it is perhaps helpful to hold in mind that the idea of professionalism has considerable broad appeal to both workers and 'customers'.

SUMMARY

In this chapter I have explored a diverse range of intellectual traditions and literature on professions and regulation. First I examined two key but contrasting texts on the HPC struggle. Waller and Guthrie (2013), drawing on a 'process model' approach to professions, contend that professions do embody diversity in the form of competing segments, and that a tendency to emphasise the homogeneity of professions fed into a misleading anxiety that

the HPC is a threat to diversity within the field of counselling and psychotherapy. I have argued that the 'segment' analysis could also easily be adopted to support the opposite view; that the HPC posed a significant threat to the autonomy and identity of some forms of talking therapy within the field, whilst offering greater opportunities to other segments within the field. I have also argued that Waller and Guthrie fail to adequately theorise the fact that the HPC plans were abandoned.

In a very different approach, Postle (2012) provides though a collection of articles written during the course of the struggle a rich normative and ideological critique of the HPC struggle. The HPC is cast as a severe threat to diversity within the field, and as a metonym for medical domination and bureaucratisation. Postle draws on Scott's (1998) distinction between metis and techne; the latter is a top-down administrative approach which does violence to specificity of that which it administrates, and metis is social organisation from the ground up, which respects diversity. Postle (2012) uses the concept of 'trance induction', conveying a sense that ideologies 'grip' people, but does not theorise how this occurs.

In the second section of the chapter I examined broader literature on professions. We looked at contrasting private and public interest accounts. Structural functionalist on the one hand, and Marxist and neo-Weberian accounts like those of Ivan Ilich, present polarised and mutually exclusive account of professions, and yet each seems to capture important dimensions of the reality of professions. Whilst structural functionalist approaches

highlight the importance of norms, values, truth, and science in the constitution of professions, Marxist and neo-Weberian accounts tend to highlight the work of power and ideology in the construction and operation of professions. All of these approaches ultimately imagine *an end to politics* (where truth supplants power). In the case of structural functionalism this tends tacitly to be seen as already achieved by professions, and in Marxist and strong neo-Weberian approaches, there is a promise of an *end to politics* to come through a communist revolution or, in an Illich style analysis, a return to *golden age of community* unencumbered by state and professional bureaucracies. I have also highlighted deterministic tendencies, tacit or express, within these accounts, sometimes coupled problematically with a simultaneous postulation of a very strong subject/agency. The governmental Foucauldian approach effectively addresses these polarisations by displacing the contradiction in theory onto the terrain of social reality itself: professions are heterogeneous and made up of competing discourses and constructions of reality. Professions are foregrounded as both the governed and the governing. Fournier (1999), drawing on the work of Foucault, argues that professions are broadly conducive to the needs of liberal government and society, inciting and governing in the name of freedom. The talking therapies too are seen as broadly conducive to liberal government. This analysis thereby softens the demarcation between emancipation and social control.

In the third section I have examined literature which focusses on the rise of the regulatory state and the simultaneous introduction of the logic of the market into public professions; all things that are often perceived to have

diminished the individual and collective autonomy of professions. Moran (2003) provides a useful historical and descriptive analysis of the general shift from a system of statutory self-regulation to the rise of the regulatory state. However, I have argued that Moran's contention that the new regulatory state brings Enlightenment revolution proper is not adequately supported. Rather, Moran's work embodies polarisation between public and private interest accounts in a single poorly integrated theory. Moran's (2003) celebration is predicated on a putative objectivity and power-free status of the regulatory state, and an examination of literature critical of the regulatory state, including audit practices, and of the evidence based practice movement within medicine and the talking therapies, throws this claim into doubt. I have highlighted as particularly pertinent to the HPC struggle, the restratification of medicine thesis, and its contention that the government co-opted research and managerial elites within medicine, creating greater differentiation between these and rank and file professionals. But whilst strong on identifying the relations within a profession, the approach tends to efface how regulatory changes have impacted the 'content' of medical practice. For this I have turned to the work of Mol (2008) and (Healey), who examine how logics of the market have diminished the capacity of doctors to be 'attuned' to the specificity of the patient as a complex subject. Fournier (2000) highlights how the logic of the market is at play within the professions in recent decades; how it is sometimes embraced and at other times resisted. She also provides for our purposes an important link between the ideology of globalisation, and the notion of complexity invoked in relation to it, and the emergence of multi-functional/professional teams within the NHS. Finally, I have touched upon

relevant literature on the policy making process (Du Gay 2000), (King and Crewe, 2013); namely the shift in recent decades towards a sharper institutionalisation of the demarcation between policy making and its administration (or between high and low levels of policy making), for example between the Department of Health and the Health Professions Council. Whilst overtly designed to increase efficiency and sharpen the instrumental power of the democratically elected, Du Gay (2000) and King and Crewe (2013) raise concerns that it has fostered an excessive 'can do' attitude within government and concomitant failure to subject policy proposals to adequate scrutiny and modification in the course of their development on the ground. I have also examined literature which addresses the political dynamics of how particular social and political regimes are installed; for example through the tendency of New Labour to depoliticise the pursuit of particular economic policy by rhetorically rendering 'globalisation' an entirely external quasi-natural phenomenon over which we have no collective control (Watson and Hay, 2003); and Clarke et al (2007) and Du Gay (2000) have identified ways in which particular policy options out of a pot of possible ones become temporalized in a manner which rhetorically renders them the only viable option – as if only one select set of policies can successfully *ride the wave of history.* In other words this literature suggests ways in which the contingency of particular policy regimes are denied in an effort to diminish their contestation.

In the next chapter I set out the contours of the theoretical and research approach I have adopted within my research. I set out some of the key ways

in which the approach draws upon some of the strengths identified within the existing literature, as well as how it helps to address some of the explanatory deficits of the literature reviewed here.

CHAPTER THREE

THEORETICAL APPROACH AND RESEARCH STRATEGY

In this chapter I set out the 'blue prints' of this research - that is the basic assumptions made by the 'logics approach' about the nature of social and political reality – as well as provide an exposition of the research process i.e. how I have 'applied' the research and conceptual tools of the logics approach to the specific case of the struggle over the HPC plans. I seek to address a number of interrelated questions and issues. These include what 'added value' the logics approach has over other approaches reviewed within the last chapter, as well as questions about the role of researcher judgment within the research process, and questions about the objectivity of this research, especially given that it is couched as an 'intervention'. I also seek to address the question of replicability of this research within other similar contexts.

I argue that the 'logics' plus 'nodal' approach, as a particular form of discourse analytic approach, shares many of the strengths of Foucauldian and discourse approaches considered within Chapter Two. I argue that the 'logics plus nodal' approach, however, has 'added value' in furnishing the ground for a more systematic and nuanced descriptive, explanatory, and critical account of regulatory struggle. As stated in the introductory chapter this includes a clear delineation between normative and ethico-ideological critique. An evaluation of what 'is' the case, how this has become the case, and how it could, and perhaps 'ought' to be otherwise are all within the scope of enquiry. The latter includes the theorisation and critical explanation of how

and why particular policy imaginaries often ‘grip’ people, thereby addressing the explanatory deficit in other accounts when it comes to the role of affect in regulatory policy and struggles. This three pronged approach to analysis, in which I address the normative, political, and affective dimensions of the struggle, helps to steer a path clear of a number of pitfalls (some identified in Chapter Two as evident within existing literature on the professions and regulation) in which lurk a myriad of explanatory excesses and imbalances, including determinism (akin to claims of ‘inevitability’); covert prescription within ‘merely’ descriptive literature; lack of normative critique; and a lack of a handle on the historical and political dynamics of the regulatory and policy controversy.

Setting out the fundamental ‘assumptions’ - the ‘ontological presuppositions’ in the parlance of political theory - made within the logics approach, and providing an exposition of the research process, are part of a social scientific and political commitment to ‘openness’; not only making the fundamentals of the approach, but also the specific reiteration, or ‘application’, of the approach within this case study more available to critique and further reiteration, or ‘replication’, within similar research contexts. This foregrounding of the blue prints and the process of working out, so to speak, helps, as Bacchi (2012) suggests, to counter a tendency of many interpretative and discourse theorists not to set out the theoretical contours, or the methodological detail, of their research, leaving their work vulnerable to charges that it is ‘glorified commentary’, laden with ideological and researcher bias, in comparison to supposedly more ‘scientific’ and methodologically driven (i.e. quantitative), or ‘merely’ descriptive approaches within social science.

As regards structure I begin by drawing out what we can assume, through the 'prism' of the 'logics' approach, about the HPC regulatory struggle; that is the assumptions that are made about the nature of reality. I then go onto set out the key aspects of the 'logics approach', namely, the concepts of 'problematisation', retroductive explanation, and the delineation of social, political and fantasmatic logics. I also examine how a nodal approach, as a comparative analytic framework, can assist in sharpening analysis of norms across the competing policy imaginaries. I then draw together the implications of this research oeuvre and 'tool box' of concepts as regards the objectivity of the research (with particular reference to the act of 'situated judgement') and normative and ethico-ideological critique. The central point is that both social reality and research are 'discursively constituted'; research is therefore always a form of 'intervention' of sorts into a relatively fluid social reality. Or, in other words, one social reality (a research one) meets with another (the subject of enquiry). In the third part of this chapter I provide a more concrete exposition of the research process, seeking to make explicit how I went about putting the blue prints of the logics approach to work within the context of building my account of the HPC struggle, addressing how I gathered and analysed data, including interview technique, and how I identified social, political and fanatasmatic logics within the sea of documentary and interview data.

THE 'LOGICS' PLUS 'NODAL' APPROACH

As Glynos et al (2014a) state, the logics approach is:

> Rooted in post-Marxist discourse theory (Laclau and Mouffe, 1985), a logics approach to critical policy analysis affirms the fundamental assumption that all social relations are in a constitutive and dynamic relation with structured fields of meaning marked by radical contingency (2014a:3).

These are the ontological coordinates of the research approach: social reality is seen as discursively constituted and marked by radical contingency. It also means that social reality and practice is fundamentally contextual and relational. This combined with radical contingency means that the social phenomenon under investigation (e.g. a regulatory regime) is seen to be fundamentally unstable in its identity and therefore (to varying degrees) open to becoming other than what it is: a reordering of the fields of meaning in which it is positioned would change its identify and practice. Social practice is discursive: that is to say social practice is a discourse which is a form of saying and doing. Regulation, policy making, talking therapy, are all forms of discursive practice, and social scientific research itself is also discursive, rather than existing in some ontologically privileged domain outside of social phenomena, and as a social activity is therefore a relatively precarious 'intervention' within the field under investigation, as opposed to an absolutely objective description or evaluation of it. This post-structuralist approach is part of the so called 'linguistic turn' across the humanities and the social sciences in recent decades, whereby language is seen as partially constituting, rather than merely describing, that of which it speaks (Glynos, 2011). Power and knowledge are seen as intricately and inextricably linked, and it is therefore not possible to speak truth to power from a position entirely free from power, since no truth or regime of truth can be fully rationally grounded. Poststructuralism is in one sense a step away from political idealism towards

the Machiavellian position – the realpolitik – in which powerful interests are seen as operating behind the back of political ideals: the latter seen as either tools of cynical manipulation, or as mere rhetorical dressing (epiphenomena) (Flybjerg, 2001). However, in another sense Laclau and Mouffe take a step back from both political idealism and realpolitik analysis in seeing interests as constructed within different discursive frames rather than as given or transcendent. Ideals, norms and values therefore play a role in constituting interests, rather than simply being tools of persuasion for 'naked' interests (Glynos and Howarth, 2007). In post-structuralist parlance, interests are not pre-discursive, but are constituted and shaped through systems of meaning. For example, whether or not it is in the interests of an individual to pay 'high' levels of income tax is not a given, but rather is shaped by one competing discourse or another. The discourse of economic liberalism, for instance, will construct the interests of the individual considerably differently – placing them in a different field of meaningful practices – than a socialist discourse.

Radical contingency, relationality, and anti-foundationalism within the logics approach afford important analytic and political advantages, but also present obvious challenges when it comes to questions of objectivity. I will address the latter below. But first I want to address some of advantages whilst providing a brief exposition of the logics approach developed by Glynos and Howarth (2007), based on the work of Laclau and Mouffe (1985).

I first examine key concepts and 'steps' within the approach, namely 'problematisation', 'retroductive' explanation, and 'logics' as an explanatory category. 'Logics' are further broken down into 'social, 'political' and

‘fantasmatic’ logics (Glynos and Howarth,2007), each facilitating an analytic focus on different facets of the HPC policy dispute and struggle.

A first step in the policy analysis process is to identify and broadly delimit the policy problem or ‘anomaly’ to be addressed. This already involves some immersion within the ‘problematisations’ within, and of, the field in question. The term ‘problematisation’ is close in meaning to ‘view-point’ or ‘discourses’. Competing problematisations about the HPC plans, for instance, are essentially competing view-points and arguments about it, or competing ways of ‘framing’ it. However, the term seeks to capture and convey the constitutive nature of discourse and of ‘arguments’. The ‘problem’ and possible ‘solutions’ are not seen as ‘givens’, simply waiting to be ‘discovered’’, but are constructed as specific kinds of problem, which give rise to particular kinds of solutions. Griggs and Howarth (2013) cite Foucault’s (1997) definition of problematisation as ‘a movement of critical analysis in which one tries to see how the different solutions to a problem have been constructed; but also how these different solutions result from a specific problematization’ (Griggs and Howarth, 2013:41).

As already noted within Chapter One, a broad ‘problematisation’ made of the field of the talking therapies in relation to regulation was that HPC regulation would deal with ‘a very small problem minority’ within the field which posed a threat to the public. Conversely, the Alliance ‘problematised’ the HPC plans as a severe threat to diversity within the field. In the main research chapters, five-seven, I start with an ‘overview of events’ which set out the main ‘problematisations’ of the key actors within the struggle. In the case of the HPC plans, for example, this includes their characterisation of the ‘content’ of

the HPC plans, what their likely impact on the field was, as well as the more ideological and political dimension of strategies towards both the implementation and derailment of the plans. I then subject these broad 'problematisations' to critical assessment and 're-articulation' through the framework of the 'logics plus nodal approach'. The concept of (re)articulation seeks to capture the fact that my account (and any account) is not simply a 'neutral' description of events, but necessarily involves a critical 'reorganisation' of key discursive elements at play within the struggle (more on this below). Before examining the explanatory category of 'logics', let me first give a brief exposition of the concept of retroduction.

Retroductive-explanation

The most important criterion for admitting a hypothesis as valid is that it accounts for the problem at hand (Griggs and Howarth, 2013). In the case of the HPC struggle a key criterion is perhaps to what extent the thesis gives a credible account of the existing multiple and contradictory accounts/problematisations of the 'rise and fall' of the HPC plans. Or in other words, to what extent does it provide a convincing account of the 'rise and fall' of the HPC plans whilst taking into account competing points of view (rather than, for example, 'bracketing off' key problematisations). The task within the retroductive operation is to establish a putative explanation and to then work 'backwards', seeking to establish what must be true in order to account for the rise and fall of the HPC plans. Or more specifically, in Chapter Six, for example, I seek to give a retroductive account of what I contend to be the

HPC's apparent failure to recognise its own plans as 'transactional' in character, and therefore their apparent failure to recognise how the plans were set to be a significant reshaping intervention within the field. The putative hypothesis/account is continuously reiterated and modified during the process of research through a continuous 'to and fro' movement between putative explanation, theoretical reflection, and discovery of empirical material. This retroduction is in counter-distinction to 'theory-driven' and 'method-driven' approaches. Shapiro (2002) claims that in the former there is a tendency to seek to 'vindicate a particular theory rather than illuminate a problem that is specified independently of the theory' (Glynos and Howarth, 2007:167). 'Method driven' research tends to be 'motivated more by the techniques of data-gathering and analysis than by a concern with the empirical phenomena under investigation' (*ibid:*167).

Let us now look at the status of the main unit of analysis: the 'logic'.

Social, political, and fantasmatic logics

The concept of the 'logic' as developed and used by Glynos and Howarth (2007) helps to tread a middle path between subsumptive explanations, in which the specificity of the phenomena under investigation tends to be effaced as it is placed under the category of a general category or law, and highly particularistic accounts, in which the phenomena under investigation is regarded as so unique as to make any generalisation worthless. An example of a subsumptive account is that of Waller's and Guthrie's (2013) tendency to subsume both art therapy and the talking therapies under the HPC as a kind

of universal regulatory approach: they contended that the regulation would not, or does, not distort the fields it regulates. They do this, I contend, without adequate forensic examination of the norms embodied within either of the fields in question, or of the norms within the HPC regulatory regime. A key contention within this research is that this account offered within and of the struggle contributed to an attempt to efface that the HPC plans, as a complex of regulatory practices, would themselves have been subsumptive, drawing diverse talking therapies under supposedly universal norms of practice, and in so doing would have exacted considerable 'violence' to the specificity of many talking therapies under its auspices. An example of an excessively particularistic account of the HPC struggle would be one that claimed that the field's resistance to the plans was driven and constituted solely by practices and concepts entirely unique to the field and to the struggle, and would be an account that falls into the error of regarding the identity of any regime or set of practices as 'hermeneutically sealed' from the rest of the world (see below in relation to the Derridian concept of the 'iterability' of the sign).

The concept of 'logic' helps forge a middle path in its counter-distinction from a 'law'. In keeping with anti-essentialism 'logics' are not regarded as having an essence, but are understood as a 'range of grammars in which 'logic' is uttered, articulated, implied […]' whose identification as grammars of logic 'does not mean that we have to isolate a feature or set of features they all have in common' (Glynos and Howarth, 2007: 134). Rather, they have, in Wittgenstein's terms, 'family resemblances'. The concept of logic does not 'establish the logical essence of a practice, for this runs the risk of 'subliming' logic by conceding it a super-hard, transcendental status in relation to the

world of empirical propositions' (*ibid*:135). Social logics concerns the rules/grammar determining what can and cannot be said, rules governing what combinations can and cannot be made. The concept of logic also helps to avoid an excess particularism, in which it is thought that the only way that social phenomenon can be properly understood is limited to a thick description of how it is understood by the actors involved. The Derridian concept of the 'iterability' of the sign helps capture how the concept of logic seeks to avoid both excess particularism and subsumption. Iterability refers to the contention that a sign is simultaneously the self-same and yet also modified when it is articulated in each new context. The meaning of a sign cannot be reduced entirely to the context in which it is articulated as the context is not entirely 'closed off' from the rest of the world. In this sense, strictly speaking, a purely hermeneutic account of a phenomenon is impossible. The iterability of the sign makes all research an intervention. But on the other hand, neither can the meaning of the sign be reduced to a meaning that is abstracted from all the contexts in which it is articulated. In other words a sign or concept is not transcendent of the contexts in which it is articulated, but nor are they reducible to the contexts in which they are articulated.

More simply, social logics are the norms governing or framing - shaping rather than simply describing - practice. Formulated in Foucauldian terms social logics concern the 'archaeological' dimension of analysis, whereby the complex of norms governing a regime are identified and evaluated (*ibid*:207) . In relation to the regime of 'transactionality', for example, the analysis of the social logics of the projected HPC plans includes the 'thick description' and

normative evaluation of the plans, including the identification and evaluation of the complex of norms articulated within the plans, including standardisation, hierarchy, transactionality, and what I refer to as 'pluralism-lite' as regards the structure of the field envisaged It is important to note that social logics are 'always contextual entities, arising in particular historical and political circumstances' (*ibid*:137), and therefore always, to use Heidegger's terminology, concern the 'ontical' dimension of the social world (*ibid*:15).

Turning now to the so called political and fantasmatic logics, these concern how regimes are built, defended, contested and dismantled. Formulated within Foucauldian terms, political logics concern the 'genealogical' dimension of analysis (*ibid*: 207), and concern the identification of how particular social regimes have become 'naturalised' and their radical contingency hidden from everyday view, or, in other words, it concerns how the social relations and practices have become 'hegemonic'. In addition fantasmatic logics help to address why particular discourses 'grip' subjects. Laclau and Mouffe (1985) identify two main political logics, the logics of equivalence and the logics of difference. Logics of equivalence refers to when elements within a 'discursive entity' (a system of meaning) are articulated together to form an equivalential chain, which, formulated in terms of a social group, predominate when differences within the group are de-emphasised and similarities are emphasised. However, the group does not cohere so much around the identification of a trait common to all members, but rather around an element of opposition, external to the group. Darian Leader for example when asked about conflict within the Alliance said that the HPC as a 'common enemy'

helped to unite the group (Glynos and Howarth, 2007).[20].Logics of difference refer to when differences within a social group are emphasised, and are therefore more internally differentiated. In Chapters Six and Seven I explore, for example, how the pro-HPC camp remained significantly divided on the detail of the HPC plans, unable to unite more fully around a 'common enemy'. Political logics have a 'quasi-transcendental' status in so far as they are necessary for the constitution of some form of social regime. The approach therefore tends to foreground antagonism as constitutive and irreducible, on the side of more Nietzschean and Foucauldian, rather than Habbermasian conceptualisations of rationality, and is sceptical about the possibility of full rational consensus (Flybjerg, 2001). In this respect the logics approach arguably tends towards a 'tragic' conceptualisation of social and political life in the sense that it tends to structure into its thinking the impossibility of an *end to politics,* or of an end to struggle. Given the levels of acrimony, antagonism, and deep pluralism within the history of regulation of the field of the talking therapies, as well as the failure of the HPC's somewhat 'rationalist' policy approach (in so far as it claimed to identify universal standards of practice), a robust theoretical foregrounding of antagonism is arguably a 'good fit' with the phenomena under investigation.

From the above we can already see elements of critique. There is the normative critique encompassed within the thick description and evaluation of the social logics of a regime, of which there are three distinct, though overlapping sources. First, an 'immanent' critique, in which a regime or policy imaginary is assessed against itself. In Chapter Six, for example, I highlight

[20] Darian Leader (Darian Leader (Lacanian psychoanalyst, Alliance co-founder), interview by author, June 2014.

tensions in the HPC's tendency to claim that the HPC allows professions to determine how it assesses the effectiveness of practice, whilst simultaneously claiming that the HPC itself guarantees the safety and effectiveness of practice. As another example, in Chapter Five, the actions of Skills for Health are subject to critique against its own professed inclusivity. Second, the counter-norms and the critique levelled by opponents of a regime are drawn upon. For instance, I draw on the material of the Alliance to critique the HPC plans, and vice-versa. Third, imported values and norms inform my critique, namely ones of democracy and pluralism. We can also discern that the political and fantasmatic logics help constitute and furnish a more ethico-ideological critique, focussed on how the pro and anti-HPC camps sought rhetorically and politically to persuade, nudge, seduce, and/or force others to embrace, accept or be resigned to their respective policy imaginaries and aims. This 'denaturalises' actual and projected regimes, helping to avoid the deterministic tendencies, either express or tacit, of many approaches to regulatory struggle. To recall from the last chapter there is a tendency within much existing literature to tacitly reify regulatory trends as if they are an unfolding of the essence of history, or as if they are 'over and above' the rest of society, rather than contingently constituted through a complex of discursive practices and political choices. Another angle on this is that the logics approach provides a more nuanced way of dealing with the agency/structure problem, avoiding the reduction of the individual subject to subject positions within and determined by reified discourses or ideologies, whilst also avoiding privileging agency over structure 'in which the subject is identified with a kind of textual dispersion and is considered to be as infinitely

malleable as the identities she or he constructs' (Glynos and Howarth, 2007:128). The logics approach, however, softens the demarcation between structure and agency, privileging neither. Glynos and Howarth quote Laclau at length and it is worth repeating this in this context:

> If the subject were a mere subject position within the structure, the latter would be fully closed and there would be no contingency at all. [Radical contingency is possible only] if the structure is not fully reconciled with itself, if it is inhabited by an original lack, by a radical undecidability that needs to be constantly superceded by acts of decision. These acts are, precisely, what constitute the subject, who can only exist as a will transcending the structure. Because this will has no place of constitution external to the structure but is the result of failure of the structure to constitute itself, it can be formed only through acts of identification. If I need to identify with something it is because I do not have a full identity in the first place (*ibid*:129).

The category of fantasmatic logics is also an important part of the 'added value' of the logics approach, helping to address how a particular regime of social relations, despite considerable opposition to it, and despite its fundamentally contingent nature, often persists. In the case of the HPC struggle the focus is on how the competing policy imaginaries drew the affective support of - at least some - people. The concept of the fantasmatic logic is drawn from Laclau's turn to Lacanian psychoanalysis, and helps to theorise responses to the radical contingency of all social relations (*Ibid)*. For Lacan, uncertainty and contingency induce anxiety: uncertainty and contingency are so powerfully anxiety provoking for us that we are often more comfortable knowing that we face a terrible fate than being uncertain as to whether or not we face a good or terrible fate (Glynos and Howarth, 2007). Contingency can otherwise be expressed in slightly different ways as radical contextual dependency or uncertainty, fluidity, indeterminancy. In the face of anxiety induced by recognition of such contingency, fantasy *steps in* to bolster

the subject's sense of 'positive' identity, or the 'naturalness' of the social regime in which they are embedded (or are to be embedded). In other words ideological fantasy produces a misrecognition about identity. A 'positive' identity (in a strict sense always only an imagined one) is essentially one not subject to the vicissitudes of history and cultural location**.** The inherent impossibility of such a full positive identity is turned into an empirical contingency through a 'fantasmatic narrative' in which the figure of the external 'obstacle' is seen as preventing the assumption of full identity, or else threatening its continued existence. The potentially damaging impact of this kind of narrative 'operation' can be clearly seen in the case of racism and xenophobia. The inherently relational, incomplete, and, in essence, 'undecidable' nature of Englishness - articulated variably though history and cross culturally with no single 'common' feature shared by all variations other than the signifier of 'English' - for example, may be 'imaginarised' as a full identity through the construction of other national identities, through which Englishness is differentially defined, as an obstacle to a full English identity and which therefore is potentially an object of deep hatred. This is what is referred to as an ideological response to radical contingency – a 'covering over', or denial of contingency. An 'ethical' response in contrast recognises the fundamental relational and contextual quality of the identity of Englishness. Whilst an ethical response cannot eradicate the differential nature of the identity, it can 'traverse the fantasy' so that the 'friend-enemy' or antagonistic relation becomes an agonistic one, marked by an 'agonistic respect' and greater openness to the 'other' and the fundamentally relational and incomplete character of our identity (Glynos and Howarth, 2007). In

other words, within an ethical response to contingency there is a propensity to recognise that, as Glynos and Howarth put it, ‘any form of identification is doomed to fall short of its promise’ (*ibid*:79).

Below I draw out more explicitly how the logics approach robustly provides the basis for both normative and ethico-ideological critique. But first let me give a brief exposition of the nodal comparative analytic framework. Glynos and Speed (2012), in their comparative paper on the time-banking industry and the UK healthcare regime, create a comparative analytic framework in which to situate and analyse how the principle or ‘social logic’ of ‘co-production’ is at play across three different ‘nodes’ within the healthcare service chain, namely the node of production and distribution, pertaining to how the social logic of co-production is at play within how services are made available, and the node of delivery, which pertains to how the principle of co-production is at play within how the practitioner-client relationship is framed, and finally, the node of governance, pertaining to how the social logic of co-production shapes how the other nodes are evaluated and governed (*ibid)* (more on this below).

So these are the contours of my approach to the HPC struggle. Before going onto a more concrete exposition of the research process I want to explore some of the ways in which the logics approach addresses issues of objectivity and critique.

Addressing concerns about objectivity and critique

Baldly put, if power and knowledge are inextricably linked and social research is always already an 'intervention' marked by its own values and set of limitations, it may be tempting to think that the implication of the post-structuralist approach is that objectivity goes out of the proverbial window, and that an 'anything goes' approach is legitimated, and that research is little more than mere opinion, motivated by political interest. This is one amongst the key charges, as noted by Glynos and Howarth (2007), sometimes levelled against post-structuralism (*ibid*:7). Let me briefly address concerns about the objectivity of my research in relation to some of the 'inherent' affinities between the research I have adopted and the different sides of the argument within the HPC struggle.

It is broadly true that the qualitative research approach I have adopted, which places significant importance on garnering and incorporating the contextualised self-interpretations of actors involved, has affinity with more contextual conceptualisations of talking therapy, and professional practice more broadly, as well as more contextual conceptualisations of regulation and policy making processes, than more acontexutal or transactional ones. It is perhaps little surprise then that my research has leaned in favour of more contextual regimes of practice and regulation. This affinity is more clearly thrown into relief if we spell out how the ethico-ideological ontology of the logics approach folds into grounds for the normative critique and evaluation of competing policy imaginaries. The ethico-ideological coordinates of the

approach, as outlined above, give rise to the question as to what norms of practice, or what kind of professional, regulatory, and policy making regimes, and, indeed, research practices, help foster more 'ethical', rather than 'ideological', responses to radical contingency. Which norms of practice help to foster an awareness of both the relationality and contingency of identity and social relations, and an enjoyment of more 'open' rather than more 'closed' identities and social relations? And which norms of practice within professional practices and services, and policy making process, acknowledge and incorporate what is taken to be the inherent impossibility of a 'complete' rational or technical solution to a problem which is genuinely and entirely above the 'fray' of politics and of competing values? In this sense I seek to address which practices *cut with* rather than *against* what is taken to be the ontological *grain* of social reality, namely its fundamental contextual, relational, and contingent nature. The ontological assumptions of this research approach obviously incline my analysis to the view that more contextual conceptualisations of practice are likely to lead to more fruitful engagement and progress. Furthermore, Laclau and Mouffe (1985) acknowledge that they import the values of democracy and pluralism: this is to an extent reproduced here. Again, this compounds an affinity with certain ways of conceptualising professional practice: for example Mol's emphasis, to recall from Chapter Two, on finding ways of democratising the relationship between doctor and patient (Mol, 2008), and Healy's (2013) recommendation that medical knowledge needs to be shaped more by practitioners *on the ground* than currently the case. Both Mol and Healy essentially claim that what we might characterise as more democratic ways of organising and

shaping medical practice is better suited to the nature of both illness and medical technologies than highly hierarchical or transactional ways of organising and framing it. Furthermore, the Lacanian inflection within the approach obviously shares sympathies, so to speak, with positions taken by Lacanian (and other schools) of psychoanalysts, as expressed for example through the Maresfield Report (Arbours Association et al, 2009), within the HPC struggle. There is a shared view of the subject as a subject of desire, as distinct, for example from being primarily a rational subject; and there is broadly a shared critical analysis of consumer capitalism. As briefly explored within Chapter Four, Lacan pitched his school of psychoanalysis against American ego psychology and its perceived tendency back in the 1950s to seek to overly adapt patients to the demands of consumer capitalism. As explored within Chapter Six, a key objection of Lacanian psychoanalysts to the HPC plans was that its consumer-contract style framework would negate the ability of the analyst to work with a client as a fractured subject of desire. So the coordinates of my research are to a significant degree predisposed to favour the Alliance over the HPC in so far as the former provides (as I argue) a much more robustly contextual conceptualisation of practice than the HPC, as well as additional affinities relating to a psychoanalytic-inflected world-view.

However, the ontological coordinates have also predisposed my analysis to be critical of the tendency of the Alliance at times towards what I refer to as ‘talking therapy exceptionalism’ in which strong demarcations between talking therapy and healthcare practices as such are made. In so far as all discourse is in part ‘performative’, and help to create that of which it speaks, talking

therapies are, to adopt the Foucauldian phrase, ‘technologies of the self’ (Rose, 2003), and therefore shaping interventions. The ontological coordinates of the logics approach have also arguably predisposed my analysis towards scepticism of the near to apriori demarcations made by some Alliance members between professional and community ways of organising talking therapy services in which ‘community’ is necessarily seen as the good other of the ‘profession’. As regards the Lacanian inflection of the logics research approach, the discourses of Lacanian psychoanalysis and other talking therapy schools of thought are not immune to critical analysis from a Lacanian inflected analysis. Strong contestation between strands of thought within Lacanian psychoanalysis and the field of the talking therapies broadly attest to this.

To reiterate the broader point I am making here, the problem of imputation, in so far as it is a problem, occurs at least in part because at an ontological level there is always already a degree of imputation into the scene of enquiry by the researcher. As noted by Glynos and Howarth (2007) any research involves a redescription of phenomena in terms of one’s own presupposed ontology (230). Ontology is perhaps analogous to the attributes of an art or technological form taken to make a record of a scene. The technological and art form of photography, for example, inherently inscribe a scene differently to the way a pen and drawing does, or the way done so by audio recording equipment. This is not a problem peculiar to qualitative research however. As contended by literature reviewed within Chapter Two, quantitative research redescribes phenomena in terms of its own ontology, and, often coupled with shady executions of quantitative methodologies, produces results –

characterised as at the height of objectivity within scientific research - in favour of particular practices which on closer inspection amount to little more than fictions (as explored within Chapter Two), (see for example Shedler, 2015, and Hammersley, 2005). There is in short, no matter the research approach adopted, no entirely neutral access to, or record of the research phenomena to be had. But notwithstanding this fundamental limit, how does the researcher avoid entirely imputing their own preformed judgements and fantasies onto the phenomena under investigation? Given that there are no 'laws' for social scientists to identify which exist independently of interpretation, it follows that research necessarily involves subjective interpretation. Glynos and Howarth (2007) note that 'subjectivity and judgement' play 'vitally important roles' within the logics approach. They contend that:

> Because no universal rule or law is given – by which one can say – yes these cases are identical instances of this 'law' [..] if these cases are to be formed into a synthesis at all, then some kind of universal form has to be constituted by the power of judgement itself (2007:183).

A norm cannot be 'identified' in a strict sense as a social, political or fantasmatic logic, but must rather be articulated as such through the researcher exercising their judgement. Glynos and Howarth (2007) argue that this should be done through the exercise of intuition, 'situated ability' and a form of expertise acquired through learning, practice and experience (84). This is against more subsumptive approaches 'built upon a spurious logic of scientific operationalisation that sets out the necessary and sufficient conditions for 'applying' a concept to an object'. Rather, a researcher must 'first immerse themselves in a given discursive field consisting of texts,

documents, interviews and social practices, before drawing on their theoretical expertise to make particular judgements as to whether something counts as an x [….] They then have to decide upon its overall import for the problem investigated' (2007:184). This is contra the cognitivist view that expertise can be reduced to a series of rules to be followed. (There are obvious affinities between this approach to research and Schon's conceptualisation of reflective professional practice, as explored within Chapter Two). The singular retroductive explanation of the problematised phenomenon arrived at is to be judged in relation to how well it accounts for the problem at hand, and how persuasive it is (2007:191). As Griggs and Howarth (2013) put it, 'the ultimate "proof of the pudding" consists in the production of narratives explaining problematised phenomena, which in turn depends partly on the relevant community of critical scholars' (2013:49). To the latter it is possible also to add practitioners within the field in question, as well as policy makers, clients and other stakeholders.

Given the broad coordinates of the poststructuralist logics approach – that there is no unmediated or non-discursive access to reality – it perhaps comes as no surprise that hard and fast methodological rules tend to be eschewed. Laclau for instance rejects methodology as embodying the 'positivist fallacy' that the research object can be *discovered as it is* without any discursive mediation and independently of the subjective involvement and judgement of the researcher (Glynos and Howarth, 2007). Method within the research process should accordingly be relatively contextual and emergent in relation to the specific and unique aspects of the phenomenon under investigation. The problem of excessively fixed method within social scientific research is

analogous to the problem within excess audit culture, as argued by Michael Power (see Chapter Two), where a practitioner whose thinking and action is overly shaped by established procedure, may well inadequately respond to unique aspects within new situations, sometimes with devastating consequences. However, whilst I have not adopted any *hard and fast* methodological 'rules', I have adopted some methodological 'guidelines'. In focussing upon these I seek to give an exposition of how the research approach was 'operationalised' within this specific research context. Strictly speaking the research approach is 'reiterated' within, rather than simply 'applied' to a new context.

METHODOLOGY

The research process: The structure of this thesis to a significant extent mirrors the research process. I began by surveying existing literature on the struggle, namely the collection of papers on psychoanalysis and state regulation (Parker and Revelli, 2008) and articles on the internet from eIPNOSIS[21]. These provided an overview of the emergent HPC struggle, key issues, themes and perspectives – the key 'problematisations' - within the field of the HPC plans, and the IAPT and SfH projects, as well provided an overview of aspects of the history of regulatory struggle within the talking therapies. Together with the logics approach adopted, this picture helped me to begin to delimit the scope of my research and the key questions I wanted

[21] See http://ipnosis.postle.net/.

to address (as outlined within Chapter One). As already outlined in Chapter One, these questions relate to the character of the plans and their associated projects, as well as to the political dynamics of how they were both promoted and resisted. Quite early in the process I provisionally delimited the research as relatively wide in scope in including the broader context of the HPC plans i.e. the inclusion of the SfH, IAPT projects and the wider healthcare regulatory reforms, as well as significant historical contextualisation, in order to draw out the broader antecedents and its broader significance. This is a key reason why I spent a significant amount of time critically reviewing a broad body of literature on the professions and the rise of the regulatory state, which helped to get a good picture of the broader regulatory context and history (some of which informed the historical contextualisation chapter). My interpretation and critique of the literature was broadly conducted through a post-structuralist theoretical prism. In this sense the research process is significantly informed from the outset by the post-structuralist theoretical approach adopted. In short, within Chapter Two, I have tended to critique the literature through the ontological assumptions of the post-structuralist approach, and, therefore, have partially sought to render aspects of existing literature and its insights compatible with my approach in order to contribute to an integrated and singular account of the HPC struggle.[22] My initial analysis of existing literature tended subsequently to predispose me to look at the HPC and its associated projects along two key critical axes. The first was a critical outlook

[22] In this sense the sequence within the structure of the thesis – the fact that I have placed the research chapter after the literature review – tacitly overstates the linearity of the research process: the reality is that the research approach adopted significantly informed how I approached the literature review.

on the evidence based practice movement and accountability as audit and a related tendency to look favourably upon more contextual and relational ways of framing professional practice and regulation. The second critical axis my critical review of the literature leaned me towards when approaching the HPC struggle is a scepticism towards any sharp demarcation between professional expertise and non-professional/community expertise. My critical engagement with the literature therefore to an extent shaped by engagement with the primary research data and material which I went onto gather. Within a qualitative research process the demarcation between data gathering and data analysis is recognised as partially heuristic in character, namely because the art of data gathering always already involves a degree of analysis: to contend otherwise is to fall into the empiricist fallacy that it is possible to gain unmediated access to the object under investigation (more on this below).

However, the research broadly followed a process in which initial intense data gathering gave way gradually to an increased focus upon analysis. Let me briefly address each in turn.

Data gathering:

The ontology of the logics approach translates into a relatively open ended methodological approach to data gathering, in contradistinction to a highly generalizable method of *hard and fast* rules and procedures. Given that reality is seen by the logics approach as constituted by competing discourses, my data gathering focussed on collecting material from a wide range of actors within the HPC struggle using a range of methods and sources. This was in

an effort to make my research more representative. Documentary evidence has ranged from the highly official – such as the Government's White Paper on regulation, and the HPC's consultation papers and minutes of its meetings – to more unofficial documents, such as newspaper articles, public letters and online blogs and comments. The HPC's tendency to value a degree of transparency in its procedures and decision making was very helpful as it meant that minutes to its meetings and other documents were easily available to me online. This was less so in the case of IAPT and SfH. A key source of data came from the interviews I conducted. I adopted a qualitative, semi-structured approach to these interviews. Potential participants were invited on the basis of their involvement in one of the projects, with my main focus on the HPC plans. In my selection there was a balance between the pro and anti-HPC camps. The letter of invitation I sent out to most interviewees can be found in Appendix C. This letter is quite generic and non-specific about the character of the research and reflects the emergent character of my research, but also my anxiety about putting potential interviewees off taking part, or excessively 'leading' responses (more on this below). As far as the HPC struggle is concerned I was unable to secure an interview with anyone from the BACP. This is significant given that it is the professional organisation with a diverse as well as the largest membership within the field. However, my interview with Fiona Ballantyne Dykes of the Counselling Central Awarding Body, and counsellor and psychotherapist, helped me address some questions about the BACP's position within the HPC struggle as she has been closely involved with the organisation. As regards IAPT and SfH health, key players declined to be interviewed, including Richard Layard, Anthony

Bateman, and Peter Fongagy. SfH agreed to be interviewed and I drew some useful resources from it. However, SfH were, unlike the HPC and other organisations, exceptionally guarded, and although SfH treated me to overtures of friendliness and promises of help, they were in fact unwilling to engage in any reflection on the SfH project to map the National Occupational Standards of counselling and psychotherapy, mirroring the reported experience of some within the field during the development of the SfH project (see Chapter Five). I prepared an interview guide for each interview (see a sample guide within appendix B**.** This included information about their professional background as well as key questions across different areas I wanted to address. Whilst aspects of some of the interview guides had common aspects, each interview guide was in effect bespoke for each interviewee. Whilst the guides were structured to structure the interview, I did not follow these to the letter. In practice the interview discussions would 'jump about', with new questions emerging in the course of the interview, and questions were often asked and addressed in the order 'dictated' to by the unfolding discussion. At a minimum, however, the interview guide served to help me to ensure that I covered ground that I wished to do so, as I found it otherwise surprisingly easy to forget about some areas once immersed within an interview. A quick scan of the guide towards the end of the interview helped rectify this. The interviews lasted between forty minutes and three hours: the node was about an hour. Being qualitative, rather than quantitative, in character, the questions were open ended and the interviews bespoke. I did not, for example, present participants with multiple choice questions, or even present a uniform set of open ended questions to all participants. The

data gather techniques were not intended to enable highly formalised comparative analysis of responses of the different respondents, but designed to illicit contextualised self-interpretations of the actors involved. This data gathering technique provides the respondent greater space and freedom to express what they think, and avoid the sense of being forced into picking – often rather arbitrarily – between different 'boxed' choices so to speak. As with the invitations to interview I was faced with the dilemma as to what extent to foreground the development of my own thinking and views within the interviews. Some interviewees at times sought to identify more expressly my own position and to challenge and engage with it. Generally I tried to avoid entering into fully forthright argumentation – partially because my own views and analysis were for most of the interviews in their early stages of development – but also because I wished to strike a more exploratory than argumentative tone so as to elicit a broad set of responses. Different types of source tended to yield different kinds of data. Official documents, unsurprisingly, were a good source for charting the development of the main and official policy positions of the Government, the HPC, and the Alliance. Less official sources, including the interviews, were good at identifying unofficial discourses within the struggle. Janet Low's blog (Low, 2008) for example identified an unofficial discourse which contended that the HPC should reinvent the field rather than worry about the HPC Standards of Proficiency necessarily conforming to existing standards within the field – a position strongly contrary to the HPC's official position that its standards were universal and very 'light touch' or neutral (Health Professions Council, 2008b). The interviews sometimes pointed me in the direction of important official

documents. For example Michael Guthrie highlighted the significance of the guidelines for applicant professions document. The less official sources tended to be key to highlighting the affective dimensions of the struggle. For example, my interview with a health scientist advisor to IAPT revealed a tendency towards a fantasy-imbued Enlightenment IAPT narrative in which so called evidence based practices are seen as supplanting ‘dinosaurs’ and people with ‘no sense’ within the field (see Chapter Five). Key sources of evidence of fantasy-imbued narratives within HPC regulatory discourses were found within online responses to newspaper articles, where the HPC tended often to be cast by zealous proponents as a wave of Enlightenment against individual and collective professional oligarchies and corruption within the field of the talking therapies (see Chapter Six).

Now let me briefly set out how I went about the data analysis. As already mentioned, data analysis, at least in rudimentary form, is at play from the moment data gathering is started. In the interviews, for example, ongoing and emergent analysis by both the interviewer and interviewees shaped the discussions and data gathering process. The following exposition of the process of analysis therefore to an extent applies to the data gathering process, as well as to the deeper and more reflective analysis I conducted away, so to speak, from the empirical scene.

Methods of data analysis

I transcribed the interviews I conducted, as well as transcribed some of the video recordings available online of the speeches and seminars This meant I

could access them as ‘text’ in the same way as other documentary material, such as policy development papers. In keeping with the qualitative methodology I did not seek to formally codify the material, but rather, following an immersion in the material – close reading essentially – I broadly broke down the material into the broad analytic categories of the logics approach, namely the broad sweep problematisations of the competing camps at play within the struggle, and the social, political and fantasmatic logics. I set out the key problematisation of the main actors within the struggle prior to the interviews as this was part and parcel of preparation for the interviews and the very process of selecting potential interviewees. Following a sketch of the main problematisations of the struggle evident within a range of sources, I ‘mined’ these documents for the key social norms of practice (the social logics) and the political and fantasmatic logics. The identification and analysis of these different aspects was broadly a concurrent process as I went through documents identifying key logics and coded them in a relatively ad hoc and informal manner.

I used and adapted, as noted above, the nodal framework (Glynos and Speed, 2012 and Glynos et al, 2014a) primarily as an aid to the analysis of the key social norms of practice within policy documents. This helped to frame my research into and analysis of the HPC regime, its associated projects, and the counter-policy imaginaries of the Alliance. In addition to the nodes of provision and distribution, delivery and governance, I added the nodes of regulation and the node of education and training, in order to address the specific context of the HPC regulatory struggle, which is obviously centred on the HPC plans as a form of ‘external’ regulation, and

includes how this was projected to impact counselling and psychotherapy trainings. I have folded the category of regulation into that of governance. For heuristic purposes I divided the field up into the following four nodes:

(i) Node of governance and regulation. This pertains largely to what we can call the node of governance through the axis of regulation. That is to say, how regulation contributes to the governance of practice. In the case of professionals situated within organisations this also refers to employer-led forms of governance. The latter are often in interrelation with regulatory requirements. The main facets of regulation are the establishment of standards of practice and training, and their enforcement through a complaints procedure, as well as more general practices of surveillance and audit, such as 'continuous professional development'.

(ii) The node of training. This refers to the norms governing and shaping training, or more broadly, the acquirement of skills and knowledge.

(iii) Node of service provision and distribution. This includes the planning, the design and the commissioning of services. It includes the kind of evidence of effectiveness is used within the public commissioning of services, such as 'evidence based practice' or 'practice based evidence'.

(iv) Node of service delivery i.e. the therapeutic relationship/ how therapy is delivered e.g. protocolised or manualised therapy versus more highly contextualised exercise of practitioner judgement. It concerns how expertise is conceptualised.

This provided an analytic-comparative framework in which I could more clearly compare and contrast the following:

(i) The continuities and divergence between the character of the HPC plans and the associated Improving access to psychological therapies and Skills for Health projects to map the standards of practice for counselling and psychotherapy.

(ii) It will help compare the key norms of the government projects with the norms of counter-policy imaginaries proposed by opponents of these projects. In short it helps us to identify and articulate the differences between the 'transactional' and more 'contextual' regimes.

(iii) It helps us to pin point the differing priorities between competing actors within the struggle. For example in Chapter Six the framework helps identify that the professional liaison group tended to prioritise their concern for the likely impact of the plans on the nodes of provision and distribution (e.g. commission) than on the node of delivery. Finally,

(iv) The nodal framework also helps to highlight relatively hidden tensions between different norms within the same projected policy regime. For example, in Chapter Five I explore how the healthcare regime tends to valorise consumer choice cum autonomy within the node of provision, but, arguably, undercuts this severely within the nodes of delivery, governance and regulation.

I went through each of the salient policy documents (including counter-policy texts of the Alliance) and simply asked what does this document say (tacitly or expressly) about the node of provision and distribution, about the node of governance and regulation, about training and provision and about the node of delivery? This helped to systematise the analysis and help ensure key areas of interest were covered. As can be seen within Chapter Six, for example, this mining and systematic analysis of the documents was a means of 'reality testing' both pro and anti-HPC camp claims about the character of the HPC plans. The 'reality testing' however is not measured against some 'concrete reality' to which I have gained unmediated access, but is rather measured against my own set of observations, critical interpretations, and values. My account is therefore a form of articulatory practice, an intervention of a sort.

Articulatory practice: My analysis of the HPC plans and what they projected about the various nodes of the 'service chain', along with my review of a wider range of literature (as discussed within Chapter Two), galvanised the naming of two broad types of competing policy imaginaries at play within the struggle, namely the transactional regime and the contextual regime. This characterisation is itself an interpretative action and political intervention encompassing a judgement 'call'. The naming of the HPC policy regime as transactional (or acontextual to borrow Fook's term from her research in a social work context) is substantively contrary to the HPC's claim to neutrality.

The naming of the regime as transactional/acontextual, as opposed to medical or healthcare, also places significantly different emphasis than that placed by much of the Alliance discourses and is contra its tendency towards a position near to talking therapy exceptionalism. In keeping with the emancipatory aims of the post-structuralist logics approach I have sought to strengthen the 'voice' of the marginalised 'contextual' policy imaginary by foregrounding the norms of the HPC, and by further helping make the rhetorical and political manoeuvres which marginalise more contextual policy imaginaries more visible.

The identification of particular logics and practices as specifically 'political' logics stemmed from the thick description and critique of the competing policy imaginaries. It became, for example, a matter of identifying the ways in the HPC's discourses rendered the transactional norms of its plans less visible, and how the Alliance conversely rendered them more visible (albeit they tended to characterise them predominantly as 'medical' and 'healthcare' norms incommensurable with talking therapy). The identification of particular logics as political also stemmed from my analysis, largely drawn from existing literature (explored within Chapter Two), of a degree of commensurability between talking therapies and more contextual conceptualisations of healthcare practice and other forms of professional practice. In this instance it became a matter of identifying ways in which such potential commensurability was made less visible or underplayed by the Alliance. My identification of the political logics that were used to make these dimensions less or more visible by competing actors therefore in one sense rests upon my 'political' re-description and re-drawing of the elements constituting the social space

under investigation (i.e. my characterisation of the social logics of the policy regimes and imaginaries). Similarly, the identification of fantasmatic logics was predicated on my thick description and critique which shaped and constructed my understanding of the struggle between the competing policy imaginaries. I was looking as to how, for example, the HPC's claim to neutrality may have affective 'grip' and therefore render other critiques of it less visible or effective. I was not, for example (as a HPC proponent might have done so) looking for clues as to how the HPC's neutrality was eclipsed or rendered less visible by an 'affective grip' within Alliance discourses. This is simply because in my view the claim that HPC was approach neutral or 'light touch' was not grounded within credible evidence. I have, however, noted ways in which a tendency at times towards a 'totalitarian' fantasmatic narrative within Alliance discourses embodied a degree of 'affective grip' against the HPC plans.

The identification of ideological constructions as imbued with fantasy is quite an intuitive process. However, there are some broad indicators, such as emotive and strong analogies (like Postle's comparison of HPC supporters within the field with French Nazi collaborators within the Second World War), and where there seems to be an excess of affect, such as within the highly charged invective within some of the comments made online against Alliance members (explored in Chapters Six and Seven). As noted above, the singling out of certain elements of the struggle for focussed attention, and the (re)description of elements in terms of social, political and fantasmatic logics is not an absolutely objective or apolitical process. But my account is the product of an articulation produced by a constant to and fro between the

theoretical research approach I have adopted, theoretical perspectives drawn from elsewhere, the empirical evidence, and my emerging analysis of the social, political and fantasmatic logics. This to and fro between these complexes led to considerable modification of the hypothesis and the developing thesis over time, as well as the taking up of positions on which I was previously undecided. Modification of the thesis often regarded considerable changes in nuance; for example the recognition of significant differences between the HPC plans on the one hand and the SfH and IAPT projects on the other, differences which at first sight may lend strong credibility to the HPC's overarching narrative of neutrality and its claimed fundamental distinction from IAPT and SfH. Indeed at moments during the research process I had a sense that my view might radically change. As regards the taking up of positions on which previously I was undecided: my thesis has to an extent been framed by a general scepticism towards strong demarcations between professional and non-professional forms of practice and organisation, as well as scepticism towards talking therapy exceptionalism. These were not positions upon which I was decided prior to the research and have therefore been fostered and shaped significantly by the research process itself.

In one sense research is always unfinished since there can be no final word on an issue, and, as noted above, social scientific research is, or should be, a grounded and yet tentative and contestable contribution to a democratic and dialogic process in which policy can (or should) be continuously reviewed and (re)shaped. The delimitation of the research as regards the decision as when to bring it to a close was therefore a pragmatic, though not arbitrary, one. In

Table 1 showing actors interviewed actors and their roles

Actors interviewed within the pro-HPC camp **Name**	**Role and background**
Diane Waller	Professor of Art Psychotherapy. Chair of the HPC's Professional Liaison Group for the Counselling and Psychotherapy. An Art Therapist and key figure in the struggle to get Art Therapy recognised as a profession, and regulated by the HPC.
Michael Guthrie	Director of policy and standards
Julian Lousada	Chair of the British Psychoanalytic Council (BPC)
Malcolm Allen	Chief Executive Officer of the BPC
Fiona Ballantyne Dykes	Counselling Central Awarding Body. She was within the Professional Liaison Group to represent the whole of the FE sector.
James Antrican	Chair of the UKCP, 2007-2009
Graham Smith	Physiotherapist and HPC registrant. One of number of non-counselling and psychotherapy field members of the HPC's Professional Liaison Group for Counsellors and Psychotherapists.
Jonathan Coe	Spokesperson for the charity Witness, which supports individuals who have abused by their therapists.

Actors interviewed within the anti-HPC camp **Name**	**Role and background**
Darian Leader	Lacanian Psychoanalyst. Member of the College of Psychoanalysis, and the Centre for Freudian Analysis and Research. Key organiser and leader within the Alliance.
Andrew Samuels	Psychotherapist and Professor of Analytic Psychology, University of Essex. Key organiser and figure within the Alliance and the legal action against the HPC.
Denis Postle	
Paul Atkinson	Jungian Analyst and member of the Alliance. Was involved with the development of competencies for psychoanalysis within the Skills for Health project.
James Barrett	Psychotherapist involved within the Skills for Health Project to develop competencies for psychoanalysis.

Other actors within the field interviewed	**Role and background**
Nick Temple	Psychiatrist and Psychoanalyst
Interviewee A	Health Scientist Advisor to IAPT

short, I drew the research to a close once the explanation had more or less reached ‘saturation’. This is to say once it seemed that my account adequately accounted for what I set out to account for. In this sense discourse approaches do not seek to provide what one might refer to as false or misleading levels of closure, certainty, objectivity, or assurance, about the matter under investigation.

SUMMARY

In this chapter, drawing extensively on the work of Glynos and Howarth (2007), Glynos and Speed (2012), Glynos et al (2014a), and Griggs and Howarth (2013), I have set out the research ‘prism’ through which I have approached my empirical research on the HPC struggle. I have provided a brief exposition of the ontological coordinates of the logics approach as well as its more detailed conceptual research tools, namely the concept of problematisation and the analytic categories of social, political and fantasmtic logics. The ontology of the approach is that, as Glynos et al (2014a) put it, ‘social relations are in a constitutive and dynamic relation with structured fields of meaning marked by radical contingency’ (3). Given that one always already redescribes a phenomenon in terms of one’s ontology, this research from the start is predisposed to be contra more deterministic accounts of regulatory struggle; for example those that expressly or tacitly see regulatory trends as a ‘natural’ progression of history, or as a response to economic shifts that are seen as ‘over and above’ the rest of society.

I have outlined how the approach not only attends to the political dynamics of how a policy imaginary is promoted, but also to the character of the policy imaginaries in question. This is the primary job of 'social logics'; encompassing a thick description and normative critique. Key generic questions include, what are the key tensions within a particular policy imaginary and how do they measure up in comparison to counter-imaginaries at play? Political and fantasmatic logics are those which help build and defend or contest policy imaginaries. The two main political logics are those of equivalence and difference, which help provide a framework for understanding how the pro and anti-HPC camps are structured, and help pinpoint their relative hegemonic-strategic strengths and weaknesses (Glynos and Howarth, 2007). Laclau and Mouffe's reconceptualization and revitalisation of the concept of ideology (as a denial of radical contingency) provides grounds for addressing the 'affective grip' of particular policy imaginaries, and how the pro and anti-HPC camps were each internally 'glued' together. To recall from the last chapter this is a key explanatory deficit in many other approaches to regulatory struggles.

As far as the status of research is concerned, I have argued that it cannot help but be an 'intervention' of sorts, and that subjective judgement of the researcher is, as Glynos and Howarth put it, a 'vital' part of the research process. Research cannot be tightly 'operationalised' in a series or complex of rules or procedures without losing much of the rich specificity of the phenomenon under investigation. Rather, a continuous 'to and fro' movement between theory, putative explanation and immersion in the 'empirical scene' is the most fruitful way to produce a robust narrative account of the struggle

which avoids the pitfalls of both theory and method-driven research. The value of this ‘intervention’ can only be assessed contextually by a relevant body of scholars and/or practitioners, clients and other stakeholders. There can be no fully objective or technical discernment of the reality of the HPC struggle, and there can be no fully objective or technical discernment of the value of any particular account of the struggle. Robust judgment, however, I have contended, involves a ‘situated ability’ and expertise. Finally, I have suggested that these ontological coordinates and research principles can partially form normative grounds upon which to assess different policy imaginaries, including how professional and regulatory practices are framed and governed: in short I have put forward the question regarding how well do practices *cut with* the ontological *grain* of reality – its fundamental contextual, relational and contingent nature.

Having drawn the contours of our theoretical and research approach to the scene of enquiry, we can now, in the next chapter, take a more empirical turn, and look at the broad historical context of the HPC struggle, sketching the myriad of historical threads, both within the field of counselling and psychotherapy, and within the broader policy and regulatory context, which preceded the HPC policy dispute.

CHAPTER FOUR

HISTORICAL CONTEXTUALISATION

In this Chapter I briefly chart the broad historical context of the HPC struggle. The multiple issues and tensions at play within the struggle did not appear ex nihilo, but have their own histories, going back years, decades, and in some instances, even more than a century. Sketching some of these originating contexts enriches the texture of our understanding of the HPC struggle. Throughout this chapter I quite expressly signal the significance of key elements within the history of counselling and psychotherapy to what was to become the HPC struggle: to borrow a popular phrase from Voltaire, 'the present is pregnant with the future'. Whilst the logics approach I have adopted eschews any deterministic view of history, this phrase aptly captures the sense that the past shapes many of the conditions of possibility (at least ontic ones) for present socio-cultural events, and these in turn, for future events. This chapter sets out key antecedents of the HPC struggle, ones relatively internal to the field of counselling and psychotherapy, as well as more external ones. The chapter is structured into three main sections. In the first I examine the emergence and early days of psychoanalysis in the late 1800s and early 1900s, and the proliferation of different forms of psychological expertise and their role within the growing 'psy-complex' within burgeoning liberal society and governance (Miller and Rose, 1988). This occurred within a broader context of a system of 'self-regulation' across sectors of the economy (Moran, 2003). Key issues to emerge during this period that were interwoven

within the HPC struggle include the practice and regulatory relationship of psychoanalysis to medicine, psychological expertise working 'within and against' existing provisions within healthcare services, as well as the formation of some talking therapies in counter-distinction to the 'medical model', and deep levels of pluralism within the field. In the second section I focus on a complex of responses within the field to recommendations by a government sponsored report in 1978 – the Sieghart Report (Sieghart, 1978) - that psychotherapy should be subject to statutory regulation. Many of the cleavages between organisations involved within the HPC struggle originated during the 1980s and 1990s. In the third section, our attention is turned to more recent developments which contributed to the greater active interest of government in regulation of the field, manifest within the HPC plans. In short, this section concerns the so called rise of the regulatory state and associated policy developments, namely the 'evidence based practice' movement and the institutionalisation of empiricist styles of reasoning and evidence within the establishment of the National Institute for Clinical Excellence (NICE).

FROM EARLY PSYCHOANALYSIS, BEHAVIOURISM, THROUGH TO THE EMERGENCE OF THE 'THIRD FORCE': 1880s – 1970s

Let me first briefly sketch key aspects of the history of the field from the birth of psychoanalysis onwards. Psychoanalysis is widely seen as the first modern form of talking therapy, though it is predated by other practices which have significant family resemblance to modern conceptualisations, namely 'moral therapy' during the 18th Century (Kennard, 1998) and, going much further back, ancient Greek philosophy, including stoicism, which has inspired

aspects of cognitive approaches to therapy (Evans, 2012). I take psychoanalysis as our point of departure, however, because key concepts to emerge within it have had significant influence on the shape of many different forms of talking therapy that have followed, and which played a significant role within the HPC struggle. I first briefly look at these concepts, followed by a sketch of some of the organisational tensions within early psychoanalysis, and then provide a sketch of the main contours of the field following the proliferation of different forms of talking therapy.

The emergence of key concepts within early psychoanalysis

Psychoanalysis was dubbed the 'talking cure' by 'Anna O', a patient of Breuer and Freud, after she gained some relief from symptoms by talking about some of her memories and associations around them. Psychoanalysis distinguished itself from the method of hypnotic suggestion developed by the Parisian neurologist, Charcot, through the method of 'free association', in which the patient, without censorship, says whatever comes to mind in relation to their symptoms (Milton et al, 2011:43). This was based on the belief that 'the underlying elements of the neurosis formed a template deep in the mind, linked to the surface by chains of associative ideas, and that the truth would be bound to bubble up to the surface, given a change' (*ibid*:43). Freud found, however, that it was not simply a matter of catharsis, since patient's found it so difficult to express freely what came to mind; strong inhibiting affects or thoughts such as embarrassment and doubting of the relevance appeared to be frequently intervening. This led Freud to the notion

of ‘repression’ and the idea that symptoms are a replacement for an intolerable (repressed) idea (*ibid*:43). Cure of, or relief from, symptoms was therefore construed as involving substantial change of the patient’s psyche. Hypnosis was understood as frequently failing, or the relief from symptoms not enduring, because it failed to address the underlying meaning of symptoms to patients’, leading either to the return of the same symptom or the development of alternative symptoms; these new symptoms giving ‘expression’ to the same repressed idea. As Milton et al point out, Freud also observed that:

> Not only did patients come to talk about their intense and disturbing memories, fears and passions to Freud, but they were starting to re-experience them in the room with him too. A version of the past seemed to be re-experienced in the present: that is, the *transference* was beginning to be noticed’ (*ibid*:44),(Italics added).

These concepts remain fundamental features of many so called ‘depth psychologies’. As we shall see below, the concept of transference is a part of the psychoanalytic oeuvre that has been adapted by numerous schools of therapy and has played a significant role in regulatory debates and struggles within the field throughout the late 20th and early 21st centuries. Transference, if accepted as a real phenomenon, in the client-therapist relationship presents obvious potential difficulties for regulation and professional governance, as well as a consumer framework, since it means that the client’s perception of the therapist becomes deeply ‘clouded’ by their own unconscious motivations. This presents the risk of the analyst being unfairly accused of malpractice or malfeasance. But conversely it also presents the risk of real malpractice or malfeasance being dismissed as mere transference (more on this below). Another central feature of psychoanalysis, in contradistinction to hypnosis, is

its relative egalitarian rather than autocratic structure. Anna O, for example, as a patient, did much of the 'imaginative work' herself (*ibid*). Gay (1989) writes: 'considering the importance that Freud would learn to attribute to the analyst's gift for listening, it is only fitting that a patient should contribute almost as much to the making of psychoanalytic theory as did her therapist' (64).Both this, and Freud's related contention that psychoanalysis is ultimately more efficacious than hypnosis because it deals with the underlying issue (thereby preventing the development of alternative symptoms), were still active perspectives within the HPC struggle (see Chapter Six).

Cultural and organisational tensions within early psychoanalysis

Psychoanalysis emerged in the late 19th century at the same time as the family as centre of economic organisation was on the wane and monopoly capitalism and 'mass' society was starting to emerge (Zaretsky, 2005). Zaretsky characterises psychoanalysis as the 'first great theory and practice of personal life' as a cultural way of seeking to understand why, despite the emergence of opportunities for extra-familial identities, individuals were still strongly wedded to strong images of paternal authority (*ibid:*5). The 'original historical telos' of psychoanalysis, as Zaretsky puts it, was '"defamiliarisation"; the freeing of individuals from unconscious images of authority originally rooted in the family' (*ibid:*5). The conditions of possibility of psychoanalysis can therefore be said to be liberal, and in turn, psychoanalysis can be broadly said to be conducive to liberal society.

I want now briefly to focus on the relationship between psychoanalysis and medicine. Although Freud's practices and theories emerged within his private medical practice, his ambition was for psychoanalysis to be a 'science of the unconscious', with therapy as only one possible application of it out of a myriad of ones. He therefore sought a position for psychoanalysis within the university. At the time, however, the university was resoundingly 'positivist' in orientation, and it rejected psychoanalysis as unscientific (Schroter, 2004). This led to the eventual establishment of a system of independent training schools and a focus, as a means of financial and institutional survival, on psychoanalysis as a form of therapeutic intervention. Nurturing a close proximity to medicine helped procure patients, as well as helped draw on the prestige and respectability of medicine. However, medicine was not a great deal more accepting than the university. The professions themselves, like medicine, in order to gain a home in the university had to accept the positivist epistemology of practice and its technical rationality (Schon, 1983). As psychoanalytic associations formed within Vienna and then other countries, some associations strongly pursued the respectability 'umbrella' of medicine. The American Association for example, against Freud's wishes, restricted psychoanalysis to those trained as medics in an attempt to avoid the field being swamped by 'quacks', especially given the strength of the popularity of psychoanalysis within the USA during the early 20th century, as well as a way of responding to public scandal caused by psychoanalysis and its practitioners (Schroter, 2004). Freud contended, writes Schroter (2004), that 'in psychoanalysis, the difference between the expert and the "quack" was determined by specialised analytic training and not by a medical diploma.

(169). Although admittance criteria varied between national associations, a 'tripartite' model of training was broadly adopted, encompassing a theory course, a training (i.e. personal) analysis, and supervised analysis of patients. This system is still in place, with an emphasis on the personal training analysis, across many trainings today (Arbours Association, 2009).

Interrelated with these tensions over the relationship to medicine and the question of 'lay analysis' were tensions over psychoanalytic doctrine. In the first generation of psychoanalysts two key divergences and splits came from Adler and Jung. They contested the prominence that Freud gave to the sexual aetiology of neurosis. Adler contended that individuals are driven to overcome an inferiority complex, and placed an emphasis upon the conscious ego. His theories came to be named 'individual psychology'. Jung contested Freud's claim that the libido is exclusively sexual and argued that unconscious motivations can come from collective unconscious archetypes. Such 'defections' inaugurated a tendency within psychoanalysis to analyse the person of the analyst; Adler and Jung both being analysed as straying from Freudian orthodoxy because unable, psychically, to face its truth. Jung was characterised as having a 'father complex' (Makari, 2008:282) to which Jung countered: 'I am forced to the painful conclusion that the majority of psychoanalysts misuse psychoanalysis for the purpose of devaluing others and their progress by insinuations about their complexes (as though that explained everything. A wretched theory!)' (2008:278). This could be construed as an early manifestation of what Samuels later refers to as the 'sadistic hierarchy' within the field (Samuels, 2009), and what Lousada and Cooper (2010) suggest, drawing on the seminal work of Menzies Lyth (1960)

on organisational dynamics within a hospital, has the hallmarks of a social defence system against anxiety i.e. psychoanalysts projecting their own deficiencies down the perceived hierarchy of modalities of practice (Cooper and Lousada, 2010:4).

As the so called ‘psy-complex’ developed there were in effect many challenges to Freudian orthodoxy, both within the psychoanalytic field ‘proper’ and through appropriations of psychoanalytic ideas elsewhere. There was also the emergence of behaviourism, cognitive psychological and therapy, and the so call ‘third force’ of humanism (DeCarvalho R.J 1990), (Burton and Kagan, 2007). Let us take a broad sweep look at the proliferation in psychological expertise across the bulk of the twentieth century.

Proliferation in psychological expertise throughout the 20th century

Notable appropriations of Freudian orthodoxy include those made during the First World War in response to the phenomenon of ‘shell shock’ (which has some family resemblance with the more recent diagnostic category of post-traumatic stress disorder). The urgency of the problem of the war effort being undermined by depleting numbers of soldiers able to return to the front line, coupled with the fact that soldiers from low and high classes were afflicted, undermined the organicist approach dominant within psychiatry at the time that contended that the illness was the result of hereditary degeneration and was therefore incurable (Stone, 1985). This gave psychoanalytic informed practices an opening. Rivers et al characterised ‘shell shock’ as an ‘unconscious flight into illness’ caused by a conflict within the mind of the

solider between fear and duty (*ibid*)**.** Rivers et al's approach perhaps diminished the mental suffering of soldiers with 'shell shock', as well as helping them to avoid the ignominy of the label of 'cowardice', but it also increased their chances of being returned to the horrors of the trenches. This is perhaps one of the starkest examples of the pronounced ethico-political dilemmas involved when psychological expertise is enlisted or appropriated by an organisation or government to help meet specific, preordained, aims.

After the First World War psychoanalysis enjoyed a rise in popularity within British society: 'psychoanalysis spoke to a 'post war' concern with understanding the roots within human nature of that unprecedented collective trauma' (Richards, 2000:187). Groups interested in psychoanalysis included students, medical professionals, teachers, educationalists, and the clergy; and 'among fiction writers and many dramatists', Richards notes, 'some knowledge of Freud's ideas was also de rigeur' (*ibid:*197). Psychoanalysis to an extent was seen as commensurate with a counter-culture that sought reconnection with the non-rational against the 'escalating success of materialist science' (*ibid*:189). The 'craze' for psychoanalysis between 1920 and 1925 prompted predominantly critical newspaper coverage and a 'virtual moral panic about the dangers of quacks and charlatans posing as psychoanalysts' (*ibid*:205). Concern was expressed that psychoanalysis 'dethrones the will' and poses a threat to morality and decency. The Times for example, in 1925, reported the suicide of a young barrister who had been in analysis, and who had written of a 'sense of degradation it had imposed on him'. The Times journalist called for an enquiry, claiming that the present situation is a consequence of the 'neglect of psychology by the medical

schools of this country' (*ibid*:215). The British Medical Association (BMA) was prompted out of its reluctance to be involved with psychoanalysis and created a psychoanalytic committee to look at this case and broader concerns that non-medical analysts were bringing the profession into disrepute. Rather like within the USA earlier, the popularity of psychoanalysis prompted closer ties to the medical establishment. Psychoanalysis gained significant influence within mainstream medical psychiatry during the 1920s, but this receded somewhat, as the British Psychoanalytic Society became more insular, 'policing doctrinal developments and excluding outsiders from constructive participation' (*ibid*:204). However, there was a proliferation of ideas and tensions among a second generation of psychoanalysts. The second generation included Melanie Klein, who built her theory to an extent on Freud's own shift away from the sexual aetiology of illness with his introduction, in the wake of the traumas of the First World War, of the concept of the 'death instinct'. Dysphoria during the Second World War made London something of a pluralist and active centre for psychoanalysis, especially given the presence of Freud, Anna Freud and Melanie Klein. The so called 'controversial discussions' between the latter two and their advocates during the Second World War are an indicative example of extensive differences in ideas and dogma. Both Anna Freud and Klein based their theories based on their work with children, yet came to diametrically opposed positions on key aspects of theory and technique (King and Steiner, 1991).

Klein's ideas partially informed Bion's work and the emergence of the 'therapeutic community' experiments during and after the Second World War. The first experiment at Northfield military hospital in Birmingham was run by

Bion, who went onto develop innovative theories regarding group relations (Kennard, 1998). Bion challenged traditional conceptualisations of the role of the expert psychiatrist: the psychiatrist of the therapeutic community 'had to give up his anarchical rights in exchange for the more sincere role of member in a real community' (*ibid*:35). Bion, on the surface at least, refused total responsibility for disorder on the ward, and instead sought to facilitate patients to form their own understanding and to change their own conduct. Again, there is an emphasis upon the client or patient doing much of the creative work.

Following the Second World War, there was a proliferation of progressive forms of psychological expertise which challenged organic approaches within psychiatry, many initiatives emerging from the Tavistock Institute of Human Relations from the late 1940s onwards. This and the Tavistock clinic became important sites for the development and use of psychoanalytic ideas and other psychological and sociological approaches in the analysis of society and of a series of problems in peacetime Britain, including absenteeism from work, industrial productivity, leadership, the selection and training of personnel, and accident proneness (Miller and Rose, 1988). The group, rather than the individual, became the central unit of analysis; tensions and conflicts within groups were identified and analysed as underlying manifest individual and discrete problems. The Glacier Project for instance advocated that the 'industrial relations model of "bargaining" be replaced by a psychotherapeutic one of "working through". Processes of 'scapegoating' in the work place were identified and alternatives for a happier and more efficient factory were pursued (*ibid:*185). Psychological expertise inaugurated

a new concern with an attempt to align the internal needs of workers with the industrial aims of organisations, marking a shift towards the democratisation of the work place. This was part of the so called ‘positive mental hygiene movement’, and not only included the application of new forms of psychological expertise to the work place, but also to child rearing in the private sphere and within the education system. There was a new emphasis upon prevention of problems and early intervention to stop them from developing. The psychoanalysts Winnicott and Bowlby, for example, popularised new child rearing advice to help prevent ‘maladaptation’ to the environment and social problems down the line, and educationalists critiqued ‘rote learning’ approaches, advocating instead that schools should regard the child as a whole person and focus on developing their personalities. Overall, a range of forms of psychological expertise were developed in a plethora of domains in an attempt to make peacetime Britain a more democratised, happier and more efficient nation (*ibid:*178).

From the 1950s onwards Lacanian psychoanalysis also emerged. I highlight this because Lacanian psychoanalysts within the UK were key actors within the moves against the HPC plans. Lacan’s approach was developed in express opposition and counter-distinction to American ego psychology, where the capacity of the conscious ego to master the unconscious is emphasised, and where the central aim is for the good parts of the client’s ego to identify with the ego of the analyst. Lacan pitched his approach as ‘against adaptation’, critiquing American ego psychology for seeking to adapt clients to the demands of mass production capitalism and the social conservativism of American mainstream society during the1950s (Turkle,

1979), (Whitebook, 1995). Indeed, American ego psychology of the 1950s is now widely agreed to have been excessively conservative (*ibid*). For example some psychoanalysts informed women patients who expressed an ambition to work (thereby breaching gender stereotypes during this US period) that they were suffering from 'penis envy' and that they should modify their ambitions accordingly (Zaretsky, 2005:377). Lacanian psychoanalysis, in contrast to the emphasis that ego psychology placed on 'adaptation' was framed as seeking to enable a client to follow their desire. Lacan focussed on the early Freud, who he saw as a thinker of 'radical doubt and discovery', and as one who continually renewed his ''own language, knowledge, and presumed basis for knowing' (Turkle, 1979:99), and was critical of Freud's shift from 'meaning' to 'mechanism' in his later work, and of Freud's increased attempts to 'codify' his work and protect Freudian orthodoxy. Lacan lamented the shift in emphasis from theory and understanding to technique. He wrote that 'meticulousness of detail is passed off as rigour, and rule confused with certainty' (*ibid*:99). He saw this as antithetical to science and innovation, and argued that 'no institution', as Turkle puts it, 'but only the analyst can authorise himself in the analytic vocation' (*ibid*:99). Lacan is resolutely anti-bureaucratic and anti-institutional, tending to construe the blind observance of orthodox technique as anti-scientific. A key example of Lacan's stance is his innovation of the 'variable length' session, by which Lacan broke with the standard fifty minute analytic session and would cut sessions at points in the patient's discourse where he felt that they would be partially jolted out of their routine ways of thinking. This outraged much of the psychoanalytic community (both in France and internationally), and it entered the public

imagination to wonder why Lacan's variable length sessions were always shorter rather than longer (*ibid*). The invention of 'the pass' was another innovation which is indicative of Lacanian anti-routinisation so to speak. It is a procedure by which an analyst gives an account of their training analysis to others in the training school. Here the emphasis is not so much on assessing a candidate's capacity to train or to practice, as to see if they have 'reached the maturity needed to use his own analytic experience as research' (*ibid*:124). A central point about Lacanian psychoanalysis to stress, for our purposes, is its emphasis upon Freud's ambition for psychoanalysis to be primarily a science of the unconscious. Psychoanalysis is not seen as a 'quasi-medical technique focussed on "cure" but as a scientific discipline and a process of individual research and self-discovery that needs no further "therapeutic" justification' (*ibid*:15). As we shall see in further chapters, this was one of the key orientations of opposition to the HPC plans. Lacan's unorthodox practices led to his expulsion from the International Psychoanalytic Association in 1963. By the mid-1960s Turkle characterises Lacan and the Freudian School, however, as emblematic of the fundamental paradox within psychoanalysis: the need for institutional bonds in order to ensure survival, but which simultaneously the practice of psychoanalysis as science seeks to continuously dissolve. Many of Lacan's anti-bureaucratic and anti-hierarchical practices in fact ended up producing informal hierarchies, reinforcing Lacan as a 'maitre' to be revered and obeyed. One analyst commented of the Freudian School within Paris: 'debate was stifled just when it might have been most productive. Lacan sent out every kind of signal that disagreement was not welcome on the things that he considered

really important' (*ibid*:126). Measured against Lacan's own pronouncements, this is a sign of psychoanalysis failing, not thriving: in the realm of an analysis, schism rather agreement is regarded as more likely a good indication of success. This is another key underpinning reason for Lacanian opposition to the HPC's consumer orientated 'quality assurance'. A key aim of analysis is to challenge the 'subject presumed to know' – the idealised all-knowing other – and it is therefore for the client to come to their own view about the meaning or 'quality' of the analysis. [23] The Centre for Freudian Analysis and Research (CFAR) was established in the UK in 1985, establishing a significant Lacanian constituency within the British context. Internationally Lacanianism, however, has gone on to become the most widely practiced form of psychoanalysis within the world (Arbours Association, 2009).

Back in Britain, during the second half of the twentieth century public services became increasingly dominated by behavioural, and later, cognitive forms of psychological expertise. Within the British Psychology Society there was, for example, a struggle between psychodynamic and experimental psychologists for prevalence. The Medical Section was strongly psychodynamic in orientation but was increasingly squeezed by an alliance between psychiatry and experimental psychology. Clinical psychology was emerging and seeking a stable role, whilst psychiatry was seeking greater credibility as a medical specialism (Burton and Kagan, 2007). The experimentalist approach of clinical psychology was a means to give scientific credibility to the diagnostic categories of psychiatry. This 'classical humanism' (Woolfolk and Richardson,

1984: 781) is a tradition of the Enlightenment that emphasises the primacy of a commitment to reason and science, believing that the latter strongly overcomes irrational authority and arbitrary privilege. The science upon which clinical psychology and psychiatry tends to be based upon, however, is a form of a-theoretical British empiricism, arguably with a tendency towards a hidden ideology of social Darwinism in which social problems are seen as rooted primarily within the individual rather than structures within society (Pilgrim, 1997). There were counter trends to this 'classical' (sometimes referred to as 'scientific') humanism, including moves from within the medical and psychiatric establishment, namely by the so called anti-psychiatry movement, spearheaded in the UK by a number of psychiatrists, including Laing and Cooper. It was an international movement, and Marcuse, Foucault and Lacan were all drawn upon to an extent. They raised concerns that the more 'humane' interventions, such as psychoanalysis and psychotherapy, may in fact be more subtle mechanisms of social control. Laing, for example, stated:

> In the best places, where straightjackets are abolished, doors are unblocked, leucotomies largely foregone, these can be replaced by more subtle lobotomies and tranquilizers that place bars of Bedlam and the locked doors inside the patient (Crosssley, 2006:884).

Laing provocatively dubbed many psychiatrists as suffering from a new mental illness, 'psychiatrosis' (Laing, 1964:64).[24] Mental illness was re-described strictly in terms of social relations and 'problems with living', rather than through diagnostic categories. Broadly they tended towards a romantic conceptualisation of mental illness, characterising it as the good 'other' of a

[24] Laing wrote: 'It would now be an interesting experiment to study whether the syndrome of 'labelling' others runs in families. A pathological process called 'psychiatrosis' may well be found, by the same methods, to be a delineable entity, with somatic correlates, and psychic mechanisms, with an inherited or at least constitutional basis, a natural history, and a doubtful prognosis' (Laing, 1964:64).

sick society (Whitebook, 1996), and aimed not simply for a revolution in the treatment of the mentally ill, but a transformation of society. The anti-psychiatry movement wanted to re-engage the conversation between the insane and the (rest of) society that existed in the Renaissance, which the 'classical' strand of the Enlightenment had severed (*ibid*). This was similar to the aims of psychoanalysis within therapeutic communities, though the anti-psychiatric movement tended to want to extend the analysis strongly against the organisation of society and not just the hospitals (Crossley, 2006). Laing and a group of psychoanalysts, psychiatrists and social workers set up the Philadelphia Association in 1965, and a number of therapeutic community households, the most (in)famous of which was Kingsley Hall in London. The Philadelphia Association established a formal training in psychoanalytic psychotherapy which continues to this day. In keeping with a desire to engage in a broader critique of psychoanalysis, and to contribute to a transformation of society, the Philadelphia Association made critical philosophy a significant feature of its curriculum, stating, for example; 'we feel that psychoanalysis has neglected the philosophical enquiry into its own basic presuppositions' (Abram, 1992:143). The Philadelphia Association adopted Lacan's innovation of 'the pass', and created less hierarchical institutional relations. This, however, is often purported to have created tensions of its own, one former trainee, for example commenting that 'tyranny could still exist in an apparently equal system, because there is a mystique as to where the power lies' (*Ibid*:143). The responses of patients and their families to anti-psychiatry have been mixed: many schizophrenics for example identified Laing's popular book, 'The divided self', as close to their own experience

(Crossley, 2006), whilst others, especially some family members of patients, expressed that they found the 'romanticisation' of mental illness, and the tendency to shroud mental illness in 'chic', singularly unhelpful in their attempts to live with and help their loved ones with their tortuous mental states (Turkle, 1979), (Crossley, 2006).

Another counter-veiling trend to that of the classical/scientific humanism of behaviourism and experimental psychology was the 're-evaluation counselling' movement which emerged from the USA. Founded by Harvey Jackins in the 1950s within Seattle, re-evaluation counselling developed entirely outside of bureau-professional structures.[25] The movement practiced 'co-counselling', and claimed that human distress is largely caused by past bad experiences that have not been properly 'discharged'. Jackins was influenced by the so called 'dianetics' of the cult movement of Scientology and similarly opposed the use of psychiatric drugs, and contested, like many within the anti-psychiatry movement, the existence of mental illness. The British Human Potential Research Project founded in 1970 at Surrey University by John Heron emerged from re-evaluation counselling and was very influential in the development of a strand of humanistic counselling within the UK (Heron, 1980).The development of humanistic counselling – the so called 'third force' – (DeCarvalho, 1990) through Rogers and others was in large part due to frustration with the limitations of both psychoanalysis and behaviourism, namely its perceived aloofness, dogmatism and medical orientation. Like the anti-psychiatry movement the humanistic counselling was

[25] Denis Postle (Alliance and IPN members, Humanistic counsellor and activist), interview by author, May 2015.

co-extensive with the 1960s counter-cultural revolution and an emphasis upon the inherent goodness of people, and the corrupting effect of unjust social structures. This has arguably underpinned an Illich-style valorisation of community organisation, unencumbered by bureaucratic or professional structures (as explored within Chapter Two) within the Human Potential Movement. This movement was one of the central pillars within the Alliance for Counselling and Psychotherapy Against Statutory Regulation.

In summary so far, we have looked at the broad sweep of the history of the ideational and institutional contours of psychoanalysis and the proliferation of new forms of psychological expertise and forms of psychotherapy and counselling between the 1880s and the 1970s. Tensions were largely around two closely interrelated axes. First, within the emerging field itself, between the protection and institutionalisation of orthodoxy, namely Freudian orthodoxy to start off with, on the one hand, and scientific, conceptual and creative freedom and innovations made by the 'rank and file', so to speak, on the other hand. The second main axis is that between the field and the medical and psychiatric establishment, mediated and constituted by a complex of contingencies, including concerns about an influx of 'quacks', uncontrolled proliferation of ideas, survival, and the rejection of psychoanalysis from the positivist orientated university. Whilst regulation through the medical establishment was an issue at play (in some countries medical status a requirement), and professional associations and training schools had been established, the question of what we now regard as external 'regulation' had not yet become a pressing issue in the UK. This was to change with the public 'scandal' concerning Scientology during the 1970s.

The Scientology scandal gave rise to calls for statutory regulation of psychotherapy, and, in turn, to a new distinct age in the life and times of the field in the UK. This was namely the development of a complex system of self-regulation, in many respects geared towards a longer term aim of statutory regulation, and which gave rise to a counter-movement against the professionalization and statutory regulation of the field (Totton, 1995). Let us now focus on this period.

TOWARDS STATUTORY REGULATION AND COUNTER-VEILING MOVEMENTS: 1970S – 1990S

The Foster Report (Foster, 1971) was a government response to public concerns about the growing international cult organisation, Scientology. Concerns were heightened when, for example, in 1965 a headmistress of a primary school in East Grinstead, who was taking a course in Scientology, reportedly 'took pupils of hers aged between 7 and 11 through an exercise in which they were to imagine that they were dead and turning to dust, as a result of which one small boy was said to have fainted' (*ibid*:3).[26] An already existing Australian enquiry stated that Scientology is:

[26] The Foster Review did not collect new evidence but reviewed evidence already in the public sphere. It looked for example at an Austrailian enquiry – the Anderson Report. Scientologists had approved the appointments to the committee and had expressed confidence that Scientology would be vindicated. The Anderson Report described Scientology as:

In response a Scientology pamphlet argued that the Anderson enquiry constituted 'a systematic and malicious attempt to belittle what knowledge concerning the human spirit there was, and to degrade decent, honest people whose only crime was that they were working to achieve a greater awareness of themselves as spiritual beings" (Foster, 1971:14). Furthermore the pamphlet argued that the Anderson finding was the product of the State of

> A fabric of falsehood, fraud and fantasy […] Scientology is evil; its techniques evil; its practice a serious threat to the community, medically, morally, socially, and its adherents sadly deluded and often mentally ill (Foster, 1971:5).

In Chapter Nine of the Foster Review, it briefly explores the characteristics of psychotherapy in relation to the concept and phenomenon of transference and the related vulnerability of the client, and recommends Parliamentary intervention to project the public (*ibid*:177). In the late 1970s a Professions Joint Working Party was established to examine the question of possible statutory registration of psychotherapists, which culminated in the Sieghart Report, published in 1978 (Sieghart, 1978). Members of the Working Party were from various psychoanalytic training organisations and from the British Association for Behavioural Psychotherapy. The Report broadly recommended the statutory regulation of psychotherapies based on the model of the regulation of medicine: a statutory council that would register practitioners and establish criteria for acceptance, standards of practice, a code of ethics, and deal with complaints. Sieghart presented the non-statutory regulation of the psychotherapies as an unwelcome anomaly. The report argued that:

> Medical practitioners, dentists, lawyers, architects, pharmacists, nurses, midwives, veterinary surgeons, opticians and dispensers of hearing aids have all achieved statutory regulation, and so have the "professions supplementary to medicine" – chiropodists, dieticians, medical laboratory technicians, occupational therapists, orthoptists, physiotherapists, radiographers and remedial gymnasts (*Ibid*:iv).

Sieghart observed that he, in contrast, without training or qualification, could legally set up practice as any kind psychotherapist or psychoanalyst. Sieghart

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Victoria's origin as a convict settlement; that it was indicative of 'the inborn criminal and suppressive nature of Australian social and legal system (*ibid*:5).

stated that: ‘provided they were above the appropriate age of consent (16 for women, 21 for men) I could go to bed with them’ (*ibid*:iv). Sieghart argued that a patient has recourse to a civil court to demonstrate that ‘I’ have done them ‘positive and demonstrable harm’, and if proved ‘I’ might ‘be ordered to pay damages, but even then no one could stop me from carrying on my practice’ (*ibid*:5). The report argued that statutory regulation of professions has two main benefits:

> First, it helps to protect the public from unscrupulous or incompetent practitioners who prey on it in the guise of “professionals”. Second, it helps to enhance the standards, and so the status, of genuine members of the profession itself *(ibid*:iv).

The Foster and Sieghart reports promoted the need for statutory regulation on the basis of (potential) harm to the public, therefore requiring, not only the demonstration that psychotherapy might have some unscrupulous practitioners, but also that the public may be particularly vulnerable to them (otherwise the former would be a sufficient condition for any occupational practice to be state regulated). The Sieghart Report is consonant with structural functionalism (as explored within Chapter Two) in viewing the psychotherapist-client relationship as very asymmetrical, in which the client is particularly vulnerable. The report construed the public as vulnerable on the basis of a psychoanalytic understanding of the process of psychotherapy, specifically the phenomenon of ‘transference’, arguing that the ‘patient’ is vulnerable because of a strong sense of dependence that they develop on the psychotherapist, leading often to ‘idealisation’ that ‘clouds their critical faculties’ (Sieghart, 1978:19). Furthermore:

> A consequence of this psychological dependence is the transference situation. Early in the history of psycho-analysis Freud discovered that patients became emotionally attached to him and that they would behave both seductively and aggressively. By “not

> attributing these phenomena to his own personal qualities" he created a treatment situation where the powerful human emotions of sexuality and aggression, of love and hate, could safely emerge and come into the area of the doctor/patient relationship (*ibid*:19)

Not only is the 'patient' regarded as vulnerable, but, drawing on the work of the structural functionalist sociological work of Parsons, Sieghart argues that:

> The powerful feelings of the patient directed to the therapist cannot fail but affect the therapist, who is subjected to a pressure from the patient – be it seductive or aggressive – to respond to the patient's feelings by acting them out […] In our view most unethical behaviour springs from the therapist's failure to withstand the emotional pressure of his patient's transference, a failure to master their own countertransference' (*ibid*:19).

The report does not explore the significance or potential problem, in terms of support for the proposals across the field, of the fact that it legitimates the need for statutory regulation on the basis of a psychoanalytic conceptualisation of transference. There was indeed considerable internal division within the Working Party between psychoanalysts and the behaviour therapists. Whilst the former were in favour of the official position of Sieghart, i.e. the establishment of a council that would set standards for practice and training, the British Association for Behavioural Psychotherapy (BABP**)** was against, arguing that there was currently insufficient evidence of what therapies were effective and whether training made any difference to effectiveness. The BABP were therefore at this time in favour only of statutory regulation that required practitioners to sign up to a code of ethics *(ibid*). The report was broadly in tune with the structural functionalist view and the self-justifying ideology of the profession, and did not address more sceptical accounts of the professions emergent within sociology during this period, as explored within Chapter Two, and also voiced by counter-cultural movements, including, to an extent, Scientology itself. The need for statutory regulation

was broadly accepted on the basis of professional opinion, rather than any formal body of evidence. Paul Sieghart emphasised that the Working Party, to his surprise, was conducted in a very 'good natured' way (*ibid*:xi), but in reality his regulatory policy proposal did not amount to a workable compromise or consensus across the field**.** In addition to the behaviourists' strong dissention, the committee had not consulted, or even considered, the growing field of humanists and counsellors.

Responses to Sieghart

Sieghart galvanized movement within the field towards a professionalised system of self-regulation, the Sieghart and the Foster Reports becoming for many authoritative points of departure in favour of statutory regulation of the talking therapies. The report also prompted a more marginal counter-movement within the field against both professionalization and the prospect of statutory regulation. Let us look at each in turn.

The so called United Kingdom Rugby Conference was established after the Sieghart Report in 1988 and was set up and hosted by the British Association of Counselling (BAC). Overall there was an attempt to unify the field and work out an agreement for regulation; the inclusion of the BAC and counselling setting the expectation that counselling should be subject to regulation as well as psychotherapy. Out of the Rugby Conference emerged the United Kingdom Standing Conference for Psychotherapy (UKSCP) (what became the UKCP), which later, in 1989, became the United Kingdom Council for Psychotherapy (UKCP) (Pokorny, 1995:415). The UKSCP/UKCP was a broad

church so to speak, encompassing a diverse range of schools of practice, including psychoanalytic organisations, humanistic, and behaviourist ones. However, the BAC declined to join the UKPC saying that the “BAC is a very large umbrella organisation and it would not seem sensible to place ourselves under someone else’s umbrella” (Aldridge, 2010:249). This thwarted attempts to unify the field under the umbrella of a single professional body, and also diminished the likelihood of a consensus being achieved within the mainstream of the field on what particular path should be taken, if any, towards statutory regulation. This was a significant cleavage within the field, a reiteration of which had a lively presence within the later HPC struggle. The UKCP’s quest to represent the whole field was further undermined by tensions between humanistic and psychoanalytic member organisations. Some psychoanalytic organisations, namely the Institute of Psychoanalysis, wanted a veto over any decisions that the UKCP committee made. This eventually led to an acrimonious break away of a group of psychoanalytic organisations, which formed the British Confederation of Psychotherapist (BCP), which later became the British Psychoanalytic Council (BPC) (Davies, 2009b:39).To an extent the split both reflected and reinforced the informal cultural hierarchy within the field in which psychoanalysis had a tendency to see other therapies as inferior derivatives or distortions of psychoanalysis. They also had a tendency towards social and moral conservativism; for example not allowing admittance of homosexuals to training. The BPC was also active in seeking to restrict the use of the title ‘psychoanalyst’, claiming that only people trained by member organisations of the BCP could legitimately use the title (Arbours Association, 2009). Malcolm Allen described

the BPC as an 'arrogant' organisation when he first joined in the 2000s.[27] It is against this background and history that the BPC was an early endorser of the HCP plans; its relative enthusiasm partially an effort to consolidate the shift away from the perception of it as arrogantly aloof (see also Chapters Two, Five and Seven). BPC member organisations tended also to have more extensive connections within the NHS. Other psychoanalytic organisations remained within the UKCP, including many that were later to oppose the HPC plans.

Whilst various factions and organisations within the field both pushed for and fought over a possible regulatory crown, the field of psychological therapies did not hold significant strategic interest for the Thatcher Governments (more on this below), and although the Major Government's initial response to calls from within the field for statutory regulation were not entirely unreceptive, it declined to pursue it on grounds of division within the field over what the character of any such regulation should be. Tim Yeo, the then Parliamentary Under-Secretary of State, in January 1993, wrote to Michael Pokorny, Chair of the Registration Board of the UKCP that:

> I am very interested to learn of the commendable progress that the United Kingdom Standing Conference for Psychotherapy has been making towards a unified umbrella organisation for psychotherapy. The forthcoming register is of particular interest and a necessary step in progressing towards regulation. We will continue to watch closely the development of the Register over the next few years. Before official recognition can be considered we will need to be satisfied that it represents all the major psycho-therapeutic approaches (Pokorny, 1995:415).

[27] Malcolm Allen (Chief Executive Officer of the BPC), interview by author, October 2014. See appendix A transcript p. 442.

This quietly stated reticence on the grounds of division within the field seems to have ‘turned’, not long afterwards, in 1996, into early indications by the Major Government that it may go down a different statutory route than that envisaged by the field (more on this below). Prior to this moment there was, in 1981, an attempt though a Private Members Bill in the House of Commons to introduce statutory regulation of the field. And in 2000 Lord Alderdice attempted to introduce a Bill. Neither Bills, without Government baking, reached a second reading (Arbours Association et al, 2009) The Alderdice Bill, arguably rather wistfully, was limited to introducing statutory regulation for psychotherapists, as distinct from counsellors.

Before looking at the regulation of the talking therapies in relation to the so called rise of the regulatory state, I want first to consider the significant counter-regulatory and professionalization movement that emerged during the 1990s.

Counter-regulatory and professionalization movement

Mowbray’s 1995 seminal text ‘The case against psychotherapy registration: A conservation issue for the Human Potential Movement’ (Mowbray, 1995) included a critique of the Foster report, effectively claiming that it used Scientology as a bogeyman to justify the pursuit of statutory regulation. Mowbray argues that the scandal of Scientology was used to set in motion moves towards forms of state regulation and professionalisation that essentially constitute a medicalisation (medical domination) of the talking

therapies, and that those seeking to suppress Scientology did so in the private interests of medical domination. Mowbray writes:

> Hubbard set up the Church of Scientology in the early 1950s specifically to be free to explore the world of the mind without being subject to licensure and to defend his 'Dianetics: the modern science of mental health' from the hostility of the American Medical Association which, in secret alliance with other members of the US establishment, was seeking to destroy the movement (Mowbray,1995:46).

Mowbray also cites the journalist, Percy: 'when Hubbard publicly denounced practices such as electroconvulsive shock therapy and lobotomy as crude assaults on the brain, the psychiatric establishment was outraged' (*ibid*:46), leading, Mowbray claims, to a sustained and orchestrated campaign by the American establishment against Scientology. Mowbray, like the human potential movement more broadly tends towards a strong intellectual prejudice in favour of non-professional and non-bureaucratic forms of organisation, and argues that it is quite possible that constant harassment from the US authorities and medical establishment actually helped foster the cultish aspects of Scientology. In the UK, factions within the humanistic counselling movement organised against professionalisation and the prospect of statutory regulation, and the so called Cambridge Lectures, organised by the Norwich Collective, led to the emergence of the Independent Practitioners Network (IPN) in 1995 (Totton, 1995). Totton wrote: 'I think we have registered that there are many therapists and counsellors who do not consent to the programme of the UKCP and BAC' (*ibid*:32). The IPN offered both a critique of and an alternative to the system of self-regulation. They critiqued the supposed self-regulatory system as hierarchical, in which psychoanalysis dominated, which in turn was dominated by a medical model; and the IPN is set up in contra-distinction to the hierarchical and centrally organised

mainstream professional associations. Each practitioner within the IPN needs to find membership within a group of practitioners that will vouch for the integrity of their practice, and, in turn, that group must have links to other groups in the network that will stand by the integrity of the group as a whole. Accountability and involvement in each other's work is described as extensive. The idea of the network is underpinned by the broader critiques of social injustice within society and by a conceptualisation of counselling and psychotherapy as a social movement, seeking to contribute to the social transformation of society. Totton for example writes: 'what is starting to emerge is a sense of the Network as part of a wider social movement towards the restructuring of institutions of all kinds on a pluralistic and non-hierarchical basis' (Totton, 1995:293). Humanistic therapists and activists from this tradition played a key role within the Alliance during the HPC struggle, forming a constituency that was not only opposed to HPC regulation but also to any form of professionalization: instead tending to see the talking therapies as a vocation or/and a social movement. To recall from Chapter Two, practitioners and thinkers within this movement tend to be against the professional hallmarks of credentialism, trainings and entry barriers to practice. Mair (1997), for example, in her paper 'the myth of therapist expertise', cites research studies which suggests that 'paraprofessionals' – 'educated people with no clinical training' – produced either better than, or just as good, outcomes for clients as those produced by professionals who had undergone a formal clinical training in psychology, psychiatry, social work, or nursing when delivering a range of therapeutic treatments (107).

In this section I have identified some of the key organisational formations and divisions within the field that developed partially in response to calls for statutory regulation of the field. Concerns about doctrinal differences, as well as differences in training standards, constituted what might be referred somewhat irreverently as a ‘turf war’ within the field between organisations, and considerable anxiety between competitors for the crown as regulator of the whole field. Members of the Human Potential Movement and of the IPN launched their own ‘turf war’, from the outside so to speak, seeking a more ambitious telos, not of statutory regulation, but of the end of bureaucratic and hierarchical organisations within the field, and in their stead the institution of an IPN-like, non-hierarchical and pluralistic network of organisations within a broader network of non-hierarchical institutions across all sectors of society (Totton, 2006). In this section I have identified the broad discursive and institutional matrices, largely internal to the field, which seem partially to have prohibited government uptake of calls from both within and outside the field, galvanised within and by the Foster and Sieghart reports, for statutory regulation to be introduced.

In the final section, let us look at the more external socio-political and policy drivers for regulation (relatively unpronounced until the late 1990s) within the talking therapies. My main focus is on the so called rise of the regulatory state. This helps contextualise the change in Government heart, within the space of a decade, from the gentle refusal or ‘stalling’ of calls for statutory regulation, to steely determination to implement a particular form of statutory regulation against the initial will of most of the field.

THE TALKING THERAPIES AND THE RISE OF THE REUGLATORY STATE

The Sieghart Report had come, as it turned out, at the tail end of the so called post-war consensus, of which full employment, 'cradle to grave' welfare, cooperation between corporations and unions, and Keynesian economic policy, were the chief hallmarks (Kavanagh, 1992). The Thatcher Governments and the New Right inaugurated a climate of greater scepticism towards the professions, construing them as 'producer monopolies' and as driven by self-interest (Exworthy and Halford, 1998:19). Self-interest was not seen as a problem in itself, but rather that the 'shelter' of the professions from the market, and their strong autonomy from government, meant that self-interest went excessively unchecked. The Thatcher Government's inaugurated a number of 'market' reforms of the NHS, including the introduction of the purchaser/provider split, so as to diminish professional clinical autonomy over services; often referred to as the restratification of healthcare professions, as explored within Chapter Two (Chamberlain, 2010). The Thatcher governments, combining moral conservativism and economic liberalism to orientate its policy, tended to cast the professions, along with unions, blacks, gays, single parents, and the political left, as the 'enemies' of national renewal (Glynos an Howarth, 2007:173). Market reform of the professions was accompanied with increased constraints on public spending. As noted within Chapter Two the rhetoric of liberalisation of the economy – the so called rolling back the frontiers of the state – making it smaller, was only part of the story: deregulation across economic sectors, including the privatisation of public utilities like water and electricity, was in reality

accompanied by the rise of multiple-layers of new regulation (Moran, 2003). As Moran and others have noted, this is not so much as government in retreat as a form of 'high modernism'; or, as Rose would put it, government at a distance. In reality the government, through market and regulatory mechanisms, extended its reach and control over the economy in many respects. The mid 1990s also saw the emergence of the evidence based medicine movement, in which, to recall from Chapter Two, there was an increased population based approach to medicine, and greater use of the experimental random controlled trial in the shaping of practice. This was a significant part of 'clinical governance' of doctors and other healthcare professionals (Department of Health, 2006a). Significant changes in law as regards the pharmaceutical industry and regulation of its market, both in the UK and internationally, made it a 'billion dollar' business (Healy, 2013), which tended to shift power within pharmaceutical companies towards the marketing departments, Healy contending, for instance, that the marketing departments have become *the tail that wags the dog*: medical conditions were starting to be created by the pharmaceutical companies in order to primarily meet demands and new opportunities for colossal profits *(ibid).*

The broader changes to healthcare were also mirrored within changes to the governance of psychological services within the NHS. The purchaser-provider split brought about a concomitant focus upon the 'cost-effectiveness' of treatments, through 'evidence based practice'. The NHS Executive sought, not only to directly influence psychological treatments provided, but also influence the regulation of private sector provision of psychotherapy (Roth and Fonagy, 1996:74), largely because by 1996 nearly half of all Local Health

Authorities purchased psychological services in the private sector. The Department of Health's 1996 review (Department of Health, 1996) of psychological services within the NHS expressed concern that 'employers, including GP's, should satisfy themselves that counsellors and psychotherapists are adequately trained and GP's should not employ staff whose qualifications have not been scrutinized' (*Ibid*:11). The review was followed by the publication of the first edition in 1996 of 'What Works for Whom?' (Roth and Fonagy, 1996). The review paper (Department of Health, 1996) noted that the broader program within the NHS to improve clinical and cost effectiveness of services draws extensively on the UK Cochrane Centre in Oxford, and the York Centre for Reviews and Dissemination (Department of Health, 1996:41). There is an assertion in the report that treatments should be tested through randomised controlled clinical trials (RCT), and that, 'much of current diversity is unjustified', the provision of particular forms of psychotherapy often based on the personal preferences and allegiances of practitioners rather than evidence of their efficacy (*ibid*:43). The review set out 'equity', 'accessibility', 'acceptability' (to service-users), 'efficiency' and 'effectiveness' as the key criteria in audit of services

The foreword of the 1996 edition of 'What works for whom?' (Roth and Fonagy, 1996) notes that 'the accountability that reimbursement parties wish and the quality of services to which patients are entitled call for new methods of evaluating treatment implementation and patient progress' (iv). It also claims that:

> Many, if not most, of the cherished beliefs of theorists and practitioners of particular methods of psychotherapy remain largely unsupported by the kinds of evidence preferred by those who control budgets of health care systems across the globe [and

> that] there has been relatively little progress in developing an evidence base for psychodynamic therapies and for longer-term treatments' (*ibid*:21).

Furthermore:

> The eschewal of existing reliable and valid measures by practitioners of psychodynamic treatment is a regrettable fact which will only be corrected by a concerted effort on the part of psychodynamic therapists to identity, in a consensual and measurable way, the outcomes their treatment aims to bring about, and to validate these against criteria that other stakeholders (such as patients, funders, and other practitioners) see as important (*ibid*:21).

It also states that treatments that are proved to be ineffective should be withdrawn, though asserts that lack of evidence should not itself be taken as evidence of lack of efficacy. Very strikingly the authors do not acknowledge that many within the field, to recall from Chapter Two, contend that quantitative research on efficacy are contrary to the values and norms of their practice. However, both reviews do acknowledge critiques of the Diagnostic and Statistical Manual of Mental Disorders (DSM), namely that its philosophical roots are within the now largely 'discredited' epistemological approach of logical positivism and operationalism:

> Leading philosphers (e.g. Polanyi, 1958; Kuhn, 1970) have demonstrated that scientific observations cannot be independent of theory to the extent that they represent theoretical constructs, and obtain their meaning through their placement in a network of concepts […] in fact the operationalism of DSM favours behavioural and biological orientations over other, potentially equally useful perspectives in the realm of psychopathology' (*ibid*:27).

Roth and Fonagy also warn against over-authoritative statements about which psychotherapies work: 'overconfidence at this point carries with it the risk not only of penalizing under-researched (but possibly effective) therapies, but also of freezing therapeutic innovation' (*ibid*:40). They argue, however, that the research on the efficacy of psychotherapy can feed back into

innovation in practice and service provision. The Department of Health review paper (Department of Health, 1996) observes that Roth and Fonagy (1996) summarise the arguments against using a diagnostic framework, but conclude that they find themselves "unable to identify a suitable alternative framework which would meet our objective of providing a scientific context of for recommendations regarding psychotherapy practice and training in the current NHS mental health services' (48). Reading these texts somewhat against themselves, but nonetheless taking their own claims to their logical conclusion, this would seem to be an indictment of current mental health services. This is in the sense that they seem to be saying that it is less because of the scientific credibility that the approach is adopted, and more because of the particular organisational features and epistemological predilections of the mental health services and their sponsors. As central texts underpinning the government's approach to mental health and psychological therapy services, they arguably offer extraordinarily lack lustre legitimation. Or more precisely, they seem to acknowledge that the research paradigm underpinning the development and assessment of talking therapies is inadequate. They seem to be saying, *we cannot find a suitable alternative scientific framework, so let us act as if this one is valid despite the fact it is widely discredited.* Here the lure of the promise of enhanced 'predict and control' capabilities, including the prediction of clear treatment outcomes, seems to supersede a concern for the scientific validity of tests, and, ultimately, the actual effectiveness of treatments.

The proliferation of regulatory practices during the 1990s, or the 'audit explosion', as Michael Power (1999) puts it (as explored within Chapter Two),

had limited impact on the sphere of private practice of psychotherapy and counselling. However, there was a project by the National Vocational Qualifications programme to map the competencies of the field in 1996, which the BPC declined to take part in, claiming that a competency approach was not congruent with psychoanalytic practice. The UKCP in contrast embraced this project, and was one aspect of the UKCP's attempt to broaden the appeal of psychotherapy. Former Chair of UKCP Emmy van Deurzen-Smith, for example, in 1995 stated that 'in order to be taken seriously as a profession we have to be able to demonstrate that psychotherapy is a scientific discipline in its own right, or better perhaps, that it is a scientific art which has a significant contribution to make to the emotional well-being of Europe' (Deurzen-Smith, 1995).

Let us now look at the early years of the New Labour government and key antecedents to the HPC plans and the associated projects of the Improving Access to Psychological Therapies, and the Skills for Health project to map the National Occupational Standards of counselling and psychotherapy.

The New Labour Years

A series of 'adverse events' and public scandals hit the NHS during the 1990s, including the Bristol Royal Infirmary cardiology scandal (1998), the Alder Hey Hospital organ donation scandal (1999), (Burke, 2008), the tumour diagnosis scandal in Birmingham, the MMR vaccine scandal (1998), as well as the serial killers Nurse Beverley Allit (1993) and the GP Dr Harold Shipman (1998) (Department of Health, 2006a), (Burke, 2008).

These scandals became closely fused with government rationales for regulatory reform, tending to be construed as central drivers of regulatory reform in government documents and the media. However, the extent to which government reforms were simply necessary responses to failures within the NHS is contested. Brown (2008), for example, writes: 'The successful way relatively isolated cases were manipulated to construct an exaggerated fear of the possibility of widespread clinical malpractice within the NHS was crucial' to pushing reform (350). It is widely accepted within medicine that some of the regulatory measures introduced, at least partially, to prevent another Shipman, would not actually do so.[28] The crisis was therefore arguably used by the incoming Labour Government as evidence of the failure of public services and as justification of its programme of modernisation (Brown, 2008). New Labour seemed to construe the need for reform in order to re-establish trust in the NHS, which it implicitly characterised as mainly having been diminished by the perception of wide spread clinical malpractice. Other factors are also likely to have contributed to a diminishment in trust, including increased education and public access to medical knowledge (e.g. through the internet) and consequent development of 'lay-expertise', and a decrease in deference towards medical practitioners, conditioned in part by a broader cultural diminishment in deference towards authority and science, encompassed within the 'cultural turn', including increased reflexivity, and 'post-modern' critiques of scientific knowledge - including the intellectual and scientific 'debunking' of practices as wide

[28] Nicholas Temple (Psychiatrist and psychoanalyst), interview by author, June 2014.

ranging as psychoanalysis (Gomez, 2005) and logical positivism (Roth and Fonagy, 1996:27) - and a proliferation in competing knowledges and forms of expertise, as acknowledged and partially fostered in the intellectual sphere by works like Kuhn's 1962 'the structure of scientific revolutions', and Feyerabend's 'against method' (Feyerabend, 1975). This thesis itself is based, as explored within Chapter Three, upon an anti-foundational ontology in which all claims to social and political truth are seen as *within history* and *culture* (i.e. contextual) and as contingent and contestable. It was against an arguably more pluralistic and tumultuous socio-cultural background, and a broad post-modern, if you like, challenge to strong claims to objectivity and certainty, that the New Labour Government placed an emphasis upon an instrumental view of trust: that is, the view that trust is primarily a product of the 'system', the 'instrumental rational efficiency of the institution' (Brown, 2008) – rather than as primarily a product of 'qualitative interpersonal communication' between individual medical practitioners and patients. This dovetailed with the government's emphasis upon the introduction of clinical governance, the increased bureaucratisation of medical knowledge, the instrumental control of medical practitioners, including the growth in the medical 'guideline' industry (more on the latter below) (Chamberlain, 2010). But rather like Moran (2003) and Maltby (2008), as explored within Chapter Two, New Labour, as with preceding and proceeding Governments, seemed to overestimate the objectivity of these technically framed interventions. These interventions restore or sustain trust in the professions in so far as the interventions themselves are trusted, but this highly technical and scientistic approach arguably attempts to address the 'cultural turn' – increased

education and ‘lay expertise’, and the proliferation of forms of expertise and contestation of knowledge – by shifting, to recall from Chapter Two, the guarantor of truth from the professional to the regulator, and in so doing, to a significant extent simply ‘shifts’ the problems, rather than robustly addressing them.

The election of New Labour in 1997 did not so much bring radical changes in the direction of regulatory struggle within the talking therapies so much as an intensification of previous movements. Jumping forward to the HPC struggle for a moment, the fact that New Labour’s plans were essentially a continuation of Conservative Government policy perhaps gives credence to Executive Director of the HPC, Marc Searle’s view that the HPC plans were ‘change of government proof’ in relation to the then forthcoming 2010 General Election (see Chapter Six).[29]

The National Institute for Clinical Excellence (NICE) was established in 1999 by New Labour, and was a means of harnessing and expanding the use and implementation of evidence based medicine, and of providing the means to determine what medical treatments (in an arena of constant medical innovation and proliferation of medical technologies) are made available on the NHS, thereby helping to address the so called post-code lottery; that is the uneven availability of treatments available on the NHS across the country. To recall from Chapter Two, NICE adopted a ‘pyramid of evidence’ which placed forms of evidence for the efficacy of treatments within a hierarchy of value.

[29] James Antrican (Chair of UKCP 2007-2009), interview by author, October 2014.

The concept of the multiple-healthcare profession regulator - the HPC- was brought to fruition in 2003. To recall from Chapter Two this can be linked to the globalisation ideology of more complex services required for more complex interconnections brought about by it (Fournier, 2000). Whilst the evidence based practice movement and 'what works' initiatives within the previous Conservative Government arguably were quite quietly developed, they took a more central stage within New Labour's ideology. This was namely a 'beyond left and right', beyond ideology ideology, whereby political and practice dogma are seen as overcome by a 'what works' pragmatism (Wells, 2007). This included a penchant for softening the demarcation between private and public sectors, seeking to involve the private sector within the NHS, encompassing a tendency towards extending regulatory reach within the private sector (Lousada, 2000). This 'beyond left and right' ideology perhaps partially helps explain why the government Skills for Health project and the HPC plans did not seem very cognizant of differences between NHS and private practice. The 'friend-enemy' relation of New Labour's broad political frontier was between modernisers and anti-modernisers: the professions and the unions as such losing their *marked* status. Rather, New Labour in seeking to meet the demands of its 'heartland' supporters, as well as those Conservative voters it had won-over, sought to reconcile the pursuit of greater social justice with market friendly policies. New Labour's policy programme to increase national skills across economic and industrial sectors is both emblematic of and a key aspect of this approach. The Lietzch Review (2006) clearly put the case for the need to develop national skills within the context of globalisation. According to this

report, reflective of the broader rationale of the government, the best and only avenue to ensure better social justice (i.e. lifting more people out of poverty and increasing social opportunities and inclusion) is to pursue market friendly policies and for Britain to take its place as a winner within what the report construes to be the zero-sum competition between nations within the new globalised economic order (Leitch Review, 2006). A key rationale of the government's skills programme, of which the SfH project to map the National Occupational Standards of counselling and psychotherapy was one aspect, was to seek to correct the claimed failure of educators and trainers to provide potential employees with the up to date skills that industry and employers really need. A key aim of the skills project was therefore to be strongly inclusive and consultative of a field in the process of mapping skills. However, this prioritisation of what the field thinks is strongly couched within the aim of national economic success within the global economy. The Leitzch Review stated: '"Economically valuable skills" is our mantra' (*ibid*:2). The Report creates a sense of urgent need to develop skills in order to survive and succeed:

> Being world class is a moving target. It is clear from my analysis that, despite substantial investment and reform plans already in place, by 2020, we will have managed only to 'run to stand still' […] the world will have continued to change and the global environment will be even harsher (*ibid*:2)

From a hegemonic-strategic point of view the report sets out a sense of inevitability of the embracement of a particular form of globalisation by setting up something of a Hobson's choice between national decline and national success, reinforcing a sense that the particular form of globalisation pursued by New Labour was an entirely external phenomenon, rather than the British government as a significant constitutive player within the developments: a

point made more broadly about New Labour by Watson and Hay (2003, as mentioned within Chapter Two. As far as the healthcare services were concerned, New Labour, seeking to reverse the Conservative diminishment of the public services, injected massive amounts of funding. But this extra funding came with the requirement for reforms within the public services, including market ones. In 2006 the White Paper Our Health Our Care Our Say (2006c) for example announced plans to open NHS services further to profit and non-profit providers. The norm of competition was to come into play at both the level of commissioning i.e. competition between providers for contracts, as well as at the individual patient level, where patients are given a choice between providers i.e. competition between providers for patients. The sense of the patient as 'consumer' was therefore being significantly developed. Another key logic or rationale within the paper governing policy development is that of 'preventative projects', seeking to reduce higher financial and social costs that occur further down the road. An intention towards a programme to address mental health in this context for example is announced within the 2006 White Paper (Department of Health, 2006c). In one sense there was a resurgence in the belief that the government can significantly socially engineer, or lay the foundations for improved life-styles. This is arguably comparable to the so called mental health hygiene movement of the 1950s and 60s briefly discussed above.

SUMMARY

In this chapter we have briefly sketched the broad historical context of the HPC struggle and of the associated Skills for Health and IAPT programmes.

This has helped to identity the antecedents of the projects. We can see from this sketch the key axes around which regulatory and governance issues have coalesced. One key axis concerns the relationship between the talking therapies and the medical establishment; there frequently being a struggle around the extent of the relationship between the talking therapies and medicine. Freud was unable, because psychoanalysis was antithetical to the positivism of universities, to secure a place for psychoanalysis within the university, and, because of similar doctrinal tensions between psychoanalysis and psychiatry and medicine, the two mixed together precariously at times. A central driver for psychoanalytic closeness to medicine was a wish to protect orthodoxy and prevent a flood of 'quacks' from entering the field. At the same time psychoanalysis often distanced itself from medicine for the very same reason, to protect the purity of its development. Significant exceptions to this included responses to psychological trauma suffered by military personnel during the First and Second World Wars in which psychoanalytic ideas were either appropriated (by Rivers et al for example) or developed, for example by Bion in therapeutic community experiments. Doctrinally, a key element of talking therapies, from psychoanalysis onwards is an emphasis upon the notion of the client or patient doing much of the work themselves. However, new modalities of therapy emerged partially on the basis of strong disagreements, and new ideas about how the therapeutic relationship should be conceptualised. A key area of tension has been to what extent talking therapies do or should seek to 'adapt' clients to the dominant values within society, and bring about an alignment between the needs, aims and wishes of government and those of the individual, involving a reshaping of both (as, for

example, in the complex of programmes around the Tavistock Clinic and the Institute of the Human Relations) or, to what extent talking therapy is, or should be, a space in which the dominant values of society need not hold sway. Humanistic, existential, Jungian, and Lacanian schools are key examples of ones which emerged in express counter-distinction to what they regarded as the excess 'medical' orientation of other therapies, or their primary focus on adapting populations to the needs of mass market consumer capitalism. As we shall see in the chapters to follow, these are the very same constituencies within the HPC struggle which were most actively opposed to the HPC plans. To a significant extent the key tensions and struggles within the period following Sieghart and the development of the system of self-regulation, which despite the Assured Voluntary Regulation scheme in place, is still largely recognisable today, provides us with a picture of the struggle to come within the HPC Professional Liaison Group over the 'nuts and bolts' of the plans. The vexatious issue of differentiation between counselling and psychotherapy and of 'entry' levels to the field have routes going back to the emergence of counselling and its role within the field and wider society. Many professional associations within the field formed were geared towards the telos of statutory regulation, but division within the field, in addition to lack of strategic Government interest, meant that the Government declined to pursue it. The final section of this chapter, focussed on the rise of the regulatory state, and to a large extent focussed on the policy developments which laid the conditions for a Government change of heart, namely its arguably aggressive pursuit of regulation of the field. New Labour to a large extent continued policy developments within the previous Conservative Government,

namely increased codification and governance of talking therapies provided through the NHS. New Labour's more 'natural' political favour for the public services, however, along with a more overt drive for social justice, re-invigorated a high-modernist belief in the power of the state to improve lives. The key constituencies, namely market logics coupled with technical expertise (marked by a strong calculative rationality) of this 'high modernism', as Moran (2003) refers to it, were set by previous Governments. Interventions were therefore set in the mould of the classical/scientific Enlightenment marked by economic liberalism. Let us now look, in the next chapter at three such interventions – the improving access to psychological therapies programme and the Skills for Health project to map the National Occupational Standards for counselling and psychotherapy, as well as the regulatory reform of the healthcare professions in which the HPC plans were embedded.

CHAPTER FIVE

THE HPC PLANS IN CONTEXT: HEALTHCARE REGULATORY REFORM AND THE IAPT AND SfH PROJECTS

> I think Peter Fonagy put it [mentalisation based therapy] together as something that would be [..] scientifically acceptable within the NHS, but of course NHS psychotherapy has been damaged a lot by IAPT […] It has robbed resources. [30]

> I've spoken to CBT therapists, and have supervised them over the years. They'll often not do CBT in session. But then they'll fill in the reports or the assessment sheets to say that they've done CBT because that's what's being funded.[31]

In this chapter I address the immediate context of the emergence of the HPC plans, covering the period from mid-2006 through to March 2007. Malcolm Allen referred to the interrelated SfH, IAPT and HPC projects as constituting a 'new zeitgeist' for the talking therapies.[32] By examining SfH and IAPT, as well as the broader healthcare regulatory reforms in which the HPC plans were embedded, I seek to understand both why statutory regulation shot up the political agenda and why and how the HPC became the government's preferred regulator. To an extent I break with the historical chronology of the SfH project by including within this chapter a look at the project to develop the National Occupational Standards for psychoanalysis, which did not actually take place until 2008, but I address here for ease of incorporation into the overall structure of the thesis.

[30] Nicholas Temple (Psychiatrist and psychoanalyst), interview by author, June 2014.

[31] Lisa Wake (Chair of UKCP 2005-2007), interview by author, April 2015

[32] Malcolm Allen (Chief Executive Officer of the BPC), interview by author, October 2014.

My main thesis in this chapter is two-fold. The first concerns the description, naming, and normative evaluation of the competing policy imaginaries at play. I argue that the HPC plans were embedded within government policy that consolidated and deepened the 'transactional' form of scientific bureaucratic and consumerist organisation within the healthcare regime, including its further extension and sway, through SfH and IAPT, within the field of counselling and psychotherapy. My second main argument concerns the political dynamics involved in the introduction of the HPC plans and related projects. I argue that the HPC plans were rendered less visible by being 'swept along' within wider regulatory reform of the healthcare professions, and that a 'problem minority' narrative helped to support a tendency to keep key characteristics of the reforms and the projects away from careful scrutiny.

The main sources of this chapter are archival material, including government policy documents, namely the 2007 White Paper 'Trust, assurance and safety: the regulation of health professionals in the 21st century (Department of Health, 2007b), and the two consultation papers leading up to it, 'Good doctors, safer patients' (2006a) (often dubbed the Donaldson review), and 'The regulation of non-medical healthcare professions' (2006b) (often dubbed the Foster review). This helps to assess the broader character of the healthcare regime to which the field of the talking therapies was arguably being 'hailed'. I draw on key documentary responses made by key organisations within the field of the talking therapies to the main government consultations, and material published on the events by the online version of the Independent Practitioners Network's journal, 'eIpnosis' (2012). I draw on

my interviews with Julian Lousada (Chair of the BPC),[33] Malcolm Allen (then Chief Executive Officer of the BPC) and with Linda Mathews of the BABCP[34]. As key members of the 'pro-HPC' camp, I draw on these interviews to further an understanding of why these professional organisations supported the HPC from the outset. I draw on my interview with James Antrican (Chair of UKPC, 2007-2009)[35], as well as documents from the British Association of Counselling and Psychotherapy (BACP), which help furnish an understanding as to why the UKCP and BACP initially opposed the HPC as regulator. As regards the IAPT project, I draw on the Depression Report (Layard et al, 2006) and other key documents, as well as my interview with a health scientist adviser to the IAPT programme. This interviewee is a strong supporter of the role of experimental and random controlled clinical trials within the provision and delivery of psychological services. I also draw on newspaper articles and other journal papers published at the time expressing both concerns about and support for the project. My interview with Lisa Wake (Deputy Chair of UKCP, 2003-2005, Chair, 2005-2007)[36] also helps illuminate the IAPT project.

As regards SfH, I examine the SfH's documents for its initial consultation (Player and Mathews, 2007), including its summary of responses, and draw

[33] Julian Lousada (Chair of the British Psychoanalytic Council, and member of the Professional Liaison Group for Counsellors and Psychotherapists), interview by author, September 2014.

[34] Linda Mathews (Psychotherapist, representative of BABCP within the HPC's Professional Liaison Group for Counsellors and Psychotherapists), interview by author.

[35] James Antrican (Chair of UKCP 2007-2009), interview by author, October 2014.

[36] Lisa Wake (Chair of UKCP 2005-2007), interview by author, April 2015.

on my interviews with James Barrett[37] and Paul Atkinson[38] of the Council for Psychoanalysis and Jungian Analysis (CPJA)**,** who were involved in the SfH project to establish the National Occupational Standards for psychoanalysis. Material from the College of Psychoanalysts, which they obtained through a freedom of information request, is a revealing source as regards the political dynamics of the project (Arbours Association et al, 2009).

This chapter is divided into three main sections. In the first I give a brief overview of the events during this period, setting out the broad 'problematisations' made by different actors and stakeholders within the regulatory reform, and within the SfH and IAPT projects. In the second section – 'competing policy imaginaries' - I dig deeper into these events and problematisations, drawing out the assemblage of norms projected within the government projects across the various nodes of the field of counselling and psychotherapy. Deploying the nodal comparative analytic framework I assess the credibility of the main competing characterisations of the projects. In the third section I go onto to explore the political and rhetorical strategies that government agencies and key actors, as well as opponents of the projects, adopted in their attempts to promote and install, or derail, the policies. To recall from Chapter Three this largely concerns how particular norms of practice were made more or less visible, and therefore more or less available for contestation.

[37] James Barrett (psychotherapist member of the CPJA and member of Skills for Health group developing competencies for psychoanalysis), interview by author, June 2015.
[38] Paul Atkinson (Jungian Therapist, member of the CPJA and member of Skills for Health group developing competencies for psychoanalysis), interview by author, June 2015.

OVERVIEW OF EVENTS

Regulatory reform of healthcare professions and early tussles over plans to regulate the field of counselling and psychotherapy

By the time consultations were being held as part of the Foster Review (Department of Health, 2006b) in July 2006 (see diagram 1 for a timeline of this period) it had become common knowledge that HPC regulation of the talking therapies was on the cards[39]. The main professional associations within the field were on the Department of Health's stakeholder list and were consulted as part of the Foster Review, but not the IPN, which enlisted the help of an MP to get it on the list after the Foster Review consultation was completed (Postle, 2012:144). In an attempt to head off the HPC plans, a group of professional associations within the field, led by the British Psychological Society (BPS)**,** put a counter-proposal called the Psychological Professions Council to the Government (British Psychological Society, 2006), which was broadly modelled on the General Medical Council and the style of regulator recommended by Sieghart back in 1978, as explored within Chapter Four. The BPC and the BABCP declined to partake in this proposal, and instead broadly welcomed the HPC plans. The proposal was rejected by the Government on the grounds that it no longer favoured, barring exceptional circumstances, single profession regulators for new professions (Department of Health, 2007c) and in February 2007 the Government's White Paper on regulation announced that the HPC would regulate counselling and psychotherapy:

[39] James Antrican (Chair of UKCP 2007-2009), interview by author, October 2014.

> Psychologists, psychotherapists and counsellors will be regulated by the Health Professions Council, following that Council's rigorous process of assessing their regulatory needs and ensuring that its system is capable of accommodating them. This will be the first priority for future regulation (Department of Health, 2007a:85).

These Green and White Papers posed a number of policy problems and solutions to them. The overarching aim of the planned reforms was the improvement in public protection and an overall improvement in the quality of services. For example, the White Paper states that the 'primary purpose of professional regulation is to ensure patient safety [and that regulation is a] vital component of the overall framework in the United Kingdom for ensuring the highest quality healthcare for the public' (2007a:13). These constituted a further explicit response to Harold Shipman and other adverse events in the NHS[40]

Key regulatory measures included the 'revalidation' of doctors and potentially also of other healthcare professionals. This is a periodic check of the capacity of an individual professional to meet threshold standards of practice. Other key measures included forms of audit; for example the measuring of both individual professionals and organisations in relation to one another through the 'benchmarking' of outcomes. As regards the regulation of regulators, a key proposal was the cessation of professionals electing fellow professionals to regulatory boards, and the introduction of parliamentary oversight of the regulator. This was in conjunction with the assertion that 'professional regulation needs to sustain the confidence of both the public and the

[40] The White Paper states: 'the past decade has seen a series of high-profile and controversial cases which have sent shockwaves through both professional and public thinking about the future of professional regulation. However atypical their behaviour, names like Beverley Allitt and Harold Shipman are now fixed in the public memory. The mounting pressure of scrutiny from the Bristol Royal Infirmary Inquiry, Alder Hey, Neale, Ayling, and the Kerr and Haslam inquiries, and other cases, has led to growing doubt in the public's mind about the adequacy of our arrangements for professional regulation' (2007a:17).

professions through demonstrable impartiality' and independence from professions, government and other interested parties (2007a:3). The White paper also implies that the new regulatory measures would not stymie the work of good practitioners**:**

> Most health professionals meet high standards routinely and have a lifelong appetite to be even better. That professionalism is an unquantifiable asset to our society, which rules, regulations and systems must support, not inhibit (2007a:1).

The importance of 'patient-centredness' and of 'good communication' are also highlighted. The White Paper states that:

> Professional practice in healthcare is not simply about technical, scientific and clinical competence, but about a relationship between the health professional and the patient in which mutual understanding and trust provide the foundation for effective healthcare (2007a:72).

Unlike the response to the HPC announcement within the field of counselling and psychotherapy, the regulatory proposals were broadly welcomed by the main healthcare professional associations. The main point of contention was the planned shift from a criminal to civil standard of proof within malfeasance and fitness to practice cases (Middlemiss, 2006).

Table 1.

CHAPTER FIVE TIMELINE

19th June 2006: *Publication of the Depression Report: A new deal for depression and anxiety disorders.*

14th July 2006: *Publication of Donaldson Report and Foster Review (consultation papers on regulation of health professions).*

10th November 2006: *Publication of the Psychological Professions Council Proposal: 'Proposals for a Psychological Professions Council (PPC)'.*

1st December 2006 (until 23rd February 2007): *Start of SfH initial consultation on development of NOS for counselling and psychotherapy.*

December 2006: *launch of IAPT demonstration sites – Newham and Doncaster*

21st February 2007: *'Trust, Assurance and Safety – The regulation of health professionals in the 21st Century': formal announcement that C & P would be regulated by the HPC.*

The Skills for Health project

In the meantime the Department of Health brought in Skills for Health to help with developing standards of practice, or competencies, known as National Occupational Standards, for counselling and psychotherapy. This followed the Department's first-hand experience of an acrimonious working relationship between UKCP and BACP in their joint report venture, funded by the Department of Health, on the regulatory terrain of the field. James Antrican described the BACP and UKCP as being 'just at each other's throats' during this process, and the report as a 'piece of crap'.[41] Rosalind Mead, the lead civil servant within the Department of Health on the regulation of counselling and psychotherapy expressed that it had become clear that the BACP and UKCP could not command the confidence of the whole of the profession', and that they had not produced competencies in sufficient detail. Mead also

[41] James Antrican (Chair of UKCP 2007-2009), interview by author, October 2014.

rebuked, in an open letter, the UKCP for publishing its own 'report to the Department of Health' on competencies within the field. In it Mead stated:

> Your publication of this report at this time is potentially very damaging. It may give the false impression that UKCP has been given the sole right to map the competences and standards of proficiency for psychotherapy, immediately before Skills for Health launches its wider consultation on a competence framework which will lead to the same outcomes (Mead, 2006b)

The National Occupational Standards were also intended to be extensively utilised within the governance of counselling and psychotherapy services within the NHS and beyond: for example within job specifications, within the development of training and supervisory criteria (Skills for Health, 2010). SfH conducted an initial consultation in December 2006. Much of the field cautiously welcomed the project, though often with a caveat of considerable concern about its capacity to accommodate diversity within the field. For example, the 'Analytic psychology, psychoanalytic, and psychodynamic' section of the UKCP welcomed SfH's 'recognition of the dangers of a mechanistic model of psychotherapy' and of the 'diversity within the field', and its decision to try to test the limits of the range of therapies currently being offered and to explore further what their similarities and differences may be' (The analytical psychology, psychoanalytic and psychodynamic section, UKCP, January 2007:1). But it went onto conclude:

> It is hard to imagine at present that anyone trained via the SfH model could do psychoanalytic work; nevertheless, we look forward to further developments with interest (January, 2007:4).

The BACP expressed its opposition to any 'modality' approach to the development of the competencies, claiming that the evidence supports the

view that the ‘active ingredients’ that make therapy effective are common to all modalities, and therefore, all therapies are seen as equally effective (Skills for Health, 2006). Others, including the BPC and the College of Psychoanalysts, welcomed the modality approach and the opportunity to differentiate in detail (*ibid*). SfH expressed awareness of the history of acrimony between different factions within the field, and offered strong assurances that the project was highly open and inclusive. SfH stated that it has a responsibility to ‘define standards or competences that carry the support of a wide range of interest groups’, and that they would seek as many contributions as possible, and ‘make sure that a wide range of evidence is used’ (Skills for Health, 2006:2).

However, the project ran into deep controversy once it appointed the University College London’s (UCL) Department of Health and Clinical Psychology as the lead body in the development of the plans. Personnel appointments to the project, the adopted methodology for developing the NOS (more on this below), and the draft content of the NOS all became subject to deepening controversy across the field (The Arbours Association et al, 2009). A modality approach was adopted and separate groups were set up to develop NOS for four main modalities of therapy. These were cognitive behaviour therapy, psychodynamic psychotherapy, systemic family therapy, humanistic psychotherapy and counselling (Skills for Health, 2010). No Lacanian psychoanalysts were admitted to the psychoanalytic/psychodynamic modality group despite attempts by them to join, and promises made by SfH that they could do so (The Arbours Association et al, 2009). The two Jungian analysts within the group, Paul

Atkinson and James Barrett, attempted to guide the draft NOS in a direction that recognised the deeply 'contextual' character of psychodynamic practice.[42] However, the development of the NOS, across all modalities, was based upon 'manuals' of practice derived from empiricist clinical trials (Skills for Health, 2010). The College of Psychoanalysts contended that 'there are simply no manuals of psychoanalysis as psychoanalysis is not a treatment that can be applied, it is invented afresh in each case by the analysand and analyst' (College of Psychoanalysts, 2008)**.**

Paul Atkinson described being on an 'assembly line' and put to the group that the 'assumptions behind the assembly line are not being talked about'.[43] He and James Barrett submitted a critical report (The Council for Psychoanalysis and Jungian Analysis, 2009) and shortly after resigned their positions.[44] Critics characterised SfH as exclusive, lacking in independence, and as dominated by people within, or closely associated with, two political groupings within the field, namely the BPC and sub faction within the UCL's Department of Health and Clinical Psychology (The Arbours Association et al, 2009). In short, the SfH was dominated by clinical psychologists, namely Roth and Pilling, predominantly working within the cognitive and behavioural therapy tradition, and psychoanalysts, namely Anthony Bateman and Peter Fonagy, who were seeking to carve a place for psychoanalysis as an 'evidence based' and short-term 'focussed' talking therapy[45]. Fonagy and Bateman for example had developed Mentalisation Based Therapy (MBT) and were seeking to

[42] Paul Atkinson (Jungian Therapist, and member of Skills for Health group developing competencies for psychoanalysis), interview by author, June 2015.
[43] ibid
[44] ibid
[45] Nicholas Temple (Psychiatrist and psychoanalyst), interview by author, June 2014.

promote it within the NHS (Arbours Association et al, 2009:31). All were committed to the development of talking therapies underpinned by empiricist clinical trials.

Improving access to psychological therapies

Running more or less parallel to these developments was the Government's IAPT programme. It was based on the 'Depression Report: a new deal for depression and anxiety disorders', published in June 2006 (Layard et al, 2006). It was billed as a programme to tackle a largely unaddressed 'epidemic of depression' through significant new investment, and an 'army' of newly trained therapists. The report claimed that the programme would 'pay for itself' through the money saved from getting people off incapacity benefits and back to work. The report states: 'At one time unemployment was our biggest problem, but we have done a lot to reduce it. So mental illness is now the biggest problem, and we know what to do about it. It is time to use that knowledge' (*ibid*:1). Two demonstration sites were launched and ran between mid-2006 and mid-2007, one in Doncaster and the other in Newham. The Doncaster site encompassed a 'stepped care' approach whereby those with mild conditions would receive computerised self-help treatments, moderate cases would receive short-term CBT treatments, delivered by 'low-intensity' practitioners (often trained psychology graduates), and more severe cases would receive more complex treatments from 'high intensity' practitioners (usually clinical psychologists or similarly experienced individuals). From its launch onwards, only NICE-approved forms of talking therapy could be

delivered through IAPT. [46] David Richards (Director of the Doncaster site), pitting the Doncaster site approach against the Newham site approach (more on this below), argued that the Doncaster programme was a challenge to entrenched professional interests, and a means of getting a large number of people trained quickly and in a targeted way to treat particular conditions effectively (Richards, 2007). At a broader socio-political level IAPT was sometimes billed as a progressive force; the Guardian journalist, Polly Toynbee, for example, describing psychiatry as offering a 'kick start' to get people out of a vicious cycle of depression and poverty, and as a 'quick win, an easy happiness hit', against a background contention that 'more money gives less extra happiness the richer we get' (Toynbee, 2006). IAPT was not without controversy however. One key controversy was the initial plan to only provide CBT-orientated therapies through the programme. Lisa Wake (at the time a former Chair of the UKCP) threatened to launch a public campaign against IAPT just prior to its launch unless it agreed to include all NICE approved therapies. This was eventually agreed, after initial threats coming from the Deputy Prime Minister's office to banish Wake from ever working again in the NHS failed to deter her from pursuing her complaint. [47]

Others had more fundamental concerns, arguing that the programme was hubristic in its claims and unrealistic in its aims. One GP for example stated: 'The notion that a few weeks CBT will transform miserable people languishing

[46] Lisa Wake (Chair of UKCP 2005-2007), interview by author, April 2015.

[47] Lisa Wake (Chair of UKCP 2005-2007), interview by author, April 2015

in idleness and dependency – at a rate of 50% - into shiny happy productive workers is embarrassing in its absurdity' (Fitzpatrick, 2006:729). Philippa Garety, professor of clinical psychology at the Institute of Psychiatry, stated 'there is a danger that CBT is being oversold as a cure-all. But no treatment is a cure-all' (Pid, 2006). Phil Richardson, professor of Clinical Psychology, stated: "While I am in no way against putting more money into mental health, the available empirical evidence does not support many of the claims that are being made for CBT […] There is a risk that those involved in delivering the psychological therapies will end up with egg on their face when the when the wild claims are shown eventually to have been false" (*ibid*). He also argued that 'Layard's big idea – the notion that it is possible to get depression people off incapacity benefit and back into work with up to 16 hours of CBT – is fundamentally flawed' (*ibid*). Fitzpatrick, a GP, in an article entitled 'A miscalculation of sublime dimensions' in the British Journal of General Practice, argued that 'extravagant claims for the efficacy of cognitive behavioural therapy' had been made 'based on extrapolating from a number of small studies to the entire population' (Fitzpatrick, 2006:729). Others saw IAPT as a barrier rather than first step to greater equality and social justice. Maloney, a counselling psychologist, for example, writing in the Guardian a couple of months later, critiqued the Depression Report as misguided in downplaying the significance of poverty, the growing gap between the rich and the poor, and the associated 'erosion of communal ties', in creating misery. Layard makes the false assumption, Maloney wrote, that 'the causes of psychological distress lie in the way that we see the world, not in the way that it is' (Maloney, 2006). He argued that CBT treatments are rationalistic;

that is, they assume that ‘rational insight will lead, magically, to beneficial change’. Rather evidence from neuroscience, Maloney argued, suggests that ‘our actions are rooted not so much in our thoughts as in our [deeply embedded] feelings’, and are not subject to easy correction. He critiqued the ‘preoccupation with happiness’ as a means of government at once appearing to ‘care’ whilst seeking to diminish social expenditure, and acts as a form of ‘insidious social control, in which we are encouraged to look inwards (and to blame ourselves) for the cause of our troubles’ (*ibid*). Finally, he argued that ‘psychic’ pain is potentially an ‘essential asset: one of the few clear signals that all is not well with our world’ (*ibid*).

Having outlined the key events and painted the brushstrokes of the regulatory reforms and projects, I want now to identity and examine the key assemblage of norms of practice within them. This will enable us to assess some of the conflicting characterisations.

COMPETING POLICY IMAGINARIES

In this section I provide a ‘thick description’ of the healthcare regulatory reform in which the plans for HPC regulation of counselling and psychotherapy were announced. This will give us a clearer picture of the healthcare regime into which the talking therapies were arguably being assimilated, largely through IAPT and SfH. I argue that the ‘transactional’ character of the healthcare regime was simultaneously being deepened. For example, in the case of medicine the shift away from individual and collective

autonomy was being further consolidated by the reforms. A significant feature of the reforms relating to the HPC plans was the shift towards a preference for multiple professional regulators for new professions (Department of Health, 2007a). I examine the norms and perspectives of responses within the field of counselling and psychotherapy to the Foster Review (Department of Health, 2006b) before the HPC plans were cemented within the trust and assurance regulatory White Paper (Department of Health, 2007a). I then go onto examine the Skills for Health and IAPT projects in some detail.

A deepening of the 'transactional' healthcare regime

Table 2

Table showing variations of 'transactionality' and other key norms across the nodes of the service chain within the regulatory healthcare reforms, IAPT, and SfH, and contrasting norms

Node	Healthcare regulatory reform	IAPT	SfH	Counter-norms
Governance & regulation	*Standardisation* e.g. minimum standards of practice & clinical guidelines. *Public protection and effectiveness* of practice *Logics of measurement and audit* (e.g. 'benchmarking') *Hierarchy*, top-down relation between empiricist research/management and 'rank and file' practitioners/practice Generic regulatory expertise: Multi-professional regulators for new professions	Hierarchy, top-down relation between empiricist research expertise and practitioners/practice *Cost-effectiveness* of practice	*Standardisation* i.e. National Occupational Standards. *Aspirational* standards, not minimum. *Hierarchy*, top-down relation between empiricist research expertise and practice	*Contextual governance* *Practice based evidence* *Evidence pluralism* *Specialist regulatory expertise*
Provision & distribution *(e.g. commissioning)*	*Competition* between providers, and *consumer-patient* choice between providers, delimited by *cost-effectiveness* assessment by empiricist research expertise i.e. NICE guidelines		Norms of *standardisation* and *transactionality* within National Occupational Standards helping to shape and influence provision and distribution.	*Provider pluralism* *Public choice pluralism* *Subject of right as self*
Delivery *(e.g. the conceptualisation of the professional-client relationship)*	*Hierarchy,* top-down relation between practitioner & client. *Acontextual/transactional* practice e.g. pre-packaged treatment applied to a passive patient/ or active consumer-patient			*Contextual/relational practice* *Co-creation of expertise/treatment between practitioner and client*

I adopt the comparative analytic framework of the 'nodal' approach developed by Glynos and Speed (2012) and Glynos et al (2014a) as outlined within

Chapter Three, to help identify the assemblage of norms projected by the White Paper. In short I examine what the paper says about the nodes of governance and regulation, provision and distribution, and, finally, delivery.

Node of governance and regulation

I focus on two key facets within the node of governance and regulation, the first concerning the governance of healthcare through the axes of regulation, and the second concerning changes to the norms governing the regulators themselves. I look at each briefly at each in turn. The trust and assurance regulatory White Paper (2007a) included measures to reinforce 'clinical governance', namely embodying a standards approach to regulation. Put simply, the regulator establishes standards and puts measures in place to enforce these standards. Clinical governance also includes NICE guidelines and measures to ensure their implementation. The White Paper (2007a) and the Foster and Donaldson reviews barely mention NICE guidelines or 'evidence based practice', but these were already central to 'clinical governance'. By 2006 it had already been long clear that it was strongly expected that NICE guidelines are to be implemented in all but exceptional circumstances where express clinical reasons for must be given to justify departure from the guidelines**.** It is therefore reasonable to surmise that the reforms would (and indeed have) consolidated and expanded the implementation of NICE guidelines. [48]To recall from Chapters Two and Four,

[48] In 2004, in a legal academic paper on healthcare, Mykhalovskiy E and Weir L wrote: 'Trusts should facilitate the implementation of guidelines from NICE an audit their use through the framework of clinical governance. In the rare event that a trust should decide to positively diverge from such guidelines, it should do so only through a mechanism of due process that

NICE and the evidence based practice movement tend to produce a sharp top-down relationship between research and practitioner. These practices entail a degree of 'hierarchy', or at least provide further tools for management in an existing hierarchy. This is consistent with the observations made by Chamberlain (2010), to recall from Chapter Two, of an increased differentiation between rank and file professionals on the one hand and a managerial and research elite within the profession on the other. The node of governance and regulation can be said to embody 'transactionality' in the sense that what counts as best practice is largely determined and shaped by empiricist clinical trials and then 'handed down' fairly 'wholesale' for the practitioner to 'apply' to the patient (more on this below).

Now let me turn to the second facet of the node of governance and regulation: the governance of the regulator. A number of changes were signalled by the trust and assurance regulatory White Paper, but the central one for our purposes, as mentioned above, is that of the cessation of rank and file professionals electing other rank and file professionals to regulatory boards. This was to prevent professionals from resisting or blocking regulatory changes. This sought to reinforce the independence of the regulator from rank and file professionals, and therefore arguably gave extra fortification against possible 'professional capture' of the regulator. This was coupled with increased parliamentary oversight of the regulator. Parliament, the White Paper argues, is more democratically representative than a faction of professionals engaged in electing board members. The paper states that it

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is required in public law for the accountability of the reasonableness of such a decision" (Mykhalovskiy E and Weir L, 2004).

is not ‘practicable’ to ensure that the electorate within professions is ‘broad and inclusive’ enough to ‘ensure confidence in the independence of the regulators. Parliament already represents that balance of interests and opinion across society’ (Department of Health, 2007a:27). The other key policy on the regulator was an express consolidation of a shift towards multi-professional regulators for ‘new’ professions, which I consider this below. But first let us examine how the key norms within the node of governance and regulation, identified above, are articulated with norms within the other key nodes of the healthcare regime.

Node of provision and distribution

The White Paper does not focus on the nodes of provision and distribution, but to recall from Chapter Four, the 2006 White Paper Our Health, Our Care, Our Say (Department of Health 2006c) set out changes which deepened the operation of the norms of competition and patient choice. This was namely the increase in competition between providers for contracts, as well as competition between commissioned providers for individual consumer-patients (*ibid*). This is consistent with the simultaneous policy of deregulation/regulation identified by Moran (2001, 2003) and others, as explored within Chapter Two, as a trend within regulation and governance across all sectors of the economy within recent decades. Although the 2007 White paper does not spell this out, it is reasonable to surmise that the tightening regulation is intended to prevent or deal with market failure, as well as help constitute the markets. Indeed the Donaldson Review (Department of

Health, 2006a) highlights that a significant consequence of increased competition between organisations is an increase in reputational risk, and therefore an increased incentive for organisations to *brush* any difficulties *under the carpet*. This is where the standards of practice, the NICE guidelines, and the norms embodied within these, come into play. They strongly delimit the norms of competition and patient choice: in short the patient is seen as being given a choice between services which meet minimum standards, including only the delivery of treatments deemed to be cost-effective. A transactionality within the framing of expertise – in which clearly defined treatment packages are framed as providing clear outcomes – dovetails with a transactionality within commercial and consumer-patient contracts, where the patient and commissioning bodies are given clear choices on the basis of detailed delineations of treatments and outcomes. The norm of standardisation encompassed within the minimum standards of practice, and protocolisation within NICE guidelines especially, also impact the node of delivery.

Node of delivery

Contra what one might expect given the significant degree of protocolisation/routinization of practice embodied within NICE guidelines, parts of the trust and assurance regulatory White Paper were actually, as noted above, rather suggestive of a demand for more 'contextual' forms of practice. In a further example, the paper states:

> Healthcare is a relationship, dependent on good communications, not simply on the delivery of a procedure or a prescription to a passive recipient. It depends on patient

> consent to effective treatment based on a proper understanding of the clinical options. Those clinical options themselves depend on a proper understanding of the circumstances, aspirations and expectations of the patient (2007a:72).

This may go somewhere towards what Mol (2008) refers to as ‘doctoring’ (as explored within Chapter Two), where the doctor takes a detailed history of the patient and seeks a contextual understanding of the patient’s illness and where the doctor is encouraged to be ‘attuned’ to the patient as a whole person (as distinct from only a ‘rational-consumer’ or ‘passive subject/object). The trust and assurance regulatory White Paper contextualises contemporary medical practice in relation to its history, stating that:

> Prior to the rapid advances in technical ability, the historic interactions between patients and health professionals were as much concerned with relationships, support and traditional bedside manner as they were with treatment (2007b:17)

There is here, however, a tacit sharp demarcation between practices associated with ‘patient-centred’ practice on the one hand and ‘treatment’ as such on the other. This tacitly relegates the former to a rather ad hoc, even if important, feature of treatment. This is in contrast to a deeper contextual approach to practice. Again, to recall from Chapter Two, for Mol (2008), in a fuller form of ‘contextual’ medical practice, gaining a fuller picture of the patient is seen as intrinsic to the treatment. At times gaining a fuller picture of the patient is even intrinsic to the determination of what counts as an illness that needs to be treated. The White Paper does not address the fact that NICE guidelines are generally weighted against ‘practice based evidence’ and a framing of face to face medical practice as itself a form of research and precarious experimentation in-process.

The broad assemblage of norms across the nodes of the healthcare service chain constitutes what I refer to as a regime of transactionality. The norms of practice embodied within the node of governance and regulation – namely standardisation, routinization, hierarchy and a complex of audit practices - strongly delimit the norms of competition and patient choice within the node of provision and distribution. This means that only services and practices which conform to the minimum standards and norms of practice embodied within NICE guidelines are provided and distributed. In turn this means that the node of delivery is marked by transactionality: where there is an emphasis upon a pre-packaged treatment being applied to a patient that is tacitly conceptualised in rather simple terms as a rational consumer of healthcare. There is arguably a sense therefore that the stated ambitions within the paper for more 'patient-centredness' seem to be largely framed as ad hoc to what is seen as the *real* substantive part of medical practice.

Government preference of multi-professional regulators

Before comparing these to the norms of practice within the IAPT and SfH programmes, let us look at the trust and assurance regulatory White Paper's pronouncements on its preference for multi-professional regulators. This was in an attempt to make regulation and standards more uniform across the healthcare professions and simpler for patients to use (2007a), and it was also multi-professional regulation for increased multi-professional team work

within healthcare services. [49] These were key reasons stated by the Department of Health for its rejection of the proposal to form a Psychological Professions Council (2007c).The latter proposal embodies a strong norm of 'specialist expertise' whereas the HPC embodies a significant shift towards 'generic' regulatory expertise, whereby the personnel of the regulator have generic regulatory expertise, rather than being drawn from the regulated profession.[50] This shift towards multiple-professional regulation arguably forms a significant part of the restratification of the profession, reducing professional autonomy, and making professionalization a 'new beast'. This is consistent with Waller's and Guthrie's (2013) claims that HPC-style regulation offered a profession less collective control over its future direction than historically the case**.** [51] My own view, drawing on the work of Mol (2008) and Healy (2013), as reviewed within Chapter Two, is that the diminishment in conditions conducive to deeper 'contextual' practice, or a more robust 'patient-centred' practice, is detrimental to both public protection and the effectiveness of healthcare (I explore this further in the concluding chapter). Overall, the regulatory reforms consolidated and deepened the long established road away from the system of statutory self-regulation, and shift towards a regime of heightened transactionality, encompassing accountability

[49] The introduction of statutory regulation of healthcare occupations traditionally supplementary to medicine, arguably reinforced the restratification of medicine, which traditionally tended to lead these occupations. By edging towards a more 'level playing field', this policy arguably reduced the sense in which these occupations are 'satellite' occupations of medicine, and thereby also diminished the role of medicine as lead professions and medicine as an alternative source of authority to government.

[50] Whilst the regulators like the HPC draw on profession-specific expertise (within both fitness to practice hearings and in drawing up some of the details of the regulatory practices, regulatory oversight and governance of the regulation remains with people who are either not drawn from any of the regulated fields, or from across the fields.

as audit. Now let me consider IAPT and SfH, and assess the extent to which they constituted an attempt to assimilate the field of counselling and psychotherapy to this deepening 'transactional' healthcare regime.

The Alliance, as we explore in the next chapter, tended to see the HPC plans, IAPT, SfH and NICE, as an institutional 'block' seeking to reshape the field of the talking therapies into an image of the government's own liking (Samuels, 2009). Critical descriptions of SfH and IAPT are therefore necessary (though obviously not sufficient) pieces of the jigsaw we need in order to assess this contention. Let us examine each in turn.

Skills for Health

The Skills for Health project to produce competencies (National Occupational Standards/NOS) for counselling and psychotherapy was in effect a resource for governance, intended, as noted above, to help inform various practices across the nodes of services. In the case of SfH I also add the node of training. To recall from Chapter Four, the broad aim of the government's skills and training policy was to try and ensure that trainees were being trained to acquire the skills that employers actually need and want (Leitch Review, 2007). The empiricist work which underpinned the project helped shape what the NOS/competencies tacitly say about the various nodes of the field. It seems clear that the decision to base the project so predominantly on empiricist work radically undercut SfH's commitment to inclusivity and SfH's

claim that the NOS would be based on actually existing practice across the breadth of the field (Skills for Health, 2006). Let us look at how this was so across the nodes of the field. The decision to take a modality approach to the NOS embodied a pluralist vision of the structure of the field, cementing the view that there are important differences between different modalities of talking therapy. To this extent SfH claims of inclusivity arguably stack up. But its inclusion of different modalities of counselling and psychotherapy was arguably strongly undercut by its adoption and continued commitment to an empiricist underpinning of the NOS. In adopting this research paradigm, SfH enacted a sharp demarcation and hierarchical relationship between research expertise and 'frontline' practice. In short in the shaping of the NOS, these manuals took precedence over practitioner experience, or 'practice based evidence', as well as over the distinct bodies of theoretical and case study literature within many traditions of talking therapy. To recall from Chapters Two and Four, (random) controlled /empiricist trials inherently involve the standardisation of practice in order to test the efficacy of a particular therapy 'package' against a control group. There is an inherent notion of transactionality, as well as causality, in this process: the same 'treatment' applied under similar conditions to a similar set of clients in 'real-life' so to speak will 'cause' similar outcomes. In other words talking therapy as a deeply interpretative and attuned activity tends to be eclipsed and instead shifted towards being a series of pre-set procedures and protocols.

As regards the node of training, the competencies, if adopted by education and training schools to shape their curriculum and approach, would reproduce the sense that 'best' practice is something handed down to them by a

research elite for them to ‘apply’ to clients. The emphasis upon competencies and skills rather than understanding is significant. I explore this further in relation to the HPC standards of education and training within the next chapter. As regards the node of provision and distribution, such as commissioning: if the NOS came significantly into play, then talking therapy services, and individual practitioners, that are orientated around the NOS competencies, and which take their lead from an empiricist research elite, are more likely to find the therapies they offer commissioned and distributed. The CPJA expressed concern that the competencies were geared towards work within the NHS, and the increasing necessity within the NHS to conform to an empiricist epistemological framework (as explored within Chapter Four). More specifically, the report contended that the draft standards promoted the style of work developed by Bateman and Fonagy’s Mentalisation Based Therapy. Furthermore, the CPJA felt that no amount of modification of the NOS statements, or rearrangement of the wording, would resolve the issue: the CPJA wrote that ‘we do not accept that the Skills for Health framework of competences based on manualised, RCT evidence-based psychoanalytic and psychodynamic work in the public sector can represent the professional practice of members of the CPJA’ (The Council for Psychoanalysis and Jungian Analysis, 2009:6). A central concern was how the empiricist approach adopted by SfH fed through to the competencies in terms of how they conceptualised the therapeutic relationship, i.e. the so called node of delivery.

Let us look in some detail at the draft NOS for psychoanalysis/psychodynamic therapy and what they tended to presuppose about the ‘delivery’ of it. Here I

focus on the critique that members of the College of Psychoanalysis and Jungian Analysis CPJA (organisational member of the UKCP) made of the psychoanalytic standards. The CPAJ was the largest representative organisation of psychoanalysts within the field [52] Below I focus on the strategies used by SfH to secure and push through the style of NOS which most psychoanalysts did not recognise as reflecting their practice. First let us examine the issue of their content. The CPJA expressed concern about specific standards as well as the overall approach in relation to how the therapeutic relationship was framed. Specific concerns were largely focussed on how the therapist-client relationship is conceptualised. For example:

> The framework is mechanical and instrumental. The therapist "does" competences to the patient/client. The fundamentally relational nature of psychotherapy cannot be expressed in this model' (The Council for Psychoanalysis and Jungian Analysis (*ibid*:5).

Similarly, the report states: 'Almost all the NOS's are formed of transitive verbs with the therapist as actor and the patient as acted upon' (*ibid*:8). The CPJA's report juxtaposes this against the view by most psychoanalysts that the 'therapeutic relation is a profound meeting of subjectivities'. Both the psychotherapist and client are seen as agents within the process. This includes the 'therapist's capacity to be acted upon' (*ibid*:8). The report also states that the competence of a therapist cannot be assumed once and for all, but rather 'must be continuously established and re-established as a living experience throughout the work' (*Ibid*:8). Some comments object to an apparent over simplification of therapeutic processes. For example Andrew Samuels cited an NOS which included the ability to understand the 'meaning

[52] Paul Atkinson (Jungian Therapist, member of CPJA, and member of Skills for Health group developing competencies for psychoanalysis), interview by author, June 2015.

in latent communication' (*Ibid*:10). Samuels writes that this is 'either very utopian, or totally ignorant of the difficulties of establishing the nature and content of meaning, and of its shifts' (*ibid*). Paul Atkinson objected to the draft requirement that the therapist is not to have any physical contact with a patient, such as shaking their hand[53]. Other concerns focussed on what the NOS left out, Samuels, for example, noting that there is little recognition of the 'creative (as opposed to the repressed or destructive) unconscious' (*ibid*:12).

Drawing on these critiques made of the SfH standards, and what their likely impact across the nodes would be, it seems that SfH's pluralism is significantly nominal in character. We have seen that the programme to develop NOS for psychoanalysis 'shoe-horned' a diverse modality, as highlighted within Chapter Four, into what is arguably not only a particular, but also a new and highly controversial, conceptualisation of psychoanalysis. The NOS for psychoanalysis, given that the largest association of psychoanalysts within the UK did not recognise them as remotely reflecting their practice, stretch credulity as regards their psychoanalytic character. It also seems reasonable to surmise that they render SfH's strong claims to inclusivity rather absurd. In short the 'empiricist' base of the SfH project assimilated the modality of psychoanalysis to a more 'transactional' framework and set of norms and the project was evidently dominated by the imaginary of a select few within the field.

[53] *Ibid*.

What is perhaps most pertinent for our purposes is the fact that the NOS were passed off , or 'signed off', as Lyall put it,[54] as representative of the modality as a whole, when in fact the largest professional body of psychoanalysts, the CPJA, emphatically rejected the approach taken by SfH. The project (whatever one's particular view about the standards) had become, to use Laclauian terminology, 'subsumptive', or, by way of analogy, it had become 'imperialistic'. Overall, it seems clear, given SfH's adoption of an RCT/evidence based practice base for the project, that the SfH project was an attempt to assimilate the field of the talking therapies (both public and private practice) to what I have called the 'transactional' healthcare regime. As in the healthcare professions a hierarchical relationship is established between research and regulatory elites on the one hand and practitioners and clients on the other. Both practitioners and clients are tacitly construed as relatively passive in relation to research and knowledge and technical know-how 'handed down' from the laboratory so to speak.

So far we have ascertained a strong family resemblance between the healthcare regulatory reforms and the SfH project. Whilst the healthcare regulatory reforms tacitly sought to consolidate the role played by empiricist research within healthcare vis a vis the implementation of NICE guidelines and increased clinical governance, SfH sought to shape the field of the talking therapies via the establishment of standards, themselves shaped by empiricist research and expertise. Before looking at the rhetorical and political strategies that were used to achieve these aims, let us first look at the third

[54] Marc Lyall (Regional Director West of England, Skills for Health), interview by author, September 2014.

main project constituting the ‘new zeitgeist’ within the field of the talking therapies – the Improving Psychological Therapies programme.

Improving access to psychological therapies (IAPT) programme

In one sense IAPT quite transparently set out to bring psychological services within the NHS up to the standard of other services, namely through the implementation of NICE guidelines. I begin with a brief exploration of the key norms at play across the nodes of the IAPT service chain. Like the healthcare reforms, NICE guidelines were at the centre of IAPT, encompassing a sharp hierarchical demarcation between research and practice, between the researcher and practitioner, and, in turn, between the practitioner and the client. Payment by results is also a significant norm at play within IAPT – where some practitioners do not get paid for the first few consultations if a client does not return for further sessions[55] This heightens the outcomes focussed nature of the service. IAPT was open, or at least became open to different providers, thereby encompassing the norm of competition and client choice within the nodes of provision and distribution. This was delimited, however, by NICE guidelines and other governance measures, thereby mirroring the broader healthcare regime. The nodes of training and provision and distribution were also shaped by empiricist research and its transactionality, evident within the fact that candidates with potentially no

[55] Fiona Ballantine Dykes (Counselling Central Awarding Body, and member of the HPC Professional Liaison Group for Counsellors and Psychotherapists), interview by author, June 2015.

previous experience or training within the field were able to train to become 'low intensity' practitioners relatively quickly (Layard et al, 2006). This was made possible by the fact that practitioners delivering specific treatment packages for specific conditions are seen as requiring only a relatively narrow scope of expertise. This also allowed, as David Richard's of the Doncaster site noted (Richards, 2007), for candidates to be drawn from the localities and cultural backgrounds of many of the target client groups i.e. where there were few trained and experienced therapists living. Let us refer to this as the norm of 'cultural proximity'. Richards seems to suggest that the close cultural proximity of IAPT therapists to clients is significant, but does not make clear in precisely what way. But it does perhaps imply that the cultural proximity may improve the practitioner-client relationship in some way (more on this in a moment). Another key norm within the node of distribution concerns the initial targeting of people in receipt of work incapacity benefits, with the express aim of getting them well, off benefits, and back to work, and in the process helping the programme to pay for itself. [56]

As regards the node of delivery, the IAPT programme, given its adoption of NICE approved therapies, placed an emphasis upon short-term 'focussed' therapies,[57] the programme broadly being a contestation of more open-ended, long term, forms of therapy, such as psychoanalysis and many

[56] This arguably is close to Yeatman et al's (2009) analysis of the shift in norms in recent decades governing welfare provision – from a 'subject of right as self' to a 'subject of right as will' as the basis of legitimating and guiding where public welfare provisions are made. The is essentially a shift from an emphasis upon seeking to ensure that an individual live as good a life as they are capable of doing so, to an emphasis upon ensuring that the individual is able to contribute to, and take part in, economic exchange. The subject of right as self is not in fact lost in IAPT, but the provision of psychological therapy becomes more strongly predicated on returning people to work.

[57] Lisa Wake (Chair of UKCP 2005-2007), interview by author, April 2015.

humanistic and existential forms of therapy (Layard et al, 2006). I do not here examine the differences between the NICE-approved talking therapies, though I think this would be an interesting exercise. Rather I make the more general point that all of them are NICE approved and are therefore to an extent shaped by an empiricist research design. This is intended to produce better outcomes and reduce the impact of practitioner 'error'. Protocolisation is intended to diminish the ideographic or idiosyncratic characteristics of each 'treatment', or at least ensure that the 'active ingredients' (tested within the clinical trials) are transmitted within each of the individual treatments. [58]

'Family resemblances' between the healthcare reforms, IAPT and SfH

Before moving onto a closer look at the political dynamics, let me briefly summarise the most salient points regarding the character of the healthcare reforms, and the SfH and IAPT projects. From my analysis, based on close examination of policy documents and interview material, we can see that the IAPT, SfH, and the regulatory reforms (pertaining to the healthcare regime) have strong family resemblance. The healthcare regulatory reforms

[58] The IAPT health scientist I interviewed made a distinction between manualisation, which he equated with a 'cook book' approach to therapy, and protocolisation. He stated: 'protocol allows much more flexibility than a manual, but you need manuals to assist people when they're following a protocol.Manualisation is, you might think that term implies some kind of robotic cook book following of work, which is certainly the criticism of some of the more traditional psychotherapies give about CBT or guided self-help. But the skill level for CBT is absolutely no less, and the decision making is no less than in these other therapies, what they're doing is following a protocol that has been tested within clinical trials and shown to be more effective, than not doing so., We know that if we let therapists diverge, there's studies shows that if we let therapists diverge from the protocolised structure then you get worse outcomes, even though they think they're being kinder to their patients, they think they're being more responsive, what actually happens is that patients don't do so well. (Health Scientist advisor to IAPT, interview by author).

introduced measures that would reinforce the acontextual/transactional orientated NICE guidelines. IAPT expressly only allows NICE approved therapies, which tend to favour short-term, focussed therapies. IAPT only directly impacts NHS psychological services, but indirectly places pressure on any modality of therapy wishing to be on the IAPT 'menu' (to succeed within the NHS part of the node of provision and distribution) to submit to empiricist trials. Skills for Health on the other hand was arguably directed at assimilating the whole of the field of counselling and psychotherapy (i.e. both public and private practice) to a more acontextual/transactional framework, via the shaping of National Occupational Standards for each of the maim modalities. These transactional-orientated standards were then billed to help shape norms throughout various forms of governance within the field, including performance and training criteria and standards (Skills for Health, 2010). As regards the HPC plans we can already see that the government's preference for multi-professional regulators for new professions was driven partially by a shift towards multi-professional teams within NHS services, overseen by increased 'clinical governance', encompassing a further shift in control to managerial and research elites.

Now to the question of *how* these projects became significantly marked and shaped by transactional norms. To put it rather badly, the above analysis shows that this process did not occur entirely through rational, scientific or political consensus, and so it is to the rhetorical and political strategies deployed within these projects that I now turn.

POLITICAL AND RHETORICL STRATEGIES

The overarching aim of this focus on the political dynamics is to understand how the HPC became named within the 2007 ‘Trust and Assurance’ White Paper as the regulator ‘to be’ of counselling and psychotherapy. To recall from Chapter Three, the post-structuralist ‘logics’ approach I have adopted makes the ‘assumption that all social relations are in a constitutive and dynamic relation with structured fields of meaning marked by radical contingency’ (Glynos et al, 2014a:3). Particular policy changes and imaginaries are not seen as some kind of ‘natural’ progression in the order of things, or determined by processes ‘over and above’ the rest of society, but rather are seen as hard fought for, and won or lost, in a struggle to shape what is fundamentally an open ended policy terrain. On a more specific empirical plain, although it is important to note (as done so above) that opponents of the HPC plans were already articulating significant responses, these are the main focus of the next chapter. My main focus here is to understand how the government initially promoted the HPC as the preferred regulator for counselling and psychotherapy. This also to an extent furthers our understanding of why the government viewed the HPC as the best option.

To a significant degree the regulatory issue of the talking therapies was ‘swept along’ with the regulatory reforms of the wider healthcare professions, and so I examine the rhetorical and political strategies adopted to promote the healthcare regulatory reforms before going onto examine the strategies within the SfH and IAPT projects which got these projects up and running. But I also examine the strategies which dented their legitimacy, presenting in turn

problems for the legitimacy and reception of the HPC plans (to be explored in the next chapter).

HPC plans 'swept-along' with healthcare reforms

Legitimation of HPC regulation of counselling and psychotherapy within the Trust and Assurance White Paper (Department of Health 2007b) was both tacit and generic. Other than the one sentence announcing the HPC as preferred regulator, counselling and psychotherapy is not otherwise mentioned. This and the fact that it was not mentioned at all in the Foster Review document (2006b) in effect helped to marginalise opposition voices and 'lock-in' the HPC as choice of regulator early in the policy-making process. Nor did the Foster Review acknowledge that they were not mentioned. It was not until July 2007 that the Department of Health published a detailed critique of the proposal of the 'Psychological Professions Council', and a defence of the HPC as prospective regulator (2007c). To recall from Chapter Four, 'restratification' was already strongly established within the healthcare professions, including the evidence based practice movement. This obviously accounts for its consolidation and deepening passing relatively uncontested: though that is not to say political and rhetorical strategies were not at play. Indeed, as we can recall from Chapter Three, all policy and practice regimes are fundamentally contingent, however well cemented and taken for granted within the fabric of day to day organisation and work. They must still secure and sustain their hegemonic status with continuous political and rhetorical effort. Let us now look at the key rhetorical strategies by which

the ‘transactional/acontextual’ healthcare regime secured and deepened its position within the healthcare professions.

To recall from Chapter Three a key criteria for calling a social norm of practice as also being a political norm is if it tends to make other norms either less or more visible, and therefore more or less available for contestation. Let us first recall the key norms of the regime. Drawing on the work of Healey (2013) and Harrison (2009) I have characterised the healthcare regime, and the SfH and IAPT programmes, as being a scientific bureaucratic regime, marked particularly by what I refer to as transactionality, and supported by increased differentiation, hierarchy, and a complex of audit and regulatory practices. Within the Government Papers, namely the Trust and Assurance White Paper (2007b), and the Donaldson (2006a) and Foster reviews (2006b), the consolidation and deepening of the transactional-orientated regime as the vehicle to achieving the overall aims, namely public protection and quality assurance, is itself largely left outside of the critical field of vision. In other words the practices being introduced and posed as solutions are not themselves subject to forthright analysis or qualification: there is, to recall from Chapter Two, as Fairclough (Williams and Apperley, 2009) would have it, an emphasis within the government policy documents on promoting policy, rather than robust analysis that would air potential problems. In short the Trust and Assurance White Paper tends to be hortatory. To place the thrust of the policy content outside the scope of scrutiny within the document is rather extraordinary, and was achieved, I contend, in the following key ways. First, somewhat paradoxically, in the Trust and Assurance regulatory White Paper the transactional-orientated system tends to be rendered rather invisible in so

far as it is a system without a name. Evidence based practice and the (random) controlled trial are little mentioned, a fact which probably reflects, as noted above, its already established hegemonic position. As explored within Chapters Two and Four the evidence based practice movement and the strong valorisation of the (random) controlled trial is something which gained 'grip' as a strong Enlightenment narrative. It is seen as supplanting power with truth: self-interested professional oligarchies are supplanted by treatments that are scientifically proven to work in the client and public interest. For the healthcare regime this narrative has already *done its work* in making the heightened 'population-based' and highly transactional system of healthcare the social and technical norm. To put it another way, the 'evidence based practice'/transactional regime of healthcare becomes the healthcare regime as such. Giving it less 'air time' so to speak arguably helps the regime appear more 'natural', thereby reinforcing its status as a solid part of the 'natural fabric' of healthcare, less visibility being likely to attract less contestation. [59] The 'seams' of the healthcare system are not foregrounded, as these seams would show it to be a particular 'style' among other possible ones. The visibility of an alternative regime – a more contextual regime – is also made less visible by not being named. To recall some of the norms that may comprise a more 'contextual' regime, and which the transactional-orientated regime contests, are 'practice based evidence', historically couched within the system of self-regulation or significant levels of collective

[59] This is not to say that there are no concerns about the overarching evidence paradigm adopted by public services. To recall from Chapter Four, even Roth and Fonagy in What Works for Whom, a central text in the government's policy programme, makes a barely veiled critique of the philosophical approach to evidence – an empiricist one – as fundamentally flawed and widely discredited across many academic fields.

and individual professional autonomy, collegiate/ 'horizontal' relations, including a softer demarcation between clinicians and managers. But the government papers tend not to expressly name the norms of practice being contested[60]. More specifically, the Trust and Assurance regulatory White Paper does not acknowledge that the regulatory and governance approach taken diminishes the possibility of a deeper contextual/person-centred practice. There is no mention that diminished person-centred practice is a necessary price worth paying for what is claimed to be better healthcare outcomes procured by heightened protocolisation of practice through, as Chamberlain (2010) phrases it, the 'clinical guideline industry' (85) and measures to implement and enforce them.

The 2007 Trust and Assurance White paper expressly states that:

> In order to assure respectful, compassionate, caring and clinically excellent care as the norm, it would be inadequate to focus solely on the regulation of individual health professionals (Department of Health, 2007a:13)

It also focusses on the regulation of organisations and the healthcare field as a whole, through numerous measures, as we have seen above, including 'clinical governance'. But whilst individual practitioners are not the sole focus of attention, the measures introduced to render practice safe and effective are not themselves subject to critical scrutiny within the paper, nor are concerns about them acknowledged. The key point I am making here is not so much that individual professionals tend to be blamed within the White Paper for organisational breaches of good standards of practice, but that the

contestability – expert on expert contestation – of what constitutes good standards of practice and good norms of governance and organisation in the first place is eclipsed. In short, and more specifically, deep concerns about the particular manifestation of evidence based practice in which clinical trials have been strongly valorised, placing other sources of clinical knowledge, and forms of research, deeply in the shadows, are effaced. This is also the case in relation to concerns about audit practice, such as the use of clinical 'targets', as for example expressed by Traynor (1999). What some experts (e.g. Healey, 2013) claim are risks and harms associated with the more acontextual practices of 'outcomes-based', as opposed to a more contextual orientated 'data-based' healthcare (Healey, 2013), are not addressed. Healy for example claims that, in the case of many pharmaceutical medicines, patients are, often unbeknown to themselves, playing a game of 'Russian Roulette' whilst being strongly assured of their safety and effectiveness (*ibid*)

Another way that the Trust and Assurance regulatory White Paper arguably makes such concerns less visible is through a problem minority narrative. The majority of professionals are cast as 'extraordinary' individuals in juxtaposition to a 'problem minority'. The Paper states that 'for every time that Harold Shipman and Beverley Allitt are mentioned, we must recall the hundreds of thousands of *extraordinary* individuals who dedicate themselves impeccably to their patients every day (emphasis added) (Department of Health, 2007a:1). The White Paper does not spell out what it means by 'extraordinary' individuals, but it arguably connotes the capacity to exercise considerable autonomy, especially given that it is followed by the statement that 'professionalism is an unquantifiable asset to our society, which rules,

regulations and systems must support, not inhibit' (2007a:1). The stark juxtaposition of the 'horrific' figures of Shipman and Allit on the one hand, and 'extraordinary' individual professionals and 'impeccable' practice, on the other hand, is arguably suggestive of a 'fantasmatic' narrative in which 'horrific' exceptions pose a threat to an otherwise 'beatific' group of professionals. This is arguably a worrying narrative in the sense that it may be contrary to cultural conditions conducive to critical and reflective professional practice and robust accountability. I return to this in the concluding chapter. The key point I am making here is that this fantasmatic narrative tends to distract attention from the specificity of 'clinical governance' being consolidated and deepened. The White Paper asserts that regulations and rules must assist not inhibit 'extraordinary' practice, but yet it does not even acknowledge any specific concerns about the erosion of clinical autonomy, or about the character of the current clinical guideline industry. The comments therefore take on the air of rhetorical 'cover' for what arguably in fact tends to be the deepening of the diminishment of the role played by clinical judgement of individual practitioners who are face to face with patients. We can reasonably surmise that these strategies helped shore up the consolidation and deepening of the 'transactional' healthcare regime (arguably spear-headed by the evidence based practice movement) and that this indirectly helped the HPC plans to be 'locked-in' early on along the road to statutory regulation of the talking therapies. As a counterfactual let us for a moment imagine that the healthcare regulatory reforms were met with deep hostility by the mainstream medical and nursing professional associations. In such a context the HPC plans would have been enmeshed within a wider terrain of contestation,

and.in such a scenario critics of the HPC plans within the field of the talking therapies would have been presented with the possibility of ‘bigger shoulders’ upon which to stand and amplify their concerns.

I would like now to look at the political dynamics which helped install and defend the transactional-orientated character of the Skills for Health project to map the National Occupational Standards for counselling and psychotherapy.

The ‘hegemonisation’ of the skills for health project as ‘transactional’

It is reasonable to surmise that the ‘background’ strategies used to constitute and support the evidence based practice movement – namely claims to be objectively ‘above the political fray’ – were at play in the Department of Health’s decision to commission the SfH to develop standards of practice, and for SfH in turn, to commission the ‘empiricist’ work carried out by the Sub-Department of Clinical Health Psychology Department of Health Psychology at the UCL (University College, London). In short the established confidence the government has in empiricist approaches is likely to have shaped these decisions. However, as noted within Chapter Four, the evidence based practice movement is not strongly established across the field of counselling and psychotherapy. Rather, its ‘sway’ over the field is limited to particular ‘segments’, presenting a problem for SfH and its adoption of an empiricist/evidence based practice approach. It also to some extent cast a shadow, as we shall see in the next chapter, over the HPC plans. SfH were not overtly ‘gun hoe’ in their approach, but rather sounded strong assurances of the inclusive approach of the project. But these rhetorical assurances took

on a strong ‘promotional’, rather than analytic, quality as SfH did not attempt to square in any analytic detail its claims to inclusivity with the fact that it was basing the development of NOS for all modalities of therapy on ‘manuals’ of practice based on controlled trials. So despite the talking therapies not being ‘natural’ ground for the empiricist approach, how did the NOS for the entire field come to be based upon empiricist clinical trials? The structure of the project (Skills for Health, 2007) partially helped to protect the empiricist base of the project from alteration, namely by splitting responsibility for the production of ‘competency frameworks’ for each modality from responsibility for turning these into NOS. This created a hierarchy which shielded the empiricist-based ‘competency frameworks’ (the foundation so to speak) from significant modification or overhaul in the light of problems and issues arising in the work of the ‘modality specific’ working groups, involving experts from the modality in question. This is a kind of ‘divide and rule’ strategy (see Diagram 1 below). Although a modality approach was welcomed by many organisations within the field (for example the College of Psychoanalysts), including those that went on to object to the transactionality of the approach taken, the splitting of the work into different groups to work on each of the modalities arguably diminished the possibility of an alliance – an ‘equivalential chain’ in Laclauian terms – between practitioners across the modalities, who found the NOS counter to their own conceptualisations of practice, against the empiricist base adopted, from developing. The administrative differentiation and hierarchy between the groups within the SfH project meant that differential relations within the project were emphasised. In the case of the development of the NOS for psychoanalysis, for example, the ‘divide and

rule' strategy arguably helped prevent opposition voiced by the CPJA within the modality group from gaining traction within that group or within the project overall. The empiricist conceptual base of the NOS for psychoanalysis survived, however, only at the cost of the departure of the CPJA, the largest professional association of psychoanalysts, from the project

Another key way that the empiricist research paradigm was installed was through a 'problem minority' narrative. The NOS were 'aspirational' rather than 'minimal' ones (2008b)**,** and in this sense the SfH project was not directly orientated towards public protection or a 'problem minority' within the field in the way that the regulatory standards and reforms were (as discussed above). However, those, namely Lacanian psychoanalysts, who were the most vociferously opposed to any kind of move towards the manualisation or protocolisation of psychoanalysis [61] were excluded from the project altogether on the basis of being a 'problem minority' (my phrase) within the project and the larger field. Whilst the 'official' discourse of the SfH project was one of inclusivity (namely a promise to reflect diversity within the field), an 'unofficial'/private discourse within SfH legitimated the exclusion of representatives of Lacanian psychoanalysis within the SfH project. Internal SfH emails, acquired by the College of Psychoanalysts through a freedom of information request, show that when Marc Lyall of SfH sent a query to Peter Fonagy about the involvement of the College of Psychoanalysts and the Psychoanalytic Consortium, Fonagy replied that the College:

[61] Paul Atkinson (Jungian Therapist and member of the Skills for Health group developing competencies for psychoanalysis), interview by author, June 2015.

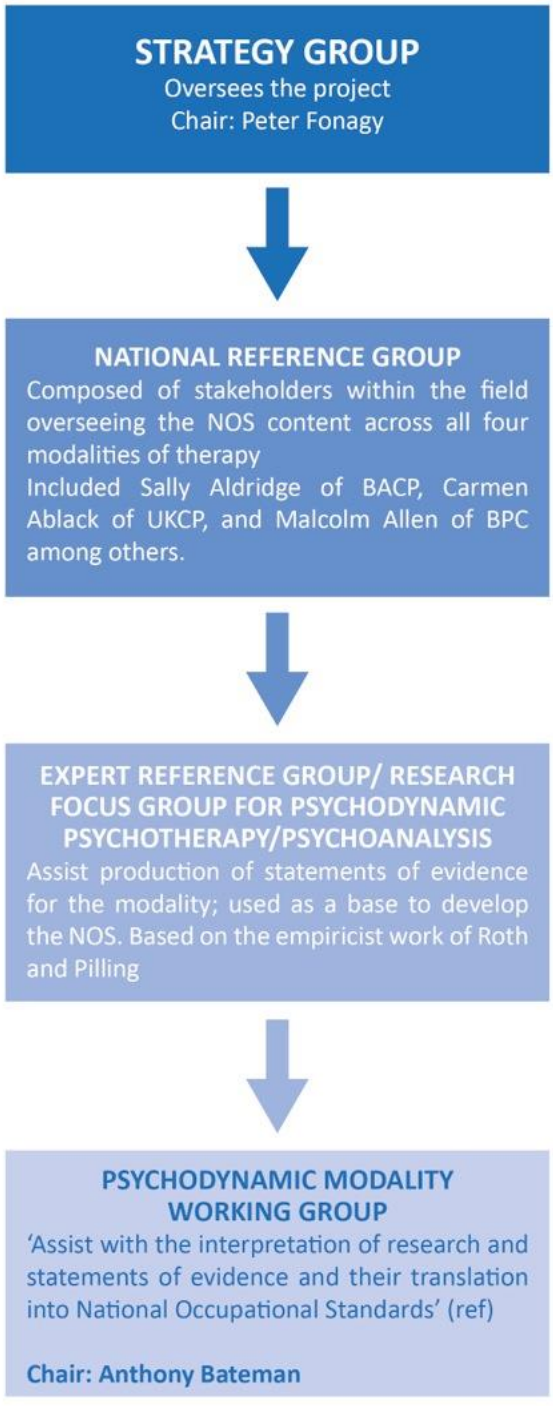
Is a largely Lacanian organisation (French psychoanalyst – Lacan – intellectual superhero but clinical and ethical problem, ultimately dismissed from the rank of the international psychoanalytic movement) (The College of Psychoanalysts, 2008).

Diagram 1

POLITICAL AND RHETORICAL STRATEGY

- The empiricist/manual base of the development of the NOS for psychoanalysis was fixed through a series of strategies, including:
  - Separation of tasks into different groups and producing quasi hierarchical relationship between them; a 'divide and rule' strategy.
  - Select appointments within the groups. Many appointments made from within BPC and UCL political grouping.
  - Lacanians excluded from the psychodynamic modality working group. This was unofficially legitimated on the basis that 'they are very much against evidence based practice and might try to sabotage the process' and because Lacan is 'an ethical and clinical problem' (Fongagy).
  - Colllge of Psychoanalysts given ' the run around', were subject to friendly-evasion, an d, finally, simply ignored.
  - SfH 'signed off' and approved the NOS for psychodynamic modality as representative of the field despite the exclusion and detailed protestations of the Lacanians, and despite the resignation from the modality group of Paul Atkinson and James Barrett of the CPJA (the largest professional association within the field of psychoanalysis) on the grounds that the NOS were completely incongruent with most approaches to psychoanalysis.

Diagram showing the structure of the SfH project, with particular focus on the development of National Occupational Standards for psychoanalysis



He then states that Lyall, SfH's overall lead on the counselling and psychotherapy project, has already appointed two members of the College of Psychoanalysts to the psychoanalytic working group (i.e. Atkinson and Barrett), and that 'this is more than enough' (*ibid*). He goes onto say that 'they are deeply opposed and concerned about regulation' and that 'they are very much against evidence based practice and might try to sabotage the process' (*ibid*). On March 19th 2008 Julia Carne and Darian Leader of the College of Psychoanalysts met with Marc Lyall and Nadine Singh of SfH: a meeting in which Carne and Leader highlighted the political makeup of the field, as well as issues around evidence within the field. As requested by Lyall, Carne and Leader forwarded articles and bibliographies, as well as information about the BIOS Centre (then at LSE), where work critical of the UCL grouping is undertaken (Arbours Association et al, 2009). Despite assurances from Lyall that the working group would be made more representative, the list of members remained the same. The College of Psychoanalysts wrote:

> Representatives of the majority of psychoanalytic practitioners currently practising in this country have been excluded from the working party responsible for the draft despite written assurances that they would be included. There is thus an astonishing contradiction between the ethos which is supposedly at the core of the document and that which has in fact been operative in its construction (2008c).

Paul Atkinson noted that SfH staff were helpful and engaging, but that it did seem that SfH had handed over substantive control of the project to the UCL and BPC-based personnel within the project, namely Anthony Bateman and Peter Fonagy.[62] Malcolm Allen stated; 'that maybe true […] they probably had a fairly tough and impatient stance on it […] they were fucked if they were

[62] Paul Atkinson (Jungian Therapist, and and member of Skills for Health group developing competencies for psychoanalysis), interview by author, June 2015.

going to be arsed around with, you know, a whole bunch of people who were just against the whole exercise'.[63] SfH seem to have abdicated from their self-professed responsibilities as regards inclusivity, and whilst it is plainly reasonable to surmise that James Barret and Paul Atkinson were always going to be opposed to an empiricist/manualised approach, they did not have an a-priori hostility to the SfH's mapping exercise as such. Paul Atkinson for example commented that:

> James and I got quite interested for a while in the project of trying basically to name what we do (which is how the thing was sold in the first place): wouldn't it be useful as a profession to be able to put into more layman, or sort of popular, or ordinary words, what it is we do. So it was quite an attractive project [64]

He contrasted this ambition to psychoanalytic literature, describing it as 'profoundly deep and bespoke and quite intellectual: most of us find it kind of delightfully exciting and exasperating at the same time'.[65]

Overall, these strategies, including SfH professions and assurances about inclusivity, enabled Fonagy, Bateman, Pilling and Roth to successfully hegemonise the NOS in terms of what I have referred to as transactionality, arguably making the NOS more conducive to the NHS regimes as currently configured. However, they are strategies which tended rather more to rely on administrative force than on the winning of hearts and minds across the field and seems to have furnished ground for further opposition to the HPC plans, which were strongly associated with SfH (more on this in the next chapter).

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[63] Malcolm Allen (Chief Executive Officer of the BPC), interview by author, October 2014. See appendix A p. 452.
[64] Paul Atkinson (Jungian Therapist, and member of Skills for Health group developing competencies for psychoanalysis), interview by author, June 2015.
[65] Paul Atkinson (Jungian Therapist, and member of Skills for Health group developing competencies for psychoanalysis), interview by author, June 2015.

And now to the political dynamics of the IAPT programme.

The installation of IAPT

The IAPT programme, broadly speaking, had two main constituencies that were potential obstacles to its installation. Rather problematically for IAPT these constituencies to an extent had competing demands. On the one hand, there were was a powerful constituency within the healthcare field, namely some pharmacologists, who were sceptical about the efficacy of talking therapies in comparison to pharmacological treatments and advocated that they should be subject to what they see as the rigorous testing of drugs (Science Daily, 2008). This view dovetailed with what is arguably a constituency, reported by Toynbee, within broader culture that tends to see the talking therapies as a 'soft' option, upon which expenditure - when it comes to tax payers' money - is not warranted (Toynbee, 2006). The other constituency, as noted above, were those who were concerned that IAPT was a form of social control: for example by reinforcing striking and growing socio-economic inequalities within neo-liberal society by de-linking poverty and depression (Pilgrim, 2008). Let us look in turn at how IAPT sought to persuade or appease each of these broad constituencies in its path to implementation.

Whilst the evidence based practice base did little for the sense of legitimacy of the programme within much of the field of the talking therapies, the 'hard science' tone shored up the legitimacy of IAPT in the eyes of other stakeholders, helping to counter the often held view of the talking therapies as

a ‘soft’, inefficient and nebulous treatment option. Toynbee (2006) for example in a Guardian newspaper article about IAPT and Layard’s ‘happiness programme’ wrote: ‘Happiness is a real, objective phenomenon, scientifically verifiable. That means people and whole societies can now be measured over time and compared accurately with one another […]. Causes and cures for unhappiness can be quantified’. The sense of IAPT as delivering ‘smart treatments’, i.e. ones that are precise in their character and that have honed ‘targets’, was arguably reinforced by decisions which strongly limited the pool of potential therapies from which IAPT could draw. Initially this was CBT only, and then was extended to all NICE approved therapies (still a small pool). The ‘smart’ character of IAPT-provided therapy is arguably overegged in two key ways. First, IAPT, in only choosing from a pool of therapies that have been actively tested against a placebo, ignored what is arguably the broad balance of empiricist evidence, as claimed, for example, by Wampold et al (1997) that all talking therapies are more or less equally effective as one another, supporting the so called dodo bird thesis (that all talking therapies therefore win prizes). Second, the measurement of IAPT success in action, so to speak, was seen by many as overegged by the ‘cherry picking’ of candidates for treatment. Fiona Ballantine Dykes, for example, commented that:

> There are some staggering statistics around IAPT, something like forty percent of clients that present to IAPT, are regarded as unsuitable for treatment. Well, I worked as a counsellor within a GP practice and ninety eight percent of clients who presented for treatment are accepted’.[66]

[66] Fiona Ballantine Dykes (Counselling Central Awarding Body, and member of the HPC Professional Liaison Group for Counsellors and Psychotherapists), interview by author, June 2015.

It also tended to measure outcome success on a short term basis, thereby excluding those patients who 'relapsed' after a longer period of time. The health scientist that I interviewed echoed the view that truths derived from empiricist trials are highly objective and unconstructed, [67] stating that 'experimental research is basically a neutral form of research'**.** Not unlike Moran (2003) in relation to professions and the regulatory state, as explored in Chapter Two, the health scientist applied a public interest-style account to this approach whilst applying a private interest style account of those that have serious misgivings about the empiricist methodology. For example, regarding the Savoy Conferences (formed of mainstream associations within counselling and psychotherapy), he stated that: 'They're stacked full of people with vested interests that don't like the fact that NICE didn't include their treatments and recommended treatment protocols for the NHS'.[68] He referred to an instance where the Chief Executive of Nice was challenged on evidence based practice. He stated that: 'these people are dinosaurs in a modern effective health care system. That is a conference that no sensible person would go to'.[69] The tacit dichotomisation between 'acontextual' and 'contextual' research practices arguably takes on a fantasmatic hue, with the empiricist research design a 'beatific' and unalloyed Enlightenment practice supplanting the dogma and 'senselessness' of 'contextual' research practices seen as driven purely by private interests.

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[68] Health Scientist Advisor to IAPT, interview by author, October, 2014.
[69] *Ibid*.

As regards the constituency critical of the neo-liberal political settlement and the role of IAPT within it: Toynbee (2006) for example contended that IAPT, along with Layard's broader 'happiness' programme, including an index of national success in improving levels of happiness, was a sign of a New Labour's shift, under Gordon Brown, away from neo-liberalism. Toynbee characterised the Depression Report as an 'essential first step' for a 'new politics that [makes] happiness the goal'. She claimed that 'inequality makes everyone unhappy, the poor most of all, and that is well within the remit of the state […] But start with step one: psychiatry can deliver the greatest release from misery - a quick win, an easy happiness hit' (Toynbee, 2006). David Richards (Richards, 2007), architect of the Doncaster demonstration site, also sought to present IAPT in a favourable light, to counsellors and psychotherapists concerned about social justice, by quite bizarrely creating a very sharp frontier between two aspects of the IAPT programme. He creates a frontier between the Doncaster site and the transformation of the field and a more just society on the one hand, and on the other, the Newham demonstration site, a professional oligarchy within the field of talking therapies and an unjust society.

Finally, Lisa Wake, with the help of Mind, by threatening public embarrassment to the Government near the public launch of IAPT, was able to open the programme up to non-CBT NICE approved therapies so that it was not entirely dominated by CBT. [70]

[70] Lisa Wake (Chair of UKCP 2005-2007), interview by author, April 2015

Again, as with the SfH project, the character and political dynamics around IAPT heightened anxiety among many in the field about the HPC plans.

SUMMARY

A lot of empirical ground has been covered within this chapter. In these concluding comments I want to further draw out how the analysis of the immediate context of the HPC plans helps contribute to an account of the HPC struggle. Through immersion within, and critical analysis of, key policy documents, we now have a clearer picture of the character of the broader healthcare regime to which the field of the talking therapies were being 'hailed', and to some extent assimilated by the IAPT and SfH programmes. The 2007 trust and assurance regulatory White Paper on the regulation of the healthcare professions signalled the consolidation and deepening of a scientific bureaucratic regime marked by transactionality. At the centre of this regime is a raft of regulatory practices which enforce, not only minimum codified standards of practice, but also NICE guidelines. IAPT and SfH for their part constituted ambitious programmes, seeking to reshape the field in accordance with empiricist research evidence. Within its ambitious 'mass' therapy programme IAPT directly implemented 'evidence-based' therapies within the NICE guidelines, excluding other therapies: in many instances challenging their institutional survival and tenability. SfH was in a sense more diffuse, casting a net of NOS/competencies, underpinned by empiricist research evidence, over the whole field, including all major modalities of therapy. This included private practice.

Returning to changes to the regulation of healthcare professions, audit practices, like ‘benchmarking’, and ‘revalidation’, signalled the reinforcement of restratification within the field, namely increased differentiation between a managerial and research elite on the one hand and rank and file professionals on the other. This included a heightened top-down relation between the researcher and the practitioner, a hierarchy which was articulated alongside, and was reinforced by, changes to the governance of regulators. One key measure here is the cessation of rank and file professionals electing other rank and file professionals to regulatory boards. More fundamentally, the confirmation of the Government’s preference for multi-professional regulators for new professions, I argue, consolidated a significant shift away from individual and collective professional autonomy through a shift from ‘specialist’ to more ‘generic’ regulatory expertise and oversight. In short the field of counselling and psychotherapy was ‘called’, so to speak, to constitute itself as a statutory regulated profession at the very same moment as the Government were seeking to soften the boundaries between healthcare professions, bringing them to an extent under the rubric of a common set of standards and regulatory framework. The HPC announcement of the plans was highly contentious in much of the field – and much of the field rallied around an alternative proposal, the ‘Psychological Professions Council’. The BPC and BABCP were notable exceptions and the BPC with links to Mentalisation Based Therapy developed by Peter Fonagy, and the BABCP with obvious interests in the promotion of CBT within IAPT, arguably had the most to gain from IAPT, SfH and HPC regulation going ahead.

In this chapter I have sought, through an analysis of the political dynamics, to explain how the HPC policy idea reached this milestone in a path to institutional hegemony. To a significant extent it was 'swept along' within wider healthcare regulatory reform, which itself had a relatively smooth path: the empiricist paradigm and restratification within the healthcare field already to a significant extent having 'won out'. I have identified a number of ways in which the sense of the heightened 'acontextual' regime as a 'natural order' was reinforced. Its 'particularity' was made less visible simply by not being named; NICE guidelines were for instance barely mentioned, and more contextual forms of practice mentioned – e.g. the importance of the professional-client relationship – but the significant tension between contextual and acontexutal approaches to practice within the regime by and large ignored. The motif of public protection, articulated within a 'problem minority' versus majority of 'extraordinary' professionals, arguably provided affective 'grip' for reforms and drew potential critical attention away from the regulatory practices, including heightened forms of acontextual medical practices dominated by the pharmaceutical industry. SfH and IAPT to an extent similarly cleared their paths to installation with 'problem minority' or, in the case of IAPT one could say **'**problem majority', narratives. The marginalisation, and at times, simple 'stonewalling', of those advancing deliberative arguments against some of the key characteristics of these projects, seems to have gained legitimacy through a broad Enlightenment narrative in which there is strong confidence in the capacity of empiricist orientated research to intervene within the terrain of services and practices seen as *darkened* by dogma, ineffective practices and professional self-

interest, and to supplant them with the *light* of cost-effective, and properly scientifically informed practices. It is within this ‘zeitgeist’ that concerns expressed by many counsellors, psychotherapists and psychologists about potentially harmful impacts of HPC regulation – both on the field and the public interest more widely - were largely swept to the side. It is to these concerns, and the HPC’s responses to them, that I now turn to in the next Chapter.

CHAPTER SIX

STRUGGLES OVER THE 'NUTS AND BOLTS' AND THE TOTALITY OF THE HPC PLANS

> We do not prescribe the nature of the therapeutic relationship for the professions we regulate now or in the future. The standards we set are broad enabling standards which do not affect the therapeutic relationship (Health Professions Council, 2008b).
>
> If government persists in its wrong-headed move to control and regulate *all* therapy practice in an undiscriminating way [..] it can expect a concerted and highly organised campaign of Principled Non-Compliance with regulation in which a coalition of practitioner-organisations will combine to resist and subvert any attempts to impose state regulation upon the psy-field as a whole (House, 2008a)
>
> When you've got one common enemy it kind of brings people together (Darian Leader on the relative harmony within the Alliance). [71]

In this Chapter we move to the heart of the struggle. I examine the formation and work of the HPC's Professional Liaison Group (abbreviated to the Liaison Group) for counselling and psychotherapy during its first wave of meetings, as well as key developments in the organisation of opposition to the plans, namely the formation of the Alliance for Counselling and Psychotherapy against State Regulation (abbreviated to the Alliance). A narrative overview of key events is followed by a critical analysis and description of the positions of the pro and anti-HPC camps. Then, developing the more ethico-ideological dimension of my analysis, I examine how each camp attempted to draw support for their positions.

I argue that the struggle was essentially a struggle between two competing regulatory imaginaries: on the one hand, a transactional HPC regime, encompassing psychiatric/healthcare and consumerist norms, and, on the other, a more contextual and relational Alliance regime, embodying norms of pluralism and more open ended practice. The HPC plans, though divergent in some aspects, had significant family resemblance to the IAPT and SfH projects. I then go onto explore key political and rhetorical strategies deployed by the HPC, and argue that the HPC's main approach was to disavow the healthcare and consumerist orientation of the plans and to frame the struggle as a misunderstanding. The identification of a fantasmatic narrative, in which a 'problem minority' within the field is seen as essentially the only threat to an otherwise 'beatific' state of affairs, helps to understand the affective 'grip' of the HPC plans. Other, more marginal approaches taken by the pro-HPC camp are also considered, including Cooper's and Lousada's (2010) characterisation of the HPC plans as a potential political catalyst or means for the field counselling and psychotherapy to push for greater social justice within wider society. In contrast the main approach adopted by the Alliance was to characterise the detail of the HPC plans as healthcare orientated and therefore as largely incompatible with much of the field of the talking therapies. At times the Alliance also took a 'wider' hegemonic and political approach, positioning the HPC plans as metonym for excess bureaucratisation and/or consumerism within late modernity/advance capitalism, and, to an extent, construed the HPC plans to be part of a wider contingent political settlement, thereby tending to contest both the supposed 'progressive' and inevitable nature of the plans.

As regards sources, I draw on the following key interviews: Michael Guthrie of the HPC: Dianne Waller, Chair of the Professional Liaison Group and registrant member of the HPC as an Art Therapist. She played a key role in the history of the regulation of Art Therapy.[72] From the umbrella organisations and the liaison group I draw on interviews with Julian Lousada and Malcolm Allen (Chair and Executive Director of the British Psychoanalytic Council, BPC, respectively). Malcolm Allen came from a background of arts management, and was part of BPC's quest to become what Lousada called a modern organisation. He was the first Chief Executive Director, and the first non-analyst to take a central role within the management of the organisation (and of other comparable organisations in the field) and was granted some autonomy from the Chair. [73] From the UKCP I draw on the interview with James Antrican (Chair). Lousada and Antrican both took the view that the HPC could potentially be sufficiently reformed from within in order to render the plans suitable for the field of counselling and psychotherapy. I also draw from my interview with the Liaison Group member Fiona Ballantyne Dykes of the Counselling Central Awarding Body, who was broadly against the plans but was engaging with the process in the hope of marginally improving the plans. From the Alliance I draw on my interviews with Darian Leader[74], Andrew Samuels and Denis Postle. They were instrumental in setting up the Alliance and drawing in supporters.

[72] Dianne Waller (Chair of the HPC's Professional Liaison Group for Counselling and Psychotherapy), interview by author,

[73] Julian Lousada (Chair of the British Psychoanalytic Council and member of the HPC's Professional Liaison Group for Counselling and Psychotherapy), interview by author,

Accounts within these interviews are triangulated with other sources, including Janet Low's (a Lacanian psychoanalyst) HPC watchdog blog (Low, 2008). Denis Postle's documented and collated accounts (Postle, 2012), as well as official documentation from the HPC, namely its minutes of the PLG meetings and papers presented to the PLG.

OVERVIEW OF EVENTS

During 2007, following the announcement of the plans to make the HPC regulator of counselling and psychotherapy, the main professional associations within the field, including the UKCP and BACP, which were formerly opposed to the HPC, now, in the face of a the perceived inevitability of the plans, did an 'about turn'. They set about making the best of what some, such as James Antrican, viewed as a less than ideal choice of regulator[75]. This was compounded by the British Psychological Society's (BPS) decision to embrace regulation by the HPC, intensifying concern amongst opponents to the HPC within the field of the talking therapies. Denis Postle, for example, wrote:

> A sad day. Practitioners with claims to have insight into the human condition fight for market share and pole position in the psychopractice pecking order and invite state to define their ethical and occupational obligations. Who next? The psychotherapists? Then the counsellors? And lastly if ever, the psychoanalysts? (Postle, 2007b).

Some across the field remained resolutely opposed and there was often a febrile atmosphere on the issue. For example executive Director of the BPC,

[75] James Antrican (Chair of UKCP 2007-2009), interview by author, October 2014.

Malcolm Allen, and executive director of the HPC, Marc Searle, respectively heaped scorn upon, and took great exception to, Denis Postle's comparison of those that made an 'about turn' in favour of the plans with French people in the Second World War Vichy Regime who collaborated with the Nazi's during the occupation (Postle, 2012), (Allen, 2008). The HPC carried out a 'call for ideas' – its initial consultation – from July to October 2008 (Health Professions Council , 2008a). Through the questions it posed the HPC framed the task as one of determining the 'nuts and bolts', as Michael Guthrie put it,[76] of the HPC plans. The central and most contentious issue was how the register should be structured, namely whether it should differentiate between counselling and psychotherapy (Postle, 2012), (Health Professions Council, 2008c)**.** Many within the field also objected to the HPC plans in their totality, arguing that the healthcare and consumerist orientation of the plans was incongruent with most talking therapies. Whilst the British Association of Counselling and Psychotherapy (BACP), the BPC, and other major professional associations made 'one voice' submissions broadly in favour of the HPC plans, the UKCP, under the Chair leadership of James Antrican, allowed a 'dissenting voice' section within its submission, presenting the views of members opposed to the HPC plans (UK Council for Psychotherapy, 2008). The main claim was that the HPC plans were healthcare and positivist in orientation, antithetical to the values and norms of many forms of talking therapies, and thereby a threat to diversity within the field. The complaints system was also critiqued as inappropriate for the field, especially in its failure to take into account the phenomenon of transference. This decision by the

[76] Michael Guthrie (HPC's Director of Policy and Standards), interview by author, June 2014

UKCP, which arguably gave an air of legitimacy to opposition reportedly invoked the 'fury' of Marc Searle.[77]

The HPC set up and appointed members to its Professional Liaison Group for counselling and psychotherapy, which included representatives from all the major umbrella professional associations and the prominent art therapist, Professor Diane Waller was appointed Chair of the group. Under the critical gaze of opponents of the plans within the HPC gallery – such as the Lacanian analyst Janet Low - Diane Waller sought to steer the group away from controversy and away from the possibility of the group recommending 'no' to the plans (more on this below). A central task was to establish 'profession-specific' standards for the field. The HPC had 'generic standards' already in place that apply to all professions under its auspices. A struggle within the liaison group ensued over whether the statutory register should differentiate between counselling and psychotherapy in relation to the profession-specific standards. Non-differentiation versus differentiation more or less corresponded to BACP versus the rest of the group. Given the majority status of the latter around the Liaison Group table, differentiation became the 'working position' (i.e. provisional position) of the group. Diagram 1 describes this and the other possibilities considered by the group at this time. As part of the HPC process, and its commitment to wider consultation, a 'stakeholder meeting' was held in Manchester in March 2009. Both the HPC and opponents were incredulous about the behaviour of the other side, Michael Guthrie, for example, stating that:

[77] James Antrican (Chair of UKCP 2007-2009), interview by author, October 2014.

> Some people were very aggressive at that meeting; unnecessarily so, in terms of their body language and what they said. It wasn't very constructive, and it was a thoroughly unpleasant meeting to be involved in. [78]

In contrast, Janet Low painted a picture of a rather 'stage managed' consultation, stating, for example, that the presentation by two women representing the Royal College of Speech and Language Therapists seemed aimed to 'reassure the stakeholders in this new profession [counselling and psychotherapy] that all would be alright. Mary Smith kicked off with a power-point presentation that many thought was pitched at the wrong level, and she went on to recount something akin to a fairy story' (Low, 2008:63). A key point of conflict concerned the presentation by Jonathan Coe, spokesperson for the charity Witness, of a formerly abused client to the meeting, and Darian Leader's claim that Coe was re-enacting elements of the original abuse suffered by the individual. This resulted in Coe issuing a threat of legal action against Leader[79]. Failing to make any significant impact within the HPC's own policy-process, those individuals and organisations that were resolutely opposed to the HPC plans were galvanised by Andrew Samuels and Darian Leader and the Alliance for Counselling and Psychotherapy Against State Regulation was formed. It was comprised of people from across many sections of the field, including humanists ,such as Denis Postle, Richard House, who, to recall from Chapter Four, led a strong tradition opposed to professionalization and state regulation within the field.

[78] Michael Guthrie (Director of Policy and Standards, HPC), interview by author, June 2014.
[79] Darian Leader (Lacanian psychoanalyst, Alliance co-founder), interview by author, June 2014.

CHAPTER SIX TIMELINE

3rd December 2007: *HPC publish their 'road map' setting out the schedule towards statutory regulation of counselling and psychotherapy.*

September 2008: *Rally of Impossible Professions*

July 2008: *HPC Call for Ideas consultation (closed 24th October 2008): The HPC asks a series of specific questions consistent with its 'nuts and bolts' strategy and remit. But it also invites more general comments.*

4th December 2008: *First meeting of the HPC's Professional Liaison Group (PLG). Reportedly quite a heated meeting. A question was raised regarding the remit of the group and whether it could recommend 'no' to the plans. The Chair, Diane Waller, averted attention from the question. The meeting was adjourned early.*

28th & 29th January 2009: *Second of the Professional Liaison Group meetings. This is focussed on the issue of differentiation between the counselling and psychotherapy. Darian Leader of the College of Psychoanalysts sends a letter ahead of the meeting outlining concerns about HPC regulation. The letter is not addressed within the meeting.*

3rd & 4th March 2009: *Third meeting of the Professional Liaison Group.*

31st March 2009: *Manchester Stakeholder Meeting: Scheduled meeting in the HPC path to regulation. A fractious meeting by many accounts. Whilst HPC representatives seek to disseminate information about the HPC within the context of the 'nuts and bolts' strategy, many members of the field used the meeting to express their fundamental concerns and disagreement with the HPC as prospective regulator; seeking to address the so called 'whether and by whom' questions.*

5th April 2009: *Inaugural Conference of the Alliance for Counselling and Psychotherapy Against State Regulation. This was organised following a telephone call that Andrew Samuels made to Darian Leader. The conference was attended by over two hundred people.*

29th April 2009: *Fourth meeting of the Professional Liaison Group. Proposes separate protected titles and profession specific standards of practice for counselling and psychotherapy. The basis of the differentiation is 'that psychotherapists work with more complex clients than counsellors, that only psychotherapists "critically evaluate" and counsellors do not, and that psychotherapists have a more advanced understanding and use of research.*

May 2009: *The formation the Coalition Against Over Regulation of Therapy: A group formed mainly of celebrities opposed to the HCP plans. It was felt that the Government were more likely to listen to celebrities than practitioners.*

26th & 27th May 2009: *Fifth meeting of the HPC's Professional Liaison Group for Counselling and Psychotherapy. Start of consultation on PLG draft recommendations on the standards of proficiency Lasts until 16th October 2009*

1st July 2009: *Psychologists become regulated by the HPC*

11th October 2009: *The second and final (during the HPC struggle) conference of the Alliance for Counselling and Psychotherapy Against State Regulation.*

12th October 2009*: The book 'Compliance? Ambivalence? Rejection?' is delivered to HPC (parts of this book were mailed to HPC July 2009 (see Therapy Futures p.268)*

October 2009: *Publication of the Maresfield Report*

Table 1 showing key options considered by the PLG

	Differentiation Approach **(Recommended by PLG to the Council in July 2009)**	**Equivalence (non-Differentiation) Approach**	**Modality-Approach**
Key proponents	UKCP	BACP	BPC, BABCP
Structure of Register	Psychotherapist Psychotherapeutic counsellor Counsellor	One part of the register for both counsellors and psychotherapists	Division of register into separate modalities – probably as sub-sections of an overall division between psychotherapy and counselling.
Protected Titles		'Counselling', 'Psychotherapy' both protected titles, and interchangeable: A practitioner could use either title	Multiple and modality-specific protected titles.
Proficiencies		One set of proficiencies, all of which applicable to both counsellors and psychotherapists.	Separate proficiencies for each modality.
Threshold Level of Entry (minimum level of qualification required for entry into the profession)		One threshold entry level applicable to both counselling and psychotherapy.	Multiple Threshold levels of entry, one for each modality.

The Alliance held two conferences, one in April 2009, and the other in October 2009. The first conference placed an emphasis on articulating rhetorical responses and critiques of the plans, and in the inaugural speech of the Alliance, Andrew Samuels challenged beliefs that the HPC was a good exception to an otherwise worrying policy terrain emerging within the field of the talking therapies. The following statement is indicative of the considerable unpopularity of SfH and IAPT in much of the field:

> People will say, HPC is ok you know, we understand your concern about Skills for Health or the National Institute for Clinical Excellence. Or the happiness system, improved access to psychological therapies. Yes those are all a croc of shit, but HPC is

> good. This is naive and I think beyond belief that the government has actually created a four pronged drive to conform psychotherapy to what the government wants. How is it possible that three of these four planks are not good, but the fourth is good? (Samuels, 2009).

In the meantime the Liaison Group had continued its work developing the 'nuts and bolts' of the plans, going through several drafts of standards: between June and October 2009 it put the latest out to consultation within the field as 'recommendations to be made to the HPC Council (Health Professions Council, 2009c). I consider these recommendations below and the responses to the public consultation in the next chapter.

Also during this period, in the face of mounting dismay across much of the field as to the character of SfH and IAPT, the HPC sought to rhetorically distance itself from the projects, strongly asserting its independence from the projects as well as its 'diverse-friendliness'. The HPC stated: 'we recognise that there are understandable anxieties at the moment about the links, if any between such projects [IAPT, SfH, and NICE] and regulation [….] There is no direct link […] the purpose of statutory regulation is firmly public protection – it is not to exclude or marginalise practitioners or to promote one modality or approach to practice over others' (Health Professions Council, 2008b).
The second Alliance conference in October 2009 focussed on planning a strategy of 'principled non-compliance' with HPC regulation in the event of it being introduced, and also discussed the ground work being done for legal action against the HPC (this legal action is considered in the next chapter). 'Principled non-compliance' refers to the planned strategy whereby practitioners were to either use legally protected or non-protected titles whilst expressly dissenting from registering with the HPC (Samuels, 2009c). In

October 2009, the Maresfield Report (Arbours Association et al, 2009) was published by a number of psychoanalytic training and professional associations, and simultaneously a group of humanistic counsellors and psychotherapists published a collection of articles, '*Compliance? Ambivalence? Rejection?* ' (Postle and House, 2009). Both publications presented the HPC with a broad critique of the HPC plans, including its complaints system, as well as a forensic critique of the HPC's generic standards and draft standards of proficiency for counselling and psychotherapy. The Maresfield Report included an outline of the alternative regulatory system, the practitioner full disclosure list system as developed by Dennis Postle, based on the work of Will Schutz (Postle, 2003). In this system all talking therapists must register and disclose their background and approach to practice, as well as disclose any legal sanctions made against them. The policy proposal includes a broad code of ethics, but no standards of practice (*ibid*). The projected HPC plans were characterised as 'state' as distinct from 'statutory' regulation (though some within the Alliance also opposed statutory regulation) and Darian Leader in a letter to PLG members in January 2009 went so far as to claim that 'the proposed process of HPC regulation will narrow the broad practice of psychotherapy, making much of what currently takes place in reputable psychotherapy consulting rooms *illegal* in the near future' [my emphasis added] (Leader, 2009).This purportedly included 'non market-based and non-healthcare orientated therapies which do not stipulate outcomes in advance. Richard House in an address to the second Alliance conference in October 2009 suggested that the HPC case raised serious constitutional issues. Drawing on the then recent

public controversy about the school regulator telling two parents that made private arrangements to babysit each other's children were breaking the law, House made allusions that the HPC plans constituted a slide towards a totalitarian state (House, 2009), (Whey, 2009).

Alliance interventions prompted some sharp responses from HPC proponents, including a member of the British Association of Art Therapists who wrote in a letter to the Guardian stating:

> What a PR coup for psychotherapy Lisa Appignanesi et al and Darian Leader make between them. "Paying for something without knowing what it is" is apparently good, whereas having "definable techniques with predictable outcomes" is a "serious misunderstanding". Would anyone care to purchase this very fine pig in a poke (Learmonth, 2009).

The above overview of events during this period identifies the main competing problematisations of the HPC plans made by key actors and stakeholders within the struggle, namely the contention of the HPC as a 'light touch'/approach neutral intervention within the field, versus the contention that the plans were a heavy handed intervention which posed a serious threat to diversity within the field, especially non-healthcare and non-market orientated forms of talking therapy. In the next section I begin to assess the veracity of these competing problematisations and policy imaginaries by digging a bit deeper, delineating the assemblage of norms embodied within them.

COMPETING REGULATORY IMAGINARIES

In this section I deploy the nodal comparative analytic framework, adapted from the work of Glynos and Speed (2012) and Glynos et al (2014a), to assist in this task. I first set out the key characteristics and norms of the HPC's node of regulation and governance and contrast these to the counter-regulatory and governance norms expressed by the Alliance. I then go onto look at how these norms within the node of governance and regulation were projected by the pro and anti-HPC camps to impact on the nodes of education and training, provision and distribution, and delivery. The next two diagrams show the contrasting interpretations of the likely impact of the HPC plans on the field.

Diagram showing the HPC's self-interpretation of its projected model of regulation for the talking therapies

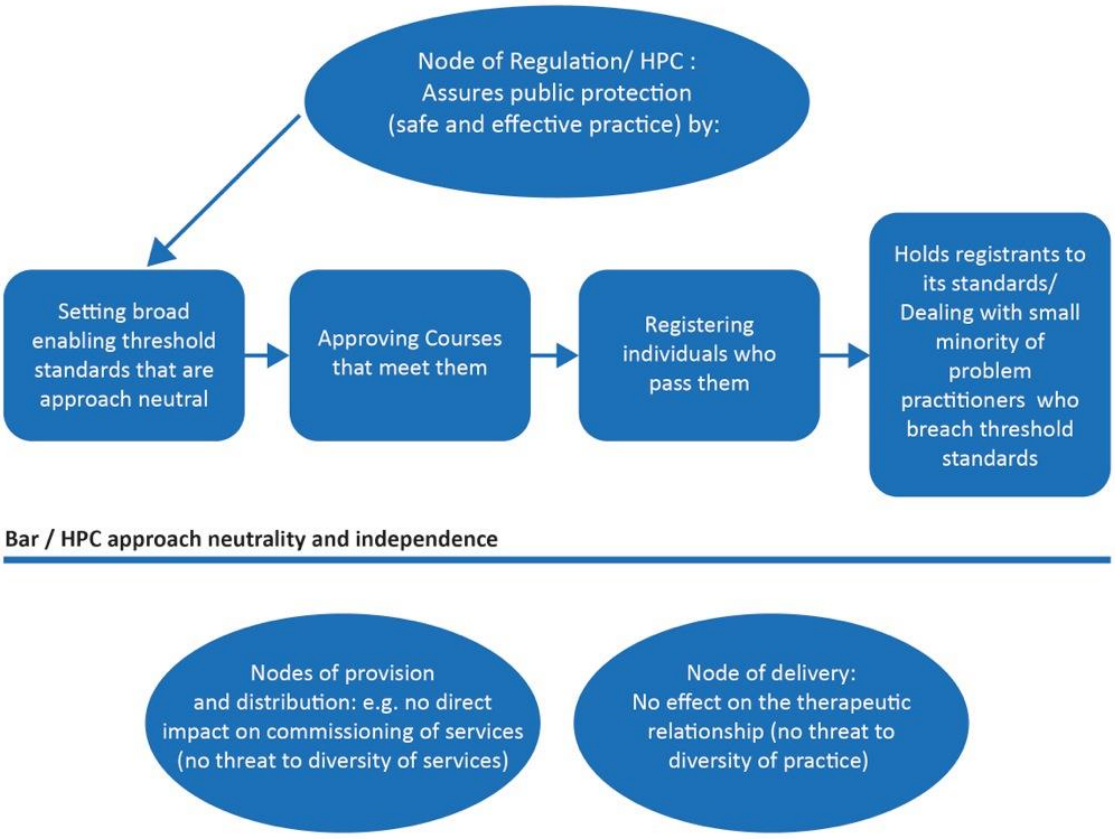
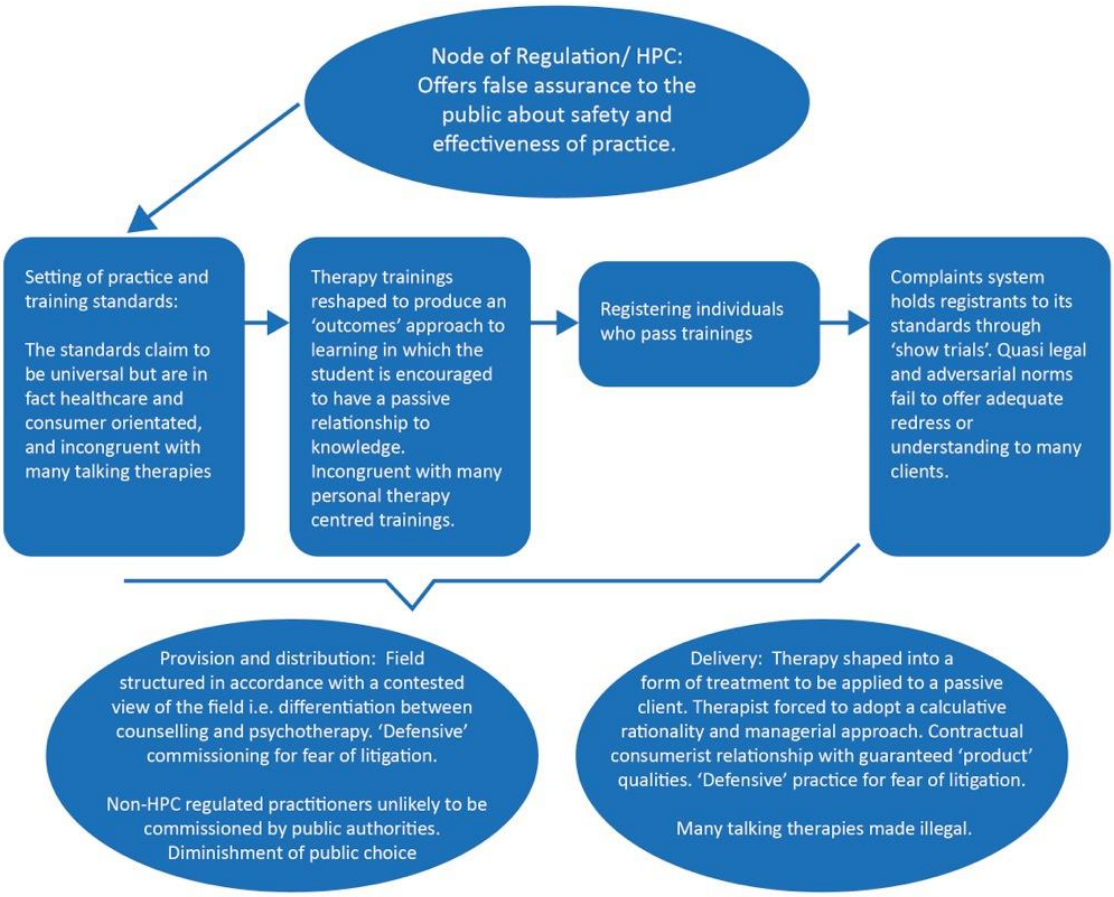


Diagram showing key features of the anti-HPC camp's characterisation of the HPC plans



The node of governance and regulation

I distinguish between three key facets of the HPC's node of governance and regulation: (i) The HPC's broad norms and criteria governing collective acceptance of a profession to its regulatory ranks. (ii) The HPC's standards approach, namely the establishment of generic standards (including generic education and training standards), and profession-specific standards. (iii) The HPC's fitness to practice hearing system i.e. its complaints system. I look at each in turn, and compare each to the Alliance's counter-policy, regulatory, and practice imaginary, which chiefly refers to the 'practitioner full disclosure system'.

Criteria of acceptance for new professions and overall aims of regulation: The two central and most controversial criteria of collective entry to the HPC is the requirement of a degree of homogeneity across a field, and the requirement that practice be 'subject to research into its effectiveness' (Health Professions Council, 2004:4). As we already know contention over whether or not the HPC's generic and profession specific standards of proficiency represented an already existing commonality/homogeneity across the field of the talking therapies, or in fact threatened to impose homogeneity on an otherwise deeply pluralistic field, goes to the heart of the struggle. I address this below. But let me first address the question of the HPC's general criteria regarding how professions should assess the effectiveness of their practice.

The HPC's guidance notes state that a profession must show evidence that it 'subscribes to the ethos of *evidence-based practice*, including being open to

'changing treatment strategies when *the* evidence is in favour of doing so' (my emphasis) (*ibid*:4). As we explored in Chapters Two and Four, the term 'evidence-based-practice' for many denotes the NICE-style prioritisation of evidence of the efficacy of treatments drawn from random or experimental controlled trials. The HPC contended that this was actually a misunderstanding. Michael Guthrie, for example, stated that 'in my experience it [the phrase evidence based practice] often means different things to different people. I know some people prefer "evidence informed" […] certainly within the organisation we don't take a positivist approach'.[80] The HPC took it to be a much more generic phrase, meaning 'evidence informed': that practice must be informed by evidence of 'some kind'. [81]Furthermore, Guthrie also emphasised that it is the profession, not the HPC, which determines what kind of evidence paradigm is used to assess the safety and effectiveness of practice, and pointed to the following statement within the notes on criteria for new professions: 'practice [should be] subject to research into its effectiveness. Suitable evidence would include publication in journals that are accepted as learned by the health sciences and/or social care communities' (*ibid*:4). This statement suggests that aspirant and member organisations have considerable autonomy in this matter. However, the guidance notes also state that an aspiring applicant profession should have 'an established scientific and measureable basis for measuring outcomes of their practice' (*ibid*:4). This statement is highly suggestive of a quantitative and 'population-based' approach to the question of effectiveness and

[80] Michael Guthrie (Director of Policy and Standards, HPC), interview by author, June 2014.
[81] Diane Waller (Chair of the HPC's Professional Liaison Group for Counsellors and Psychotherapists, interview by author, June 2014.

governance. The Alliance system in contrast is deeply pluralistic and does not require registrants to frame their practice in relation to proofs about its effectiveness, or even necessarily the concept of effectiveness altogether. House stated that the HPC standards assume that 'actual/phenomenological therapy experience/practice is amenable to nomothetic research findings, which many anti-positivistic practitioners and authorities completely refute' (House, 2009:112). Many talking therapies eschew science and outcomes based approach and is contra the 'case study' approach and what might be referred to as the 'practice based evidence' tradition within many of the more professionalised talking therapies, in which there is a tendency towards an ideographic approach, and much caution as regards constructing generalisations (more on this below). Furthermore, the statement on evidence based practice cited above – that a profession must be 'open to changing treatment strategies when *the* evidence is in favour of doing so' (emphasis added) - implies that evidence only ever points in one direction. This is indeed suggestive of a singular epistemological plain, rather than suggestive of recognition on the part of the HPC that there are different paradigms of evidence, or different 'evaluative perspectives'. Furthermore, many forms of talking therapy eschew the concept of 'treatment', or, in the case of psychoanalysis, at times, even the concept of therapy. For example the Maresfield Report claims that the 'symptoms may disappear during therapy, but this is not the cardinal goal. Rather, therapy involves an exploration of human life, a journey (Arbours Association et al, 2009:15-16). To recall from Chapter Four, Lacanian psychoanalysis, for example, tends to regard

psychoanalysis as a science of the unconscious, requiring no further justification (Turkle, 1979).

Guthrie's claim that professions chose their own method of assessing the effectiveness of their practice also seems incongruent with a very general characteristic and aim of HPC regulation. That is its aim to strongly assure the public of the safety and effectiveness of practice, which necessarily entails that the HPC at least tacitly endorse how a profession assesses the effectiveness and safety of practice. In fact the Health Professions Order, which forms of the legal bedrock of the HPC, seems to state that the HPC is legally required to do so:

> In accordance with the provisions of this Order the [HPC] Council shall establish and maintain a register of members of the relevant professions. (2) *The Council* shall from time to time [..] establish the standards of proficiency necessary to be admitted to the different parts of the register being the standards *it* considers necessary for safe and effective practice under that part of the register' [italics added] (Health Professions Order, 2001:5).

In contrast the projected Alliance regulatory system makes no claims about the effectiveness or safety of the practice or practices of its registrants. Rather registrants must disclose and describe their approach. The practice itself is not assessed or endorsed by the register. I explore the reasons for this below. Another 'architectural' difference between the approaches is that whilst the HPC system is regulation by 'title', the practitioner full disclosure list system is by 'function'. This simply means that, in the case of the HPC, only those that wish to call themselves by legally protected titles – to be decided through the work of the Professional Liaison Group – fall within the auspices of the regulation. It remains the case that anybody can practice any form of therapy under non-protected titles. In contrast, within the the Alliance system,

anybody that practices talking therapy, regardless of what title they use, must legally register. The HPC system therefore tends to create a sharp frontier between the 'safe and effective' HPC registrant, and the non-HPC registrant.

In summary so far, we can say that from the HPC's own criteria of acceptance for new professions there is considerable incongruence between the HPC regime and the conceptual outlook of many talking therapies.[82] The overall aim of regulation within the HPC plans is to offer strong assurance as regards the safety and effectiveness of registrants and their practice. In contrast, the Alliance proposal offers no such assurance: in the practitioner full disclosure list system there is a tendency to highlight the inherent risks and unpredictability of talking therapy (more on this below) and, rather than provide assurance, the system seeks to provide information and aims to educate and engage with the public (Arbours Association et al, 2009). Let me now move from the broader architecture and processes of the HPC to the more specific regulatory features planned for the field.

The standards approach: The 'standards approach' is at the centre of HPC regulation and, as noted above, is the establishment of universal threshold standards and their enforcement, largely through the fitness to practice system. As noted within Chapter Five the multiple-professional regulator arguably marks a shift towards greater generic regulatory expertise, as distinct from specialist regulatory expertise. Each profession within the HPC must adhere to these common standards. There is therefore, prior to any

specific content, so to speak, a significant amount of 'power sharing' with other professions and the HPC as regards the definition of the basic 'building block' standards of proficiency. Profession-specific standards must be consistent with the generic standards and consequently there is a degree of hierarchy. In contrast the projected Alliance system, to reiterate, does not embody any specific standards of practice, but rather a broad code of ethics, namely regarding financial, sexual exploitation and abuse (Arbours Association et al, 2009). In not setting any standards of practice, the full disclosure list system is deeply pluralistic and inclusive: a broad code of ethics can, it is claimed, apply across this pluralism so to speak. Darian Leader for instance stated: there is 'no reason why you can't have the same regulation for all the therapies, you just need to think very carefully about what that regulation will consist of. And I think the main things which are - sexual and financial exploitation are covered by nearly, I think all, the codes currently in existence'. [83] In contrast the HPC's standards, in keeping with the HPC's admittance criteria considered above - namely the requirement of considerable 'homogeneity' across the field and the requirement of a scientific way of measuring efficacy and outcomes of practice – tend to embody healthcare and consumer norms in the way it conceptualises talking therapy practice, as well as within the norms to enforce these norms. I focus on the issue of enforcement/governance now, and the conceptualisation of practice below.

[83] Darian Leader (Lacanian Psychoanalyst, founding member of the Alliance, and member of the College of Psychoanalysts), interview by author,

Many of the generic standards seemed to suggest that practitioners should be assessed against both a consumer ethos and an 'outcomes' model. That is to say the standards seemed to demand that a practitioner be able to self-impose, or shape their practice in accordance with a consumer and outcomes framework. For example, one HPC generic standard states that a practitioner must 'be able to evaluate intervention plans using recognised outcome measures' (Health Professions Council, 2010:11). Another suggested that a practitioner must be able to use audit practices in order to help ensure that practice is of a certain quality and that it achieves particular outcomes: a practitioner must 'be aware of the role of audit and review in quality management, including quality control, quality assurance and the use of appropriate outcome measures' (*ibid*:9). Similarly, a practitioner must 'understand the principles of quality control and quality assurance' (*ibid*:9). Other standards implied a hierarchy, and that the required 'quality' of practice is handed down to the practitioner within a bureaucratic system of governance. For instance one standard stated that a practitioner must 'be able to keep accurate, legible records and all other information in accordance with applicable legislation, protocols and guidelines' (*ibid*:8). Another standard stated that a practitioner must be able to 'understand the need to use only accepted terminology in making records' (*ibid*:8). Another standard would not be out of place within a text extolling the virtues of an approach to management: a practitioner must 'be able to maintain an effective audit trail and work towards continual improvement' (*ibid*:9). Overall these standards are suggestive of a consumer model in which practice is seen as a quality 'product' with clearly delineated and assured 'input' and 'outcomes'. This

dovetails with a heightened calculative rationality, in which the patient or client tends to be presupposed to be an object to be acted upon. These are, to recall from Chapter Five, rather characteristic of the consolidation and deepening of the restratification of the healthcare professions began in the late 1980s and 1990s, encompassing increased hierarchy between a regulatory, managerial, and research elite on the one hand, and 'rank and file' practitioners on the other. In contrast the Alliance tends to emphasise that the authority concerning the character and evaluation of practice resides with both the client and the practitioner. Both The Maresfield Report (Arbours Association et al, 2009) and Postle and House (2009) contended that the aim of many talking therapies is to provide a space free from dominant societal norms, and to free clients of irrational social authorities. In his address to the Alliance conference Andrew Samuels spoke of the 'third party' that is always within therapy – whether that be society, culture, the regulator, the professional association, the family. The HPC as *the* potential third party evoked much anxiety (Samuels, 2009a). The Maresfield Report expressed that 'many therapies today do not accept the basic concepts of mental health, of wellbeing, of normality, or even of expertise. These concepts, they argue, are part of a market based vision of human life, and not the spiritual, ethical journey of a therapy' (Arbours Association, 2009:18). A similar critique of a tendency to assume continuous progression is found in a response to the HPC Standard of Proficiency that practitioners must be able to 'understand both the need to keep skills and knowledge up to date and the importance of career long learning'.[84] The Maresfield Report contended that for many

schools of therapy it is important to engage robustly with the 'limits' of human knowledge, and recognise the 'vanity' of human knowledge (2009:25) and linked the notion of continuous professional development with a 'market'/consumer orientated ideological vision of life in which the self can be continually 'bettered' through acquisition of new skills and knowledge (seen as packaged into 'products'). [85] Members of the Alliance tended to highlight more processual and 'horizontal', rather than hierarchical, forms of governance. For example the Independent Practitioners Network advocates that talking therapists voluntarily scrutinize and vouch for each other's practices within a community and network of groups of practitioners (House, 2009b).

The fitness to practice hearing/complaints system: Another important facet of the node of regulation and governance is of course the fitness to practice/complaints system. The HPC system is strongly marked by quasi-legal and adversarial norms, to a significant extent mirroring the procedures, structure and culture of a law court. Articulated with a set of threshold standards of practice the HPC system seems intended to provide a clear cut way of dealing with breaches of its standards, whilst the Alliance, in contrast, advocated a system in which the norm of mediation predominates. The HPC system, given the establishment of fixed threshold of standards could be said

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[85] The Maresfield Report does not use the term, but essentially seems to be saying that the HPC regime (imbricated with a transactional-style sense of mastery, coupled with a consumerist ethos) tends to fail to facilitate what Joel Whitebook (1996) refers to as the political problem of fundamental human narcissism that any political system, culture or society, needs to address. Rather the HPC tends to fuel narcissism. In short the suggestion seems to be that the HPC regime tends to foster excess belief in the capacity of trainees, practitioners, and clients to 'master' whatever is the object of their concern.

to be quite transactional in so far as the process is seen as simply a matter of assessing whether the registrant has breached the standards or not i.e. whether or not they have broken the contract. In contrast we could say that the Alliance proposal is more processual in character, as mediation between the practitioner and client occurs without any fixed or precise notions – barring the broad code of ethics – about what the therapeutic relationship or the practice should be like. A key consequence of the transactionality of the HPC system is that a formal complaint, once made by a client or patient, is then either dismissed or goes to hearing, and, if a complaint goes to hearing, the findings then tend to be given in a binary guilty/not guilty style. The complaints process is held in public, thereby embodying the norm of transparency (Arbours Association, 2009:9). Proponents of the HPC plans claimed that this process would help address the problem of complainants feeling pressured within the process of mediation, which, managed entirely by the profession, tends often to be marked by practitioners 'closing ranks' and protecting each other from being held accountable for breaches of standards and codes of ethics.[86] They argue that the concept and phenomenon of transference from the client to practitioner – where, for example, the practitioner may come to represent to the client an abusive partner – is often used disingenuously to dismiss cases where there are *real* grounds for complaint. Malcolm Allen, for example stated that: 'all psychotherapeutic organisations have a natural tendency to pathologise complaints: that's what they do'.[87] The Alliance on the other hand tended to highlight a different set of

[86] Michael Guthrie (Director of Policy and Standards, HPC), interview by author, June 2014.

[87] Malcolm Allen (Chief Executive Officer of the BPC), interview by author, October 2014.

dilemmas; for example they point to the problem that the majority of complaints made to the HPC are dismissed at the first stage. In contrast the proposed Alliance system seeks to engage all complainants, emphasising the norm of mediation in relation to the phenomenon of transference in the early stages of a complaint, unless that complaint relates to serious misconduct that breaches the law. This ideally means that all complaints are explored in some detail and. in this sense the Alliance proposal (at least at an abstract level) tends to embody a stronger form of pluralism and focus on client experience. That is to say a client's complaint is purportedly explored seriously regardless of its status vis a vis any external set of standards. Contra the HPC's take on transparency the Alliance advocated some privacy within the individual complaints process in order to protect both clients and practitioners. The HPC system, the Maresfield Report contended, 'risks alienating potential complainants who do not wish to enter into such formal procedures, held in public with none of the confidentiality that a hearing may require' (Arbours Association, 2009:9). As regards practitioners in relation to the HPC style fitness to practice hearing system, Darian Leader, for example, stated that: 'the human costs [..] the tragic breaking of lives that [the HPC] investigations can involve; even if the person is exonerated, it's difficult for a human being to recover from that'.[88] Another fixed element of the HPC regulation is the standards of education and training which apply to all professions under the regulatory umbrella. Let us briefly look at this.

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[88] Darian Leader (Lacanian psychoanalyst, Alliance co-founder), interview by author, June 2014.

The node of education and training

The training standards tend similarly to be marked by a norm of transactionality. There is a focus upon trainees acquiring a preordained set of skills and competencies which they can then go on to 'apply' in their practice. Learning tends to be seen as linear. In contrast the Alliance tends to emphasise the processual and non-linear qualities of learning. Learning spaces, whether training schools, or the more informal/community based spaces preferred by, for example, the Independent Practitioners Network, tend to be seen as sites of contestation – where 'received wisdom' is subject to critique. In the HPC's standards of education and training there is a sense that knowledge is handed down as 'received wisdom' to trainees, its validity secured elsewhere. Parker (2010) for example argues that:

> Training is reduced to the logic of compliance to a programme of study. This problem is manifest in the attempt to ensure good practice in training by monitoring attendance at courses. What is important is that the trainee is *seen* to learn, not that they actually learn anything at all. This buys into the worst models of education that are now increasingly rife in the university sector in the UK in which 'learning outcomes' take the place of independent thinking by the student (Parker, 2010:33).

Within the HPC system knowledge is seen as something 'packaged', and to be uncritically absorbed, and there is an emphasis upon 'outcomes': what students learn should be predicted in advance, and there should be audit practices to assess and evidence that they have done so. The Maresfield Report also emphasised that many training schools, in contrast to the more transactional educational and learning imaginary, are centred around the 'personal therapy based paradigm' in which exploration of unconscious, rather than conscious, knowledge is the primary focus. The report states that

many trainings are centred around personal therapy, and the notion of 'unconscious knowledge' and profound personal change: 'it is not about acquiring skills and knowledge, but rather about losing them, to open oneself up to another human being' (Arbours Association et al, 2009:54).[89] [90] Furthermore, it states:

> For many schools, there can be no linear path through a training, and since one's own therapy is the central component of training, results can never be predicted in advance and, indeed, no standardised feedback can be given' (*ibid*:24)

Contrary to an emphasis on predicted 'outcomes', in which a goal is strongly fixed from the outset, some therapy trainings emphasise that they may not wish to finish their training or become analysts at the end. The HPC's education and training standards make, as Parker notes, 'no acknowledgment that the learning process might include learning that one does not want to be an analytic practitioner or any kind of psychotherapist for that matter' **(**Parker, 2010:33).

Let us now look at how these characteristics of the node of regulation and governance of the HPC were projected to impact, and would likely to have impacted, the node of provision and distribution.

Node of provision and distribution

To recall from Chapter Three, the node of provision and distribution concerns the norms which structure the field, including the shaping of commissioning practices, what treatments are provided and in what circumstances. There were two pronounced frontiers within the policy dispute in relation to the node of provision and distribution: the first was between the Alliance and the HPC, as per the other nodes, and, a more pronounced one – a fault line - within the Professional Liaison Group in relation to how the plans would impact the node of provision and distribution. The latter pertained largely to the structure of the register and the planned differentiation between counselling and psychotherapy within protected titles and the profession specific standards. I look at each briefly in turn.

A key concern for the Alliance was that an overwhelming number of the generic standards tend to assume that talking therapy is provided and distributed by health and social care organisations. Just to cite three: the 3a.3 standard referred to the ability to 'establish safe environments for practice […] including the use of hazard control and particularly infection control' (Health Professions Council, 2009c). One sub-heading of a set of standards was entitled 'identification and assessment of health and social care needs', and another, 'the formulation and delivery of plans and strategies for meeting health and social care needs' (*ibid*). The standards unsurprisingly contained ones that are consistent with the key rationale for the establishment of multi-professional regulators, as explored in Chapter Five, to assist multi-professional team working within the NHS: Standard 1b.2 stated that a

practitioner must ‘to be able to contribute effectively to work undertaken as part of a multi-disciplinary team’ (Health Professions Council, 2009c). The contention of the Alliance was not only that these were not relevant to many talking therapies, but that both the generic and profession-specific standards, orientated towards healthcare and consumer norms, would render many forms of talking therapy illegal and therefore radically diminish public choice. The Maresfield Report for example stated that:

> By marginalizing and even making illegal those forms of therapy which follow a different model, HPC regulation would deprive the public of their free choice of which therapists to consult (Arbours Association et al, 2009:9).

So whilst the HPC regime can be said to strongly delimit public choice by the technical practice of measuring the ‘efficacy of practice’, the Alliance tended to argue for a deeper public choice. In my view it is reasonable to surmise that the HPC plans if implemented may well have diminished the provision and distribution of ‘non-outcome’ based therapies within the NHS. It is rather less credible to suggest that the plans would have rendered certain forms of talking therapy illegal as the HPC plans were for regulation by title only, so anybody would be able to practice any form of talking therapy they wished, so long as they did not use any legally protected title. Being banned from using a tittle, or being excluded from employment within public services, though possibly negatively impacting, is substantively different from a legal or ‘totalitarian’ ban on the right to practice a form of talking therapy as such.

Let us now look at the *profession-specific* standards in relation to the node of provision and distribution.

The professional liaison group's deep split on the issue of differentiation between counselling and psychotherapy predominantly reflected concerns about how the nodes of provision and distribution would be impacted. It seems reasonable to surmise that the BACP wanted the structure of the register to keep the 'market' open and non-differentiated: that is to say once an individual is over an initial universal entry level hurdle into the field, the BACP wanted the internal/closed market to be equally open to both counsellors and psychotherapists. The UKCP, BABCP and BPC, on the other hand, wanted a formally more differentiated 'market'. Concerns of the latter grouping were focussed on differences in training standards set by them and those of the BACP.[91] Contra BACP wishes, successive drafts of profession specific standards of practice broadly differentiated between counselling and psychotherapy on the basis of level of client needs, essentially between more 'common' and more 'severe' mental health difficulties. In the second draft (May 2009), for example, within the standards for counselling only, there was the statement that counsellors: 'must understand and work with *common life problems'* (emphasis added), and with 'common mental health problems' (Health Professions Council, 2009c). Counsellors must be able to 'recognise and, where appropriate, refer clients with severe disturbances' (*ibid*). As regards the specific standards for psychotherapists the same draft stipulated that psychotherapists should not only be able to recognise but also work with

[91] Fiona Ballantine Dykes (Counselling Central Awarding Body, and member of the HPC Professional Liaison Group for Counsellors and Psychotherapists), interview by author, June 2015.

'severe mental disturbances in clients' (*Ibid*) [92] The profession specific standards embodied what I refer to as 'pluralism-lite': that is, the field was projected to be structured by a distinction between counselling and psychotherapy where the former is aimed at life problems, and psychotherapy at more serious mental health difficulties. It is pluralistic is the sense that the HPC plans envisaged the provision of different forms of therapy – counselling and psychotherapy – for different levels or types of client need. It is 'lite' in the sense that it does seek to 'ratify' and institutionalise, through regulation, a contested view of the structure of the field, as well as a contested view of the character of talking therapy, especially relating to the concept of 'mental health' and 'illness' (more on this below). In contrast the full practitioner disclosure system makes no assumptions about the structure of the field: the system itself does not take a view on how the field should be structured, or a view on any of the arguments over the definition or character of different forms of talking therapy. We can therefore say that it can encompass a 'deep pluralism'. It does not, however, force pluralism on the field: hypothetically if all practitioners within the field were of one modality of therapy then the register would simply reflect this.

Let me now look more specifically at how the healthcare and consumer/market orientated standards of practice were projected to shape

[92] The third draft (which went out for the July-October 2009 field consultation) in essence encapsulated the same differentiation, with some modification of language used. The fact that this was articulated with a differential entry level (level five for counselling and seven for psychotherapy) reinforced the sense the hierarchical relation between the two. For the BACP this did not accurately reflect existing structure of the field (many counselling training courses being at postgraduate level for example).

the node of delivery, or, to put this slightly differently, what did the standards of practice presuppose about the practitioner-client relationship?

The node of delivery

The tendency towards a hierarchy within the nodes of governance and regulation and within education and training between standards and research on the one hand, and the practitioner on the other, tends to be reproduced in how the node of delivery and the relationship between the practitioner and the client is tacitly conceptualised. That is to say the client is tacitly characterised, to a significant extent, as in passive receipt of the expertise of the practitioner, just as the practitioner is seen to be in passive receipt of standards of practice determined by a research and regulatory elite within the field. The field is not regarded as closed to innovation, but the innovation tends to be viewed as located within research activity as a sharply separate activity from practice. In short expertise is broadly framed as something that is 'applied to' or 'done to' a client. The client, however, does tend also to be constructed as an active consumer in so far as the practitioner-client relationship is tacitly characterised in terms of a consumer contract, whereby the client or patient should be clear about what outcomes are likely to be achieved. To recall from above, the stipulation that an aspirant profession should deploy a quantitative/scientific means of measuring outcomes is suggestive of the expectation that clients, or at least commissioners of the treatments, should be told with some accuracy what the outcome of their 'treatments' is likely to be.

In contrast the Alliance tends to emphasise a more contextual and relational view of practice where therapy is seen as a function of the relationship rather than something that is applied. The Maresfield Report (Arbours Association et al, 2009) stated for example that the draft standards of proficiency:

> Suggest time and time again the image of a patient as an object being described, assessed, evaluated and acted on by a team of experts. This view completely ignores the central feature of psychotherapy: the fact that it involves a relationship between two parties, and that the main work of the therapy is conducted not by the therapist but by the patient (2009:48).

Given that expertise is not seen as something pre-packaged and 'applied', but as 'co-created' anew in each new and unique context, it cannot be predicted with certainty what the outcome will be. In a sense practice is seen to be a form of research and experiment in process. Rather like Healy's (2013) call that medicines should be respected as poisons, and therefore as encompassing an inherent danger, many Alliance members emphasised that therapy involves inherent risks and has uncertain outcomes. The Alliance imaginary encompasses in effect a much softer demarcation between the node of governance and regulation and the node of delivery. Knowledge, expertise, insight are seen as being contextually created within the therapeutic relationship, and the character and the 'standards of practice', so to speak, therefore tend to be seen as being shaped from the *ground up,* rather than shaped by norms of practice entirely handed-down by the regulator, researchers, or by training schools. In short the therapy itself tends to be seen as a form of research and the client is often construed as the primary agent in the research process. The Alliance contention is essentially that it is only through a refusal to allow a 'third party' to stipulate or definitively fix the character of the therapy that this is rendered possible.

Whilst the Alliance tended to either want, or were willing to concede, a deep pluralism within the nodes of governance and regulation, and provision and distribution, so as to achieve a more 'open' and 'free' therapeutic space, the primary focus within the Liaison Group seemed to be the potential impact of the node of governance and regulation, namely the issue of differentiation between counselling and psychotherapy, on the node of provision and distribution e.g. what the plans may have meant for access to jobs in the NHS. The UKCP for example tended to eschew medical conceptualisations of psychotherapy, yet it seemed more concerned to create regulatory differentiation between counselling and psychotherapy than it was about avoiding medical conceptualisations of psychotherapy. Malcolm Allen stated that the UKCP representative within the Liaison Group:

> As much as anybody argued for as much elimination of medical concepts as was possible. Equally, she also had to have in mind, if we had in mind something that was too indistinguishable from counselling she would have lost the argument she was much more passionate about, that there was still a distinction between psychotherapy and counselling [93]

It is noteworthy therefore that it was people within the field itself – around the Liaison Group table – which further pushed the HPC plans to a deeper healthcare/medical conceptualisation psychotherapy practice. At one level this affirms that it would be overly simplistic to say that the HPC was an entirely external 'imperialistic' power imposing a healthcare model on the field. However, having said that, it is also suggestive of the potentially deep impact of the general temper of HPC-style plans, namely in the sense that the HPC plans seemed to drive a key professional association within the field –

[93] Malcolm Allen (Chief Executive Officer of the BPC), interview by author, October 2014. See appendix A transcript p. 454.

the UKCP - towards cementing in regulation a psychiatric/medical conceptualisation of psychotherapy, with which they were significantly uncomfortable.

From this analysis of HPC documentary material, and drawing on Alliance critiques, the Alliance claims that the HPC plans were a threat to the diversity of the field seem credible. The HPC plans were set to be a significant reshaping intervention within the field. The competing characterisations of the plans, and their likely impact, were part and parcel of the political and rhetorical efforts of the pro and anti-HPC camps to install and derail the HPC plans respectively. Let us now focus on the 'political logics' during this period of the struggle.

POLITICAL AND RHETORICAL STRATEGIES

Let us start with an examination of the key political dynamics of the pro and anti-HPC responses to the announcement of the HPC plans in the 2007 White Paper (Department of Health, 2007a). It will be useful to structure this in broad accordance with the chronology of the history of the struggle during this period. First I focus on the broad strategies and actions which established the key 'frontiers' of the struggle, including bald forms of 'agenda' and 'remit' setting. I then go onto to look closely at how the pro and anti-HPC camps sought to 'hegemonise' the plans, and how their respective narrative accounts of the ensuing policy dispute provided the 'glue' for their policy aims.

Early responses to the White Paper announcement: setting the agenda

To recall from Chapter Five the Department of Health had to a significant extent side-stepped any detailed policy engagement with concerns expressed across the field about the fundamentals of the projected HPC regulation of counselling and psychotherapy. The HPC in effect continued this through its focus on what Michael Guthrie referred to as the 'nuts and bolts' of the HPC plans.[94] The Department of Health's response to the Psychological Professions Council proposal in July 2007 (Department of Health, 2007c) did not address some of the concerns specific to the counselling and psychotherapy that had been expressed to an extent previously, and which was certainly expressed afterwards. The 'nuts and bolts' strategy was established through and within the 'Call for Ideas' (Health Professions Council, 2008a) and the 'road map' to regulation (Health Professions Council, 2007). Many responses to the call for ideas did not stick to the parameters of the questions and expressed concerns about the fundamentals of the regulation: Musgrave (2008) and The College of Psychoanalysts (2008d) for example expressed concerns about a fundamental lack of congruence between the HPC and many talking therapies. The HPC in its document responding to submissions to the consultation acknowledged that many within the field opposed the HPC plans (as had the Foster review document response to submissions to it) and the HPC consultation process was in this respect transparent and open, as promised within the 'road map' document

[94] Michael Guthrie (Director of Policy and Standards, HPC), interview by author, June 2014.

(Health Professions Council, 2007). But the HPC simultaneously tended to occlude the very points of view it relayed. This was largely done through its tendency towards 'parrot listening', by which I mean the tendency to simply summarise responses to the consultation, rather than provide an analysis of the material, or attempt to integrate the various demands with indications of possible compromises. So opposition comments were 'aired', but the lack of substantive engagement gave the HPC response a rather tokenistic flavour, as if to formally satisfy the requirement to consult, yet give the points made by members of the field no traction or role within the development of the HPC's own thinking. For example the HPC summary of responses to its Call for Ideas (Health Professions Council: 2008c) in effect noted concerns essentially expressing that the HPC plans would make the node of governance and provision incompatible with the field i.e. it would reshape the nodes of provision and distribution, and delivery in accordance with healthcare and consumer norms. But it did not analytically engage with these concerns, but rather tended simply to make general assertions about it being diverse friendly (more on this below). The HPC's 'road map' (Health Professions Council, 2007) document already included a hint of the 'problem minority' narrative to come in implying that those opposed to the HPC plans must either be unethical, or incompetent, and therefore be attempting to avoid accountability. The 'road map' states:

> There might be a small but vocal minority of individuals and organisations who may want to avoid statutory regulation for a variety of reasons. They include: Unable to meet competence standards […] Their application would be rejected due to inability to meet ethical standards, for example a previous conviction or a determination by a statutory or non-statutory regulator (*ibid*:3).

Other reasons given also tend to connote self-interested motivations, such as 'reluctance to pay the registration fees' and concerns about the 'future financial viability of education and training programmes' (*ibid*:3) The only statement within the HPC's 'road map' which arguably relays more principled reasons for opposition to the HPC plans is that opponents may be 'opposed to the concept of statutory regulation' (*ibid*:3). The latter, however, equates opposition to the HPC plans with opposition to statutory regulation as such, thereby making opponents seem like a smaller group at the margins of opinion within the field. The HPC's list of reasons also occludes those objecting to the HPC plans on the grounds that the plans would likely impact negatively on client and public interests. The phrase 'opposed to the *concept* of statutory regulation' may also connote the view that opposition to HPC regulation is rather abstracted from the lived realities of the problems at hand within the field, and that the concerns expressed are *merely* intellectual or philosophical. These manoeuvres, including allusions to opponents as largely a 'problem minority' helped to shore up the 'nuts and bolts' strategy and the marginalisation of fundamental concerns about HPC regulation.

The 'nuts and bolts' strategy was reflected within the appointments to the professional liaison group: Diane Waller, the appointed Chair, perhaps unsurprisingly, was strongly pro-HPC regulation. No one that was appointed to the group was resolutely committed to opposing the plans. It was partially a narrative of 'political realism' permeated by an 'inevitability thesis' which shaped the turn-around of those professional associations and individuals

previously opposed to the plans**.** Fiona Ballantyne Dykes for example stated that:

> We would have preferred not to come under a regulated umbrella at all. I think we just thought that it was going to happen, and therefore we had to make the best of whatever it was that was put on the table in front of us (Fiona Ballantyne interview. [95]

James Antrican's preferred form of regulation was a 'licensing system', such as the full practitioner disclosure system, but he stated:

> Who were we going to push. The government had made up its mind. We had had meetings with MPs, with bureaucrats with everybody, and this had been going on for six years by this time. [laughs]. There's a time you have to say well we've lost the battle.[96]

There was however a considerable split between the leadership and a significant number of individual and organisational members within the UKCP, and the decision of the incumbent Chair, James Antrican, to allow a 'dissenting voice' section within its document response to the HPC's Call for Ideas (UKCP, 2008), was a compromise which allowed significant expression to opposition, but which simultaneously held the UKCP's official and lead line in favour of the HPC plans.

To return to the Professional Liaison Group, another crucial strategy used by the HPC to narrow the agenda still further was through the obfuscation of the liaison group's formal right, if it so wished, to recommend that HPC regulation of counselling and psychotherapy is not feasible. Diane Waller regarded this only as a theoretical possibility. In my interview with her she stated: 'it's possible, if there had been no agreement whatsoever on any commonality, then it would have been very hard to see how it [HPC regulation] could have

[95] Fiona Ballantine Dykes (Counselling Central Awarding Body, and member of the HPC Professional Liaison Group for Counsellors and Psychotherapists), interview by author, June 2015.
[96] James Antrican (Chair of UKCP 2007-2009), interview by author, October 2014.

happened, so in *theory*, yes, it was possible. "[97] However, it was Waller's actions which partially headed off a 'no' recommendation as a serious possibility. The decision of the HPC not to deploy its 'new professions process' – assessing aspirant and applicant professions against the HPC's broad admission criteria - was controversial among some members of the Liaison Group and when the issue was raised the meeting had become, reported Simona Revelli of the College of Psychoanalysts, who was sitting in the public gallery, 'visibly tense' (Low, 2008). When Brian Magee of COSCA (Counselling and Psychotherapy in Scotland) raised the issue of whether or not the Liaison Group was entitled to decide that the HPC plans were not in service user interests, Postle reported that Diane Waller gave a 'somewhat perfunctory response of "no, that's not what we're here for … we will have to manage difference' [ ] followed rapidly, much too rapidly by her announcement as chair that we would now break for lunch'. After lunch the question was not referred to again – Professor Fonagy was invited by the Chair to talk about SfH (2012:216). And despite the meeting having been scheduled to last until 3.30pm it was 'suddenly brought to a closure at 1.30' (Low, 2008). Opposition to the HPC plans had gathered a head of steam and as well as an organised intellectual force by the time of the Manchester Stakeholders meeting. This meeting was clearly a clash of agendas, the HPC seeking a 'nuts and bolts' agenda, and opponents seeking to address fundamental questions of 'whether and by whom'. The HPC's disseminative and hortatory approach (seeking to educate and assure its audience) failed to

[97] Diane Waller (Chair of the HPC's Professional Liaison Group for Counsellors and Psychotherapists, interview by author, June 2014.

persuade opponents of its position, and failed to 'smooth over' differences. Equally, opponents failed to persuade the HPC to change its stance. The HCP understood, quite reasonably in some ways in my view, its role as that of administrator of the Department of Health's instruction to implement HPC regulation of the field, and therefore did not see itself as being in a position to negotiate with opponents on the policy fundamentals (more on this in the next chapter) (Bircham Dyson Bell, 2009e). It was this incapacity, or unwillingness, of the HPC to consider the policy fundamentals that created the conditions of possibility for the emergence of the Alliance. So far I have focussed on some of the balder strategies of marginalisation and agenda setting in the policy process. Let us now look at how the pro and anti-HPC camps sought to build and legitimate their identities and aims. I start with the HPC and then move onto the HPC.

The Alliance: building cohesion within a disparate group

The Alliance was comprised of a diverse range of practitioners from a range of factions and approaches within the field. For example it included humanists as well as Lacanian and Jungian Psychoanalysts, and also a few CBT practitioners. [98] To recall from Chapter Four, Postle had described psychoanalysis as a different 'world-view' and as dominated by the medical model. Janet Low noted the humanist discomfort at the Lacanian use of the

[98] Darian Leader (Lacanian psychoanalyst, A

lliance co-founder), interview by author, June 2014.

terms ‘diagnosis’ and ‘subject’ (Low, 2008), yet the Alliance was able to unite, as Darian Leader put it, against the HPC as a ‘common enemy’. [99]

Differences within the group became de-emphasised, whilst similarities were emphasised. The HPC, along with SfH and IAPT, were seen as a ‘block’, or single frontier, and consequently the deep unpopularity of IAPT within much of the field (largely due, to recall from the last chapter, to its strong favour of CBT, and its healthcare and positivist orientation), and, to a lesser extent, SfH, carried over to the HPC, fostering a degree of guilt by association. As we have seen, the Alliance also critiqued the norms within the HPC regulatory system as healthcare orientated, and therefore as a threat to diversity within the field. Alliance members were broadly united around a ‘relational’, as opposed to a healthcare or transactional conceptualisation of talking therapy. In this respect the Alliance tended forward a position close to a talking therapy exceptionalism i.e. that talking therapies (or at least some forms) are fundamentally different to healthcare practices. That is to say that some talking therapies are totally incommensurable with healthcare practice (more on this in Chapter Eight). The Alliance conferences provided space which enabled the sharing of concerns and the facilitation of the development of conceptual arguments and ideologies against the HPC plans.

The Alliance also had the advantage that the alternative regulatory programme proposed, the practitioner full disclosure system, was deeply pluralistic and so capable of absorbing differences between practices within the Alliance and not ring alarm bells about the field being structured according

[99] Ibid.

to the view of any particular faction. [100] In other words the Alliance proposed system of regulation and governance did not make any presuppositions about other nodes of the field – training and education, provision and distribution, and delivery – other than that they may be mediated by a plurality of norms. The Alliance as a group was therefore more 'organic' than the pro-HPC camp. It is noteworthy, however, that there was not support for the practitioner full disclosure system across all of the factions within the field prior to the HPC struggle. Denis Postle, for example, claimed that psychoanalysts previously tended to be opposed to practitioner full disclosure on the grounds of disrupting the client transference onto the blank canvass, so to speak, of the analyst. [101] In a wider approach, Alliance members also tended to characterise this 'block' - the HPC, SfH, IAPT and NICE - as a metonymic aspect of the broader political regime of neo-liberalism, bureaucratisation, the regulatory state, and/or late modernism, and drew a frontier between this and talking therapies embodying a relational paradigm that offer an alternative space with alternative values e.g. open ended practice (Arbours Association et al, 2009), (Samuels, 2009b). Opposition broadly characterised the government as motivated by a desire to use psychological therapies as an instrument of social control. Some critics drew an equation between most of the talking therapies and the professions characterised as having already suffered from attacks from Thatcherism**.** Thorne (2009), for example, in his speech at the inaugural Alliance conference, claimed that teachers have flocked to the field of therapy, fed up with the inhospitable regulatory and

[100] Postle noted however surprise that the psychoan
alysts/Lacanians asccepted this given their tendency to want to not give anything away of themselves to clients and remain a 'blank canvass' upon which clients can project.
[101] Denis Postle (Alliance and IPN members, Humanistic counsellor and activist), interview by author, May 2015.

governance climate within teaching. In relation to university research the Lacanian Psychoanalyst, Janet Low, recounted at the Alliance conference:

> In the rest of my adult life I've been studying ethnographic research, sociology, and becoming quite skilled at hanging out watching what a tribe does and writing about it. It's the kind of research that has been squashed to death by the evidence based ideology that has been sweeping through the universities for at least the last ten years. And in fact I allowed it to squash me out of the universities in 2005, thinking well I'll settle down with the psychoanalytic group that I've been studying with for the last ten years; only to discover three minutes later that it was coming to get me there. So that's when I discovered that I couldn't run any further (Low, 2009).

To some extent the opposition drew a further frontier within the talking therapies between most of the field on the one hand and CBT and the Freudian tradition within psychoanalysis on the other, thereby characterising these to some extent as an *enemy within* the field of the talking therapies, put to work by malign political forces. For example, at times CBT seems to be ascribed this status by virtue of its intrinsic qualities – aimed at correcting 'faulty thinking' (Leader, 2007, 2008): Darian Leader within the Guardian, for instance, stated that:

> Cognitive therapy was perhaps used most widely in the Cultural Revolution in China, where people were taught that depression was just wrong thinking. Separated from their families, unable to contact loved ones, subject to cruel punishments and witness to the murder or "vanishing" of those closest to them, millions of people were "taught" to devalue their reactions. The world should be thought about in a different way, and happiness and enthusiasm replace despair and despondency. Positive thinking should banish unhelpful negative attitudes (Leader, 2008).

At other times CBT seems ascribed the 'enemy within' status based on a general tendency of the CBT community (namely through the BABCP) to uncritically accept the HPC plans, IAPT and SfH, and the tendency of the government to promote a flawed view of CBT as far more effective than any

other modality.[102] Motivations of professional self-interest, namely the pursuit of securing jobs, were ascribed to both the CBT and Freudian traditions. The BPC's support was seen as partially driven by support of Peter Fonagy's Mentalisation Based Therapy (Arbours Association et al), (Low, 2008); the Alliance effectively drawing a sharp demarcation between the public and professional interest, arguing that the latter diverged radically from the former in the instance of the BPC 'political grouping' (Arbours Association et al), (Low, 2008), (Thorne, 2009). Overall the Alliance in effect sought to identify the political and motives and meanings which lay behind the HPC plans and their supporters, and in so doing the Alliance challenged the 'inevitability thesis': the belief that there was no (viable) alternative. The Alliance foregrounded the politically contingent nature of the HPC plans by pointing towards the broader political contours and the 'ignoble origins' of the HPC plans. This helped galvanise and legitimate more concrete plans to resist the HPC plans. The exploration of legal avenues (see next chapter) gave succour to the contention that the HPC plans were not inevitable. The possibility of the HPC plans reaching the statute book was still perceived to be a likely eventuality however. The contingency plan of 'principles non-compliance' was therefore regarded as central to the Alliance strategy and was the focus of much of the Alliance's second conference.

Fantasmatic narrative with the Alliance discourses: Now let me briefly focus on the 'affective grip' of the Alliance discourses: to recall from Chapter Three, this concerns an examination of what underlying fantasies may furnish

[102] Denis Postle (Alliance and IPN members, Humanistic counsellor and activist), interview by author, May 2015.

the narrative with a strong affective appeal for subjects; essentially fantasmatic narratives which help quell the subject's anxiety about their constitutive 'lack', or emptiness, and the radical contingency of their identity and any social relation, formation or regime in which they are positioned (Glynos and Howarth, 2007). There are arguably two distinct but closely interrelated fantasmatic narratives which are discernibly at play within the Alliance discourses. The first relates to what I refer to as the 'totalitarian narrative' in which the HPC plans are characterised as an existential threat to talking therapies. The second relates to the tacit view that is arguably discernible within some Alliance discourses that talking therapies (or at least some modalities) transcends the discursive limits placed upon all other forms of communication. Let us look at each in turn.

In the 'totalitarian narrative' the HPC is posed as an overwhelming existential threat to therapies which provide an 'alternative space', and alternative values, from mainstream society. There is a 'David and Goliath' quality to the narrative in which the HPC is seen as a monstrous threat and obstacle to the marginal spaces and practices of freedom which the practitioner must heroically defend. As noted above, HPC regulation would have been by title, not function, and therefore any practitioner would have been be able to continue practicing as before (at least in private practice) under any title other than those legally protected. The Alliance's apparent 'raising of the stakes' – to an existential threat - seems likely to have helped galvanise interest in an area that most practitioners, as noted by James Antrican, have little active

interest in.[103] In short a fight for the very right of a particular type of practice – a particular kind of social relation – to legally exist is likely to be affectively much more rousing than a fight for the right to be properly 'heard' or recognised within the regulatory sphere. Whilst the impact of the former is clear cut, the latter is rather more nebulous. By way of analogy the perceived certain prospect of an individual drowning is much more likely to invoke resistance in them to entering the water than if there is the vaguer, and more open ended prospect that they may get into some or severe difficulties. This fantasmatic narrative was not always at play however. Andrew Samuels for instance within the second Alliance conference made it very clear that practitioners would be able to legally continue practicing in their talking therapy under non-protected titles (Samuels, 2009c).

The second element within this fantasmatic narrative is the tendency to allude to the view that talking therapies offer a position that is able to speak truth to power from a position entirely free from power. This is arguably tacit for example within the Maresfield Report's drawing of a sharp demarcation between talking therapy as social control, in the form of the hygiene movement on the one hand, and on the other hand, therapy as emancipatory practice. The Maresfield Report states, for instance, that:

> Psychotherapy has, for the last 100 years, offered the patient a system of values freed from the moral judgments of social authorities. This has indisputably been the central characteristic of psychotherapy and what set it aside from the mental hygiene movement and from techniques of social engineering. Therapy provides a space for challenging received wisdom, social imperatives and norms of all kinds (Arbours Association et al, 2009:12).

[103] James Antrican (Chair of UKCP 2007-2009), interview by author, October 2014.

This statement is indicative of the report's broader tendency to eclipse contentions made elsewhere (e.g Rose, 2003), (Parker, 2009) that all talking therapies and psychologies are forms of social control and socialisation, shaping the subjectivity of individual clients and broader populations. To eclipse this dimension is arguably to deny radical contingency and fails to address the problem that any talking therapy are built upon discursive ground: to recall from Chapter Three the normative parallax hypothesis, as Glynos (2014 puts it, 'affirms the idea that one's discursive position or identity shapes the way one understands and evaluates the world, including one's own interests', and that no particular discursive position or identity can be fully rationally grounded (185).

Let us now look more closely at the HPC's rhetorical strategies.

Pro-HPC camp strategies

A particular question I seek to address is the following one: if it is true that the HPC's claim to 'approach neutrality' quite starkly lacked credibility, how did this position muster considerable support? I argue that the HPC tended towards a 'narrowed down' hegemonic strategy, drawing a 'friend-enemy' relation between the majority of good practitioners on the one hand and a 'problem minority' on the other (a 'very small minority' as the HPC put it) (Health Professions Council, 2008b). The 'problem minority' was seen as the primary concern in relation to the motif of public protection. This 'problem minority' narrative was key in making the HPC's transactionality within the node of governance and regulation, and how this would likely have impacted

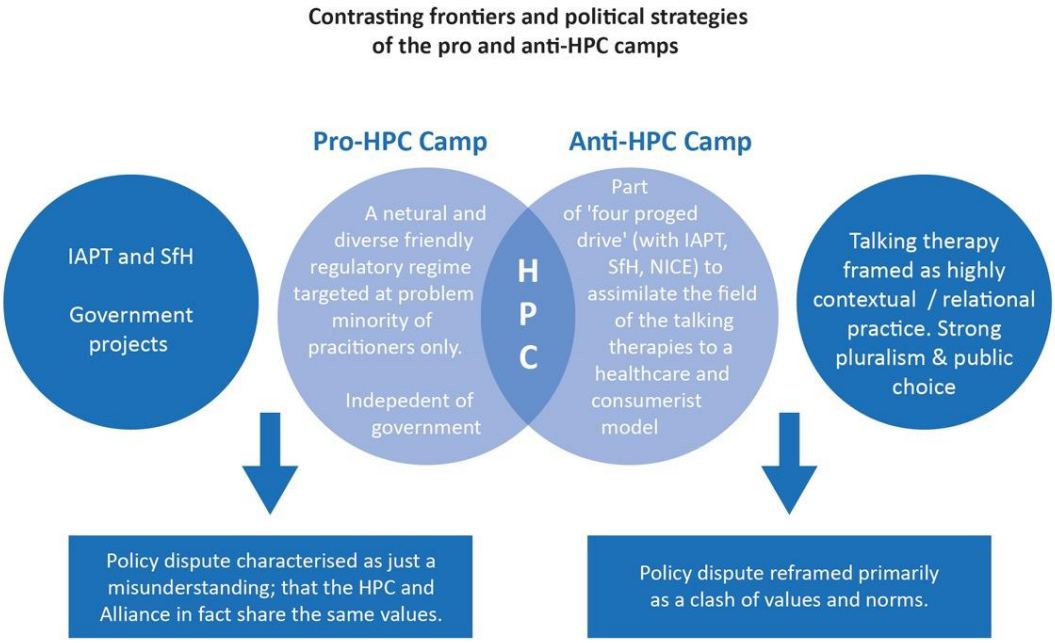
the nodes of education and training, provision and distribution, and delivery, less visible. This problem minority narrative supported, and was supported by, strategies that marginalised opposition voices from the main policy making arenas. [104] Simultaneously to the 'nuts and bolts' strategy, which excluded an examination of the policy fundamentals, the HPC also took the 'it is just a misunderstanding' stance, suggesting that the HPC and its opponents actually shared the same aims and values, only the opponent's had a false understanding of the plans (Health Professions Council, 2008b). This was coterminous with, and helped shore up, the HPC's claim to 'approach neutrality', as described above, namely that the regulation would not significantly impact other nodes of the field, such as particular forms of talking therapy not being provided and distributed, or the therapeutic relationship within the node of delivery being reshaped in accordance with healthcare norms. It also did this by distancing itself from IAPT, SfH and NICE; to challenge the 'resonance' across some of the field that the HPC was 'guilty', so to speak, by its association with these controversial projects.

One way that the HPC sought to achieve this disassociation was by emphasising its status as operationally independent from government, in contrast to IAPT and SfH's more dependent status. In short the HPC highlighted that neither the SfH nor IAPT, nor the Government, could direct it as regards the specificity of the standards of practice for counselling and

psychotherapy. I address the HPC's somewhat paradoxical claims about its independence in Chapters Seven and Eight.

Another way that the HPC protected its claim to 'approach neutrality', as I have phrased it, is through its non-engagement with the forensic critique of the standards of practice and of the overarching plans made by the Alliance (its 'parrot listening' as noted above for example). Such an engagement would still have been within the HPC's narrow remit of addressing the 'nuts and bolts' of the plans given that much of the Alliance's concerns were about the 'nuts and bolts' of the plans. There were moments when pressed in dialogue that the HPC seemed to avow the consumerist and healthcare values of the HPC standards. For example in late February 2009 a meeting was held between Darian Leader and Andrew Hodgkiss of the College of Psychoanalysts, and Diane Waller, Michael Guthrie, and Marc Seale of the HPC. During this meeting, Marc Seale, Chief Executive and Registrar of the HPC, reportedly, in response to the claim that many talking therapies are incompatible with a healthcare and consumerist framework, stated that 'if a practitioner receives money from a member of the public and does not offer a predictable healthcare outcome, they just shouldn't be allowed to practise' (College of Psychoanalysts, 2009a). However, the HPC did not expand on these comments, or seek to square them with what I have described as its overarching claim to approach neutrality. In other words the HPC did not seek to address broad inconsistencies in its own position.

As described above, the claim to ‘approach neutrality’ was most often articulated with the claim that the HPC would simply deal with a ‘problem minority’ of practitioners who did not meet what the HPC claimed to be universal minimum standards. This narrative, by definition, given my analysis above analysis of the character of the plans, played a significant role in ‘skewing’ (for some) the recognition and visibility of the transactional character of the HPC plans. So let us look at this in some detail.



The ‘problem minority’ narrative and the individualisation of risk

The ‘problem minority’ narrative along with the motif of public protection served to distract attention from the contested nature (both empirically and inherently) of the supposed universal threshold standards of practice. In other words the frontier between the ‘problem minority’ and the majority of safe practitioners turns the focus of attention on the inadequacies of individual practitioners rather than on difficulties in determining what is a ‘good enough’ approach to practice. In other words it helps shore up the HPC’s image of neutrality by dint of distraction. Furthermore this problem minority narrative seems to have a significant fantasmatic hue, furnishing the HPC plans with affective ‘grip’. The ‘problem minority’ tended to be neatly conflated at times with those vociferously opposed to the HPC plans, and there was a sense that to voice opposition or doubt about HPC regulation was morally and professionally beyond the pale (more on this in a moment). The claim to ‘approach neutrality’ not only (in effect) made the ‘transactional’ nature of the HPC plans less visible, and therefore less available for contestation, it also arguably had an affective appeal in the form of assurance. To recall again from Chapter Three, according to Laclau, drawing on Lacanian psychoanalysis, recognition of ‘radical contingency’ causes the individual considerable anxiety, and therefore often, in an ideological response, s/he seeks to cover this over by ‘imaginarising’ a full identity (Glynos and Howarth, 2007). The ‘imaginarisation’ of the HPC standards as genuinely universal - rather than imposed or ‘subsumptive’, or to put it less pejoratively, ‘reforming’ - helps quell anxiety about the radical contingency, and ultimately

‘indeterminate’ nature of ‘good enough’ practice. The ethical, in the Laclauian oeuvre, means that one must act with uncertainty about the ‘goodness’ of one’s actions, not least because one cannot be certain of the impact of one’s actions. Glynos for example states that ‘a deconstructive ethics of the political is one that privileges guilt, or at least a lingering doubt as to whether one has acted or decided in good conscience’ (Glynos, 2000). Let me reiterate and evidence these points further. My key argument here is that the HPC’s claim to universal threshold standards shields from view two things. First the de-facto pluralism within the field, i.e. the fact that there are lots of different schools of thought, often with mutually conflicting views on what counts as basic good practice, and therefore also what counts as unacceptable or bad practice. To use the terminology appropriated by the logics approach, this pluralism relates to the ‘ontic’ level - the everyday empirical variation in and competing ways of defining and delineating practice. Second, the HPC’s claim to universality and neutrality arguably also hides the radical contingency that goes to the heart of any practice or world-view – the radical relationality and instability of all forms of identity. To recall from Chapter Three this relates to the ‘ontological’ level of pluralism: the fundamental fact that talking therapy (like any social practice) is without essence and must be hegemonised empirically in a particular way out of a myriad of possible ones, and is necessarily done so in a fundamentally precarious and incomplete way. No empirical discourse can have the ‘final’ or ‘definitive say’ on the identity of a practice. To recall from Chapter Three, Glynos (2014b) states that the ‘normative parallax hypothesis affirms the idea that one’s discursive position or identity shapes the way one understands and evaluates the world,

including one's own interests' and that no discursive position or identity can be fully rationally grounded (185).The HCP's response to both this ontic and ontological pluralism and contingency was what we might call ideological-cum- fantasmatic. Rather than seeing the question of what counts as basic good and effective practice as a difficult and in many instances intractable problem that goes to the heart of the limitations of knowledge production, of claims to truth and (professional) practice, the HPC denies the inherent 'threat' - the inherent contingency and uncertainty - and instead tends to locate uncertainty-cum risk almost exclusively in a small minority of practitioners in the field unable to practise 'safely and effectively' according to a particular set of standards. In the fantasmatic narrative this minority becomes seen as something of an obstacle to an otherwise fully assured field of good and effective practitioners. They are constituted as the primary and pretty much essentially the only problem for a regulatory system. The HPC-registrant therefore takes on something of a 'beatific' or idealised hue. The 'problem minority' narrative is evident, for example, within Jonathan Coe's Guardian newspaper article where he states that 'while many practitioners and the major professional associations have welcomed regulation, seeing it as essential to protecting the public and weeding out unsuitable people, a group is organising to oppose these developments' (Coe, 2009). It is worth noting that Coe's comments subtly imply a link between the 'unsuitable people' and those opposed to the plans. In many comments made by pro-HPC supporters on the periphery of the campaign the fantasmatic hue becomes much stronger or evident. One online respondent, named 'Undercooked', to Coe's article, for example, characterised opposition to the

HPC plans as 'the arm waving rhetoric of the quack practitioners [….] genuine and constructive professionals will work to bring this level of regulation about sooner rather than later' (Coe, 2009). A few commentators made requests for a list of practitioners against the plans to be published. One, named 'Lizbeth', for example, wrote:

> All 2000 of them should have their names recorded so that unsuspecting clients can avoid them. They are the "creative" ones who think clients are playthings for the therapist's amusement (Coe, 2009).

As another commentator within the same online thread suggested these comments imply that those 'resisting the current regulation are resisting the notion of ethical practice and are somehow tainted, on the side of the abusers' (Musgrave, 2009c). The issue of good, effective and bad practice is tacitly construed as a simple matter and the HPC tacitly celebrated as a body that can save the client from professional self-interests. At times professional expertise as such, or the counselling and psychotherapy field collectively, tends to become situated as the obstacle in the fantasmatic narrative. For example one respondent replied to a post sympathetic to the Alliance:

> So come on then, how about a bit of public disclosure, if you're not a therapist what is your interest in these matters. Can't wait to be ohhhh soooo impressed by your professorships (Coe, 2009).

There is here a tendency to apply a public-interest model of analysis (e.g. like structural functionalism as explored in Chapter Two) to the HPC, whilst simultaneously applying a private-interest model of analysis to the Alliance. In these comments no consideration is given to the possible self-interests of the HPC (e.g. expansion of its jurisdiction, or the large increase in number of registrant fees to be gained, let alone possible broader links to interests within

the neo-liberal political settlement where, as Pilgrim (2008) suggests, mental suffering and growing differentials in wealth tend to be politically delinked, or indeed the possible self-interests of the main professional associations that supported statutory regulation such as increased prestige and increased market share of NHS contracts. Again, this uneven analysis was perhaps partially motivated and supported by a desire to quell anxiety about the uncertainty of what is good and bad practice, and, indeed, more widely, what is the 'good life', or a good political settlement.

The Alliance was dubbed by one respondent as the 'Alliance of self-interests' (Coe, 2009). No consideration in these comments is given to the Alliance arguments that the Alliance was seeking to defend ethical practice, to be against HPC regulation was regarded as proof enough of lack of ethical commitment. As Richard House responded within the thread, HPC proponents often engaged in 'ex cathedra gesture condemnation of people's position without any attempt to engage with the substance of the argument' (Coe, 2009)**.** This uneven application of scepticism tacitly positions the HPC as a 'beatific' element that transcends, through the exercise of reason and the identification and enforcement of universal standards, the 'muck' of politics which marks the (rest of the) terrain of institutions, organisations and practitioners. The anxiety regarding radical contingency, both ontic and ontological, can also perhaps be seen in the reply that Malcolm Allen donned to Postle's 'Vichy France' letter in which Allen mocks opponents to the HPC plans for drawing on a plurality of intellectual approaches and traditions in their critiques of the HPC plans. Allen wrote: 'in addition to neo-Foucauldian critiques of the state, appeals to chaos theory, and God knows what else,

they are now trying to don the mantle of the maquis' (Allen, 2008). Plurality here is cast as both a ridiculous and a dangerous obstacle to proper debate about the regulatory plans, rather than as a potentially enriching or essential aspect of such debate. But the 'problem minority' narrative coupled with marginalisation of opposition voices, were not enough to create what we might call an 'organic' unity within the HPC camp. As described earlier, the liaison group was deeply split on the issue of differentiation between counselling and psychotherapy, especially on its likely impact on the node of provision and distribution.

So finally, let me briefly examine the political dynamics within the Liaison Group. To emphasise again, this is significant because the fault line running through the liaison group was a major problem for the credibility and feasibility of the HPC plans, and would have been even had HPC proponents been able to wish away the Alliance.

Political dynamics within the Professional Liaison Group

SfH had been brought in to help overcome acrimony within the field, arguably supported and partially driven by a tacit Enlightenment style confidence in the capacity of the 'evidence based practice' movement (embodied, in the case of SfH within the UCL Health Psychology Department) to be above the political fray, as explored in Chapters Four and Five). The HPC were now, only a short time later, in retreat from its identification with SfH, amidst the latter's deep unpopularity. The HPC executive were making strong assertions

that it was diverse friendly and approach neutral, whilst simultaneously (and rather contradictorily) the HPC's own Liaison Group were locked within what many members within the group saw as a struggle over the shape and character of the field. A semblance of unity was created within the Liaison Group through the adoption of a 'working position', a rather euphemistic and arguably misleading phrase given that the BACP, by far the largest professional association within the field , fundamentally disagreed with it.

SUMMARY

In this chapter we have considered the responses to the announcement within the White Paper of plans to make the HPC statutory regulator of counselling and psychotherapy. Responses constituted two key frontiers. The first was between the HPC and the Alliance, encompassing a struggle over the 'totality' of the HPC plans. The second was within the HPC's Professional Liaison Group on the issue of differentiation between counselling and psychotherapy. As regards the character of the HPC plans I have argued, contra the HPC's claim to approach neutrality and diverse friendliness, that the HPC plans were set to significantly reshape the field. This conclusion is after having taken into account the significant misunderstanding as regards the phrase 'evidence based practice'. My contention is based on the following key grounds. First, a close reading of both the generic and profession-specific standards of proficiency and of the HPC's criteria of acceptance for applicant professions reveals a significant leaning towards an 'outcomes' and 'population-based' model of governance, regulation, provision, distribution

and delivery. This is contra the more ‘contextual’ orientated outlook of the Alliance, and contra the ‘deep pluralism’ of the proposed regulatory alternative of the ‘practitioner full disclosure list’ system’. But perhaps the most telling indication that the plans were set to reshape the field was the somewhat intractable struggle within the HPC’s own Professional Liaison Group over the issue of differentiation. Put simply not even HPC proponents around the liaison table believed the HPC plans were approach neutral or ‘light touch’. I have also drawn on critiques of the HPC’s complaints system, and an incongruity between Alliance and HPC key norms governing their visions of a complaints system, namely a more contextual versus a more transactional one respectively. Whilst the former is marked predominantly by mediation and understanding, the more transactional system is marked predominantly by quasi-legal norms and a leaning towards the framing of conflict between the client and practitioner through a binary of the guilt or innocence of the practitioner vis a vis a fixed set of standards of practice.

Exploration of the HPC’ assemblage of norms has revealed some tensions, and possible contradictions, between, on the one hand, the HPC’s rhetorical stance of providing strong assurance to the public about the safety and effectiveness of HPC registered practitioners, and the responsibilities of the HPC as outlined within the Health Professions Order – that the HPC itself must ensure the safety and effectiveness of practice - and, on the other hand, the HPC’s claims of approach neutrality, especially in relation to Waller and Guthrie’s claim that the professions choose their own methodology by which the safety and effectiveness of their practice is assessed.

Moving onto the more ethico-ideological dimension of my account of the struggle, I have identified a complex of bald strategies of marginalisation adopted by the HPC and its allies within the professional associations. The HPC adopted a strict 'nuts and bolts' agenda, excluding any robust consideration of the policy fundamentals - the so called 'whether and by whom' questions. This exclusion could be described as a key condition of possibility, or a key catalyst, for the emergence of the Alliance. I have argued that it was able to forge a united front against the HPC and the 'healthcare model' as a 'common enemy'. Whilst some in the Alliance tended to adopt a relatively narrow hegemonic strategy - the relationship paradigm versus the medical model - others tended to broaden the horizon of the socio-political meaning of this dichotomy, making the HPC struggle a metonym for broader political struggle, between psychoanalysis and late capitalism (e.g. Darian Leader's, 2007, 2008, analysis), or between the 'psy-commons' and bureaucratic/professional edifices (e.g. Postle, 2012). These critiques tended to contest, not only the HPC's norms of practice, but also the perceived inevitability of the plans, by contextualising them to an extent as historically contingent. The 'deep pluralism' of the proposed alternative, the practitioner full disclosure list, meant that all groupings within the Alliance were able to subscribe to it; though, by some accounts, the threat of HPC on the horizon seemed to have galvanized an acceptance of this alternative proposal by psychoanalytic associations previously uncommitted to it. I have argued that the affective 'grip' of the Alliance discourse to some extent rested upon a sharp dichotomisation between talking therapy as social control and talking therapy as a practice of freedom. This sharp dichotomy dovetailed with the

Alliance tendency, at times, to adopt a ‘totalitarian narrative’ in which the HPC plans were cast, somewhat misleadingly, as an existential threat to the right to practice certain forms of talking therapy, invoking a heightened David and Goliath narrative in which the talking therapies tacitly become cast as the beacons of ‘power-free’ practice.

In this chapter I have also examined the HPC’s rhetorical strategy. I have argued that the ‘problem minority narrative’ at times took on a distinctly fantasmatic hue: the ‘problem minority’ within the field is seen as a threat to an already otherwise established (i.e. ‘imaginarised’) state of ‘harmony’, or, more specifically, a state of complete safety and effectiveness under the HPC umbrella. This fantasmatic narrative both supported, and arguably, partially drove, the lack of detailed analysis and engagement with the concerns of the Alliance about the HPC plans, helping to shield from visibility the contestability of the very measures e.g. the codification of threshold standards of practice, which the HPC claimed would help ensure public protection and effectiveness, as well as helping to shield from view the deep pluralism and contingency of what counts as ‘good’ practice across different, and even within, different schools of talking therapy. Obviously the HPC’s strategies of marginalising and of occluding opposition to the HPC plans within the official policy arena worked to a limited extent, given that the opposition grouped and redoubled outside, in less official arenas, in the form of the Alliance. But the success of the HPC’s strategies also had limits within the narrower confines of the official policy path to implementation. The acrimony and division within the field, which had acted previously as a barrier to statutory regulation (as

explored within Chapter Four), and which the Government had expected the HPC and SfH to overcome, was now in fact nestling, in a subdued yet persistent fashion within the HPC's own Professional Liaison Group. This was to a large extent 'covered over' by the BACP's willingness to 'sit' with a 'working position' it seemed to otherwise wholeheartedly contest. In short the 'problem minority' narrative, encompassing a friend-enemy relation between this minority and the majority of good practitioners worked to an extent, but it was not enough to overcome the major cleavage within the Liaison Group on the issue of differentiation. The HPC project was therefore significantly internally divided over significant details, as well as subject to strong contestation, in its totality, from the outside. Let us now look at how these tensions played out in the final stages of the struggle, represented in the final of the three main empirical chapters of this thesis.

CHAPTER SEVEN

THE FINAL STAGES: LEGAL AND OTHER CHALLENGES TO THE HPC PLANS

> What do you take as inevitable and what can you change. It's the political dilemma of life.[105]
>
> I don't think we'd reached an agreement even if we'd carried on forever.[106]

In this chapter we move to the later stages of the struggle. On the part of the HPC and pro-HPC camp this includes the review of its generic standards of proficiency, concerted attempts to resolve the issue of differentiation within the Liaison Group, and an intervention from Lousada and Cooper (2010) seeking to widen the political appeal of the HPC plans. On the part of the Alliance the late stages of the struggle include 'attacks' on the HPC on several fronts, including legal action, the courting of the Official Opposition party within the House of Commons, and the contestation of the leaderships within the main professional associations and their support of the HPC plans. In short this Chapter seeks to contextualise and understand the final stages and eventual 'fall' of the HPC plans. A key focus within this chapter is the character of the policy making process and competing visions of it in relation

[105] Julian Lousada (Chair of the British Psychoanalytic Council, and member of the Professional Liaison Group for Counsellors and Psychotherapists), interview by author, September 2014.

[106] Michael Guthrie (Director of Policy and Standards, HPC), interview by author, June 2014. Jonathan Coe (Member of Witness and PLG representative of service users), interview by author.

to different interpretations of the law. I argue that a transactional orientated policy imaginary of practice and regulation dovetails with a tendency of the HPC to see the policy making process in transactional terms. Conversely, the Alliance's 'contextual' practice and regulatory imaginary dovetails with its more relational imaginary of the policy making process. In this Chapter I set out the myriad of events and discourses which led to the shelving of the plans by the Coalition in February 2011, including the Government's overarching rhetorical and pejorative characterisation of much regulation across industrial and service sectors as part of a 'nanny' state. The key sources drawn upon within this Chapter include the 'court bundle' for the Judicial Review which was instigated by members of the Alliance. I draw from a range of the interviews I conducted, particularly my interview with Fiona Ballantine Dykes, which helps to illuminate the work in the final stage of the Professional Liaison Group and its endeavour to resolve the differentiation issue. As regards the structure of the chapter, I first sketch the key events and major 'problematisations' reiterated and made during this period and I then critically assess these problematisations through documentary and textual analysis. Key problematisations include the claim of the pro-HPC camp that the changes to the generic standards made the plans more congruent with the field. And as noted above, another key focus is the competing problematisations of the policy process in relation to the law. I then go onto examine the political and rhetorical dynamics of the policy dispute during this period. A key focus is Andrew Samuels' election to the Chair of the UKCP in 2009 on an 'anti-HPC ticket', which seems to have been a key turning point in the struggle and evoked some vociferous responses from pro-HPC

campaigners. I argue that the latter responses reveal, and further evidence, a fantasmatic narrative at play, similar to the one articulated within Chapter Six, partially constituting the ‘grip’ and attraction – for some – of the HPC plans.

OVERVIEW OF EVENTS

The formation of the Alliance had galvanised opponents of the HPC plans, and they were increasingly on the front foot from October 2009. The Alliance made headway more or less concurrently on three key fronts: first, the contestation of the UKCP and BACP leaderships and their support of the HPC plans; second, the lobbying of shadow ministers in

CHAPTER SEVEN TIMELINE

October 2009: *Five psychoanalytic organisations initiate legal proceedings against the HPC.*

November 2009: *Samuels is elected Chair of the UKCP with 66% of the vote. 48% of registrants voted.*

4th February 2010: HPC: *Publication of Responses to the Consultation on PLG recommendations*

12th May 2010: *6th PLG meeting*

30th September 2010: *Seventh meeting of the Professional Liaison Group*

January 2010: *'Confer-conference' is held. Debate between pro and anti-HPC constituencies and others on more 'neutral ground'.*

19th October 2010: *Eighth meeting of the Professional Liaison Group*

10th December 2010: *Judicial Review permission hearing gave the go ahead for a full Judicial Review to take place. Five psychoanalytic organisations contested the legality of the HPC regulation. The central legal contention was that there was a legal requirement for the HPC to consult on the 'whether and by whom' questions (whether the field should be regulated, and, if so, by which and what kind of body), and had failed to do so. The Judicial Review did not happen given that the Coalition Government abandoned the policy in favour of Assured Voluntary Regulation.*

15h December 2010: *Professional Liaison Group meeting.*

January 2011 *The HPC publish proposed new Generic Standards of practice which apply to all HPC regulated professions. This follows an initial consultation which closed within October 2010. Standards expressly referring to healthcare contexts no longer present.*

2nd February 2011: *Final meeting of the Professional Liaison Group Meeting*

February 2011: *Coalition Government publish Command Paper 'Enabling Excellence, outlining government policy on professional regulation. The Paper outlines an 'assured voluntary regulation' scheme as the way forward except where a compelling case is made for professions where this does not sufficiently manage the risks involved.*

2011 *HPC receive a letter from Anne Milton of the Department of Health confirming that it is not the Government's intention to proceed with statutory regulation of psychotherapists and counsellors.*

the light of a possible change of government in the forthcoming 2010 general election; and third, the threat and initiation of legal action against the HPC in

the form of Judicial Review. However, the HPC remained steadfast in its policy course, not only defending its project but also continuing to develop the 'nuts and bolts' of the plans through a second wave of Professional Liaison Group meetings. The HPC also conducted and completed a long scheduled HPC-wide consultation, independent of the work on counselling and psychotherapy, on a new draft of Generic Standards of Proficiency. Let us look briefly at each in turn.

The UKCP's and BACP's pro-HPC position came under increased pressure from its own rank and file members. In the case of the UKCP this was spearheaded by Andrew Samuels', to the surprise of many, successful election to the Chair on an anti-HPC ticket, and was a significant turning point in perceptions within the field as regards the inevitability of the plans. Paul Atkinson for example expressed that:

> To have the chair of the UKCP in on all the committees that the national organisations were discussing going into HPC arguing against it was very powerful, very powerful. The two to one vote was very powerful. That shocked everybody, that really did alter the game [..] because it had all been, this is inevitable, this is the way society is going. [107]

There was also a backlash against the result. A TV television producer Howard Martin, for example, campaigned against Andrew Samuels, claiming that Samuels had strenuously supported the therapist Derek Gale, who Martin described as a 'cult leader', and that Samuels had lied about his own involvement with a HPC fitness to practice case involving Gale in his capacity as a registered HPC art therapist (Martin, 2009). In an open letter to Samuels, Martin wrote:

[107] Paul Atkinson (Jungian Therapist, and member of Skills for Health group developing competencies for psychoanalysis), interview by author, June 2015.

> In your manifesto videos you come across, in my opinion, as a person who is full of anger and vitriol against a system run by the HPC that you have taken no time to understand. Your personal attacks and open threats against Marc Seale as CEO of the HPC and his staff not only depict you as a vicious bully but also seem to represent an anger that does not stem from any justifiable doubts about the HPC but from a deep seated fear of loss of your power over your peers, clients and students (Martin, 2009)..

The BACP, similarly to the UKCP, was becoming increasingly split on the issue of HPC regulation. The BACP leadership seemed increasingly opposed to the HPC plans: Samuels for example noting in his election campaign material that the BACP had come out against the HPC plans, citing the headline in the BACP publication Therapy Today: 'BACP rejects HPC Plans' (BACP, 2009). The BACP's objections to the plans were quite comprehensive. Samuels took encouragement from this stating that:

> BACP is a well-organised professional body that fights hard for the interests of its members. If they can do this, then one wonders why it has been stated so passionately by my opponents as out of the question that the UKCP might? Most of the BACP's points are identical to what I have been saying for many months and in all my election messages (Samuels, 2009).

However, although this headline implied a possible total rejection of HPC, the BACP remained committed to the reformist agenda, though by this stage many members were calling on BACP to completely withdraw its support of the HPC plans. For example in a letter to Therapy Today in November 2009, Paul McGahey stated that: 'There is now a window of opportunity available to strengthen the integrity of the organisation by providing a clear and decisive lead -- a rejection of a regulatory body (HPC) that is clearly unpopular and is simply not fit for purpose'. Similarly David Murphy warned that 'getting caught up within the 'spin' of the debate regarding differentiation risks statutory

regulation being ushered through on the 'quiet' and with minimal opposition being voiced' (Murphy, 2009).

There was also an intensification of lobbying of policy makers during the period approaching the 2010 General Election. Lord John Alderdice wrote:

> While this Labour Government, with its over-centralizing approach, is committed to the HPC as the regulator, it would in practice be very difficult to get this on to the statute book before the upcoming election in 2010. It is entirely possible that a new incoming Government could be prevailed upon to take a quite different approach, and so those who do not want to have regulation through HPC ... should be lobbying their political representatives now, rather than simply assume that nothing can be done. Democracy is after all supposed to be about engaging in the debate (Samuels, 2009)

There were suggestions, however, that there were also growing doubts in New Labour, the former UKCP Chair, Lisa Wake, commenting: **'**I am delighted that Andrew [Samuels] reports that all 3 parties are now having second thoughts' (Samuels, 2009). Despite Marc Seale's reported claim that the HPC plans were 'change of government proof', [108]the general election by this time was close on the horizon, and opportunities to lobby the Conservative opposition, perceived to be more sceptical of regulation and 'big government', were seized upon. A three hour meeting between Anne Milton, MP and Shadow Health Minister, and all major stakeholders within the field of the talking therapies took place in November 2009. The meeting took the form of a panel and an audience, with the panel members making statements about their organisation's position on statutory regulation, followed by questions and discussion. As panel members, Anne Milton and Earl Howe (then shadow Health Spokesperson in the Lords), were joined by Lynne

[108] James Antrican (Chair of UKCP 2007-2009), interview by author, October 2014.

Gabriel, then Chair of the BACP, Marc Seale, Chief Executive of the HPC, Colin Walker of Mind, and Darian Leader of the College of Psychoanalysts. Anne Milton reportedly stated that:

> She had not experienced the level of lobbying and volume of mail she had received in relation to statutory regulation. She believed that this set the regulation of counselling and psychotherapy aside from other professional groups taken/being taken into regulation and impressed upon the HPC that it must be cognisant of this difference (BACP, 2009c).

Therapy Today characterised the Shadow Minister as having 'repeatedly and firmly held' the HPC 'to account' throughout the meeting (*ibid*). It was expressed widely among participants of the meeting that the HPC plans were not fit for purpose. For example the BACP reiterated its position that differentiation between counselling and psychotherapy was not acceptable (*ibid*).

Plans to take the policy dispute to Judicial Review were also already afoot by this time. In October 2009, the human rights solicitor firm, Bindmans LLP, sent a letter on behalf of five psychoanalytic organisations (Bindmans LLP, 2009a).[109], to the HPC, stating that its planned act of recommending HPC regulation to the Government would in fact be illegal, and demanded the cessation of the plans (*ibid*). Following an exchange of solicitor letters, and a meeting between the HPC and the plaintiffs, in a failed attempt to resolve the issue out of court, Bindmans LLP initiated Judicial Review action against the HPC. To put it baldly the plaintiffs contended that the HPC had a legal responsibility to robustly and systematically address the 'whether and by

[109] The instructing psychoanalytic organisations were: The Association for Group and Individual Psychotherapy, The Association of Independent Psychotherapists, The Centre for Freudian Analysis and Research, The College of Psychoanalysts-UK, Guild of Psychotherapists, and The Philadelphia Association (2010a).

whom' questions, and that it had failed to do so, whilst in turn the HPC contended that it had no such legal responsibility, and had, in any case, given significant consideration to these questions 'in the background' (2009d). The HPC claimed that it was simply following the directive of the Government and that the plaintiffs' case should be taken to the door of the Department of Health (Bircham Dyson Bell, 2009e). Despite accusations by the HPC that preliminary soundings about possible legal action were merely a 'publicity stunt' by opponents (2009b), the preliminary hearing of the Judicial Review ruled favourably towards opponents, saying that it could go to a full Judicial Review, and ordering the HPC to pay part of the court costs. The latter is unusual in Judicial Review hearings (Postle, 2012:184).

Policy ideas and deliberations continued to be exchanged between the pro and anti-HPC camps within less formal arenas, which unlike the Manchester Stakeholder (as explored within Chapter Six), involved but were not organised by the HPC; most notably at the 'Confer Conference' in January 2010. A flyer for the conference characterised the field as being at a cross-roads between a reformist and a more 'radical solution' to the dispute. It stated:

> Until the transfer of qualified practitioners' names to the HPC register there may be a narrow window of opportunity for the agreement on the HPC's standards of proficiency and academic thresholds for qualification to be refined. A more complex model, with closer alignment to the professional community may resolve the problem of regulation for some. For others, a far more radical solution will be sought (Confer, 2010).

In the meantime the Professional Liaison Group continued in its struggle to overcome the differentiation issue, meeting once in December 2009 following responses to the consultation on the draft standards of practice. It was confirmed that there would be a second wave of meetings, in addition to the

ones initially scheduled, in an attempt to overcome the dispute within the group over the details of the plans (Health Professions Council, 2009a). Meanwhile, in February 2010 the HPC published its summary of responses to its consultation on the Liaison Groups recommendations. A majority of individual respondents had expressed opposition to the recommendation to differentiation between counselling and psychotherapy in the structure of the register. A majority of organisations responding, however, favoured differentiation (Health Professions Council, 2010). Antrican argued that the BACP had conducted a well organised campaign to get its individual members to respond to the consultation.[110] This second wave of meetings began in May 2010. The Liaison Group, in effect, sub-contracted the work on differentiation and standards to a group created specifically created for the task, named the Psychological Professions Association Group (PPAG), comprised of the main associations within the field and around the Liaison Group table. The debate was largely around the possibility of a level 5 and level 7 (of the National Qualifications Framework) training for counselling, and a level 7 training for psychotherapy. There was a debate over whether or not the level 7s should be interchangeable, or whether or not counselling and psychotherapy should still have separate sets of standards of proficiency at level 7. [111]

4. James Antrican (Chair of UKCP 2007-2009), interview by author, October 2014.

[111] Level 5 of the NQF is equivalent to a HND/higher national diploma or a foundation degree, and level seven is equivalent to a post-graduate qualification, such as a postgraduate certificate or masters degree **(https://www.gov.uk/what-different-qualification-levels-mean/list-of-qualification-levels - government website).**

During this period the HPC 'reformist' camp, including Julian Lousada and Malcolm Allen of the BPC, James Antrican of the UKCP, and Sally Aldridge of the BACP, drew encouragement from the fact that the HPC was due in 2010 to review its Generic Standards of proficiency (applying to all HPC professions), which could lead to the proficiencies being less 'healthcare' orientated (Low, 2010). Lousada for example stated that: 'my sense is that combination of robust opposition (to the HPC as regulator) and the sustained discussions that we've been having with them on the same issues have together resulted in their [HPC] acknowledgement that there will have to be a substantial rewrite (of generic standards of proficiency) in order to accommodate us' (New Associations, 2010:2). Attempting to reinvigorate the pro-HPC camp in the face of mounting pressure Cooper and Lousada (2010) characterised HPC regulation as a vehicle for greater equality within the field of counselling and psychotherapy, as well as a means to facilitate greater social equality within wider society. Set against these broader political aims, they argued that:

> The objections of some to the feared intrusion of regulatory principles into the free associative space in which psychoanalytic psychotherapy takes place, appear abstract, philosophically self-indulgent and individualist (*ibid*:9).

In May 2010 the seismic external event of the General Election intervened in the struggle. The newly formed Coalition Government was broadly of a different ideological bent in relation to regulation and announced a raft of policies rolling back regulation, including plans to abolish or reform a myriad of armed length government agencies; a policy raft which became dubbed the 'bonfire of the quangos' (Walters, 2010). The Coalition Government consulted

Andrew Samuels, asking if an Assured Voluntary Regulation scheme would be accepted by the Alliance. It broadly drew the support of the Alliance and in 2011 the government published a command paper 'enabling excellence (Department of Health, 2011) announcing that the HPC plans were**,** along with a plethora of other regulatory plans, shelved. They were to be replaced with the Assured Voluntary Regulation scheme. The HPC nonetheless completed and published its recommendations to the Department of Health. It recommended that the HPC would be able to accommodate the field, and that differentiation between psychotherapy and counselling to be incorporated into the structure of the register. It noted that these recommendations were not arrived at or supported by consensus. The HPC plans were then placed to the back of the shelf. Anne Milton, appointed as Parliamentary Undersecretary of State for Health in 2010, said in a private conversation with Andrew Samuels that the Alliance had 'won the argument'. [112]

Let us now examine the key norms and policy-content and policy-making imaginaries embodied within the respective problematisations of the policy-content and policy-making process made by of the pro and anti-HPC camps during the final stages of the struggle.

Here I focus on two key aspects: (i) the struggle over the policy 'content', and (ii) the norms embodied within the struggle over the policy-making process. The former pertains to the character of the 'nuts and bolts' of the plans – in relation to the struggle within the HPC's Liaison Group between the main professional organisations – as well as the overall character of the HPC

[112]Andrew Samuels (Chair of UKCP 2009-2011), interview by author, June 2014

plans - the HPC versus the Alliance. Given that many (though not all) rhetoric on the content of the HPC plans were reiterations from earlier periods in the struggle (as explored in Chapter Six) my main focus here is on the struggle over the legal status of the HPC plans, as well as the struggle over the norms of organisation and decision making processes within the main professional associations.

Competing policy-*content* imaginaries

The increased role for profession-specific standards across the HPC arguably answered objections that the Psychological Professions Council Proposal (PPC) had raised, and which had advocated itself as a resolution to, in 2006, prior to the formal announcement of the HPC plans (as explored in Chapter Five). To recall, the PPC proposal claimed that both the HPC structure and its 'content' would be insufficiently cognizant of the (sub) specialisms within the field of the psychological therapies. This included an excess orientation towards healthcare practice. Those who had expected the HPC to modify itself to be more *accommodation-ready* for the field of counselling and psychotherapy (and other fields, such as social work) arguably were to an extent vindicated. For a start some of the overtly healthcare orientated Generic Standards of Proficiency were removed. To recall from Chapter Six the original generic standards included the ability to carry out the 'formulation and delivery of plans and strategies for meeting health and social care needs' (Health Professions Council, 2009a). The new Generic Standards removed the prior tendency to assume that regulated practitioners were working within

organisations and teams, as evident, for example, in the ability to 'contribute effectively to work undertaken as part of a multi-disciplinary team' (2009a). Also removed from the new Generic Standards was the more overtly managerial toned language, such as 'effective self-management' and the ability to 'audit' practice. As regards the Profession Specific standards, the HPC reiterated its claim that they were in effect 'neutral'; that they would not impact upon the 'therapeutic relationship' or NHS commissioning. I explore the credibility of these claims in a moment. Antrican also claimed that there were indications that the HPC were willing to consider mediation as a possible first port of call in a complaints procedure. [113] Such a move would temper the tendency of the HPC to almost exclusively prioritise, to recall from Chapters Two and Six, a highly adversarial and quasi-legal approach to the fitness to practice hearings: a huge 'sticking point' for the Alliance.

Having spelt out the broad changes to the generic standards, let me now address the question of how substantive the changes were. I have reproduced the new Generic standards below in table 1. They are considerably more generic and it seems likely that these generic standards would have engendered less opposition within the field had they been in place sooner. However, they are arguably still within a broad 'language game' (to borrow Wittgenstein's phrase) of 'mastery' or at least of a particular style of mastery incongruent with many talking therapies. Some of the problems raised within the Maresfield Report (Arbours Association et al, 2009) and within the Alliance's collection of papers (Postle and House, 2009) about the

[113] James Antrican (Chair of UKCP 2007-2009), interview by author, October 2014.

then existing generic standards still seem relevant to the new standards. The ability to keep administrative records, to assure the quality of practice, and to practice in a non-discriminatory manner, are all suggestive of a node of governance and regulation in which particular norms and standards of practice are set from 'above' and 'handed-down' to practitioners and clients alike. These standards perhaps at one level seem rather innocuous; but at a minimum I would contend that the new generic standards do not, despite the standard referring to the ability to 'reflect on and review practice', form a robust basis for highly reflective, critical or 'contextual' forms of practice.

Table 1 showing the HPC's draft new generic standards (2010)

Registrants must

1. be able to practise safely and effectively within their scope of practice
2. be able to practise within the legal and ethical boundaries of their profession
3. be able to maintain fitness to practise
4. be able to practise as an autonomous professional, exercising their own professional judgement
5. be able to practise in a non-discriminatory manner
6. be aware of the impact of culture, equality and diversity on practice
7. be able to maintain confidentiality
8. be able to communicate effectively
9. be able to work appropriately with others
10. be able to maintain records appropriately
11. be able to reflect on and review practice
12. be able to assure the quality of their practice
13. be able to draw on appropriate knowledge and skills to inform practice
14. understand the key concepts of the bodies of knowledge which are relevant to their profession
15. be able to establish and maintain a safe practice environment. (Health Professions Council, 2011)

There are multiple ways in which these standards could be said to speak to a particular form of mastery. The first generic standard - to 'be able to practise safely and effectively within their scope of practice' – for example arguably suggests that practice is not inherently 'risky', and presupposes that it is easy to evaluate the effectiveness of practice. To recall from Chapter Two, even

the testing of the effectiveness of treatments that are absolutely standardisable, namely pharmaceutical drugs, is an interpretative, highly contentious and tentative task (Healy, 2013)**.** These standards suggest that the effectiveness and safety of practice, as such, is assured and constituted entirely prior to 'delivery', rather than something that must be tentatively assessed and sought in the ongoing process of work with a patient or client, as, for example, characterised in the case of medical practice by Mol (2008), as explored within Chapter Two. Similarly, the ability to 'assure the quality of their practice' seems to speak to a fantasy that practice is only ever contingently 'unsafe' or of questionable quality, or that errors and mistakes can, in theory at least, all be avoided. Many of the standards are also still tacitly suggestive of practice as a form of expertise entirely possessed by the professional and 'applied' to a client or patient, rather than suggestive of expertise as partially co-created with the client or patient. So whilst the new generic standards are less exclusive to healthcare professions, they are still suggestive of a regime of transactionality, including standards which are suggestive of consumerist like guarantees about the quality and outcomes of practice (pertaining to the node of governance) and the relationship between practitioner and client as the application of pre-packaged forms of expertise applied to a relatively passive client, pertaining to the node of delivery.

Let me now look at the profession specific standards, which were continuing to be reiterated during the second wave of the Liaison Group meetings.

The profession specific standards

The norms within the profession-specific standards remained essentially the same. All the drafts of Profession-Specific standards submitted to the Liaison Group, with one exception, continued to structure the field according to the norms of pluralism-lite, with counselling generally accorded the role of treating 'common mental health problems', and psychotherapy with the additional capacity to treat severe psychological disturbance or distress. The one exception was the UKCP's draft submission (United Kingdom for Psychotherapy, 2009), in which differentiation between counselling and psychotherapy tended towards an empty formalism, or at least a very vague set of differentiations. This draft included separate standards for psychotherapy at level 7, and for counselling at level 7. For example, one standard for counselling states that a practitioner must have the: 'Ability to demonstrate knowledge and understanding of research methods relevant to major models of counselling, including ability to apply such knowledge and understanding' (*ibid*). Its counterpart for psychotherapy reads that a practitioner must have the: 'Ability to demonstrate knowledge and understanding of research methods relevant to major models of psychotherapy, including ability to apply such knowledge and understanding' (*ibid*)**.** Some standards are different in some detail, but they do not amount to a clear differentiation between counselling and psychotherapy. This perhaps reflected the UKCP's strong ambivalence towards psychiatric norms, as evidenced in Chapter Six. Presumably this 'formalistic' approach did not hold much water with the HPC as differentiation within the structure of the register needed to be based upon substantive claims. Apart from this 'empty

formalism' submission no alternatives to the 'psychiatric' orientated differentiation were proposed within the PPAG and liaison group. Overall then, HPC claims as to the neutrality and inclusivity of the plans were still not supported by the draft profession-specific Standards, albeit these were developed by people within the field. The node of governance and regulation remained geared towards a significantly contested vision of the structure of the field of counselling and psychotherapy (pertaining to the node of provision and distribution) and to a contested view of the character of talking therapy, pertaining to the node of delivery. Considerable attempts at a rapprochement between the BACP demand for non-differentiation and the UKCP, BABCP, BPC and others' demand for differentiation ultimately failed. However, the sands shifted to an extent towards a system of three stipulated titles and sets of standards: a training level' 7 for psychotherapy, and a level 5 and 7 for counselling. Counselling at just level 5 would likely, at least nominally, have impacted the field as it would not have recognised the fact that many existing counselling trainings were equivalent to level 7 or above. And a level 5, rather than 4, for the FE (Further Education) sector was just about tolerable. [114] The UKCP, however, remained steadfastly opposed to the titles as 'interchangeable' i.e. a level 7 for both counselling and psychotherapy, sharing the same standards of practice. [115] Overall, the changes to the generic standards and the profession-specific ones do not significantly impact

[114] Fiona Ballantine Dykes (Counselling Central Awarding Body, and member of the HPC Professional Liaison Group for Counsellors and Psychotherapists), interview by author, June 2015.

my analysis made in Chapter Six. The HPC plans remained tacitly orientated toward a 'pluralism-lite' vision of the structure of the field and towards transactional-based norms within its vision of practice (i.e. the node of delivery). In short HPC claims that it was able to robustly embody diversity within the field continued to lack credibility.

A new development within the struggle was the pro-HPC camp's expansion of the socio-political meaning of the HPC plans.

The HPC as facilitator of social justice

Turning the tables on the Alliance, and focussing on the node of provision and distribution, Lousada and Cooper (2010) claimed the mantle of 'social justice' for the HPC plans, arguing that HPC regulation could become a spring board from which to challenge rampant inequality within society and the prevailing tendency to diminish the link between poverty and poor mental health (Lousada and Cooper, 2010). Their argument that the HPC plans would help talking therapy alleviate the suffering of a larger number of people through public provision self-evidently embodies a strong commitment to public provision of the talking therapies. They claimed that the BPC has placed itself within 'a psychoanalytic tradition of radical social provision'. They go onto cite Freud:

> At present we can do nothing for the wider social strata, who suffer extremely seriously from the neuroses…the poor man should have just as much right to assistance for his mind as he now has to the lifesaving help offered by surgery out-patient clinics will be started to which analytically trained physicians will be appointed (Cooper and Lousada, 2010:9).

So there was arguably quite a stark divergence between the Alliance and the BPC on the issue of public provision. This divergence, however, had a lot to do with sharp differences in view of the character of the HPC, and, or professions more generally. Darian Leader for example stated that he is not opposed to the provision of psychoanalysis within the NHS 'if the conditions are right'.[116] Denis Postle (2012), to recall from Chapter Two, in a more fundamental critique, identifies the professions as the main cause of the problem of 'scarcity' i.e. lack of psychological help, not the solution. Lousada's and Cooper's intervention, however, throws into relief what is, in my view, a relative weakness in the Alliance stance: its apparent relative abandonment of public provision, and a tendency to view it as either an irrevocably 'lost', or an inherently impossible, terrain (e.g. House, 2008) as far as progressive and emancipatory policy and practices are concerned (more on this in the final chapter).

Before examining the political and rhetorical strategies used during this period let us look more closely at the policy making process. This became a key point of focus within the legal action against the HPC. The clash of views on the 'content' of the HPC plans fed into and was of course a key factor leading to the legal contestation of the policy-making process.

[116] Darian Leader (Lacanian psychoanalyst, Alliance co-founder), interview by author, June 2014.

Competing interpretations of HPC's legal responsibilities

As noted above the legal contestation centred on whether or not the HPC had a legal responsibility to robustly address the so called 'whether and by whom' questions. Essentially, Bindmans claimed that the only powers that the HPC could use in order to lawfully make recommendations on professions that it does not already regulate, and when the field in question has not requested to be regulated, is Article 3 (17) of the Health Professions Order (Bindmans LLP, 2009f). This order states that the HPC must substantively address the 'whether' and by whom' questions i.e. whether the field should be subject to statutory regulation at all, and if so, then it should address whether or not the HPC is the most suitable body to do so. Bircham Dyson Bell in contrast claimed that the HPC had acted under Article 16 (1) of the Health Professions Order. The crucial difference between Article 16 (1) and Article 3 (17) is that the former would include a focus on the regulatory needs of counselling and psychotherapy in relation to the likely impact on the HPC's current regulatory functions, whereas Article 3 (17) is wider in scope, requiring that the regulatory needs of the profession concerned are considered independently of any whether or not the HPC could feasibly regulate the profession in question. Dyson also claimed that the Government can use the Section 60 of the Order to introduce regulation without recommendations from the HPC (Bircham Dyson Bell, 2009b). Another central point of divergence was competing interpretations of the White Paper Statement. Whereas the plaintiffs contended that the White Paper had clearly asserted and settled the 'whether' question (whether there should be statutory regulation) it had not settled the 'by whom question'; this was only to be settled after an

assessment of the fundamental regulatory needs of the field of counselling and psychotherapy (Bindmans LLP, 2009f). In contrast Bircham Dyson Bell argued on behalf of the HPC that the White Paper clearly established the HPC as the regulator of the field (2009b).

'Transactional' versus 'contextual' views of the policy-making process: some 'structural' tensions

Here I forward to key arguments. First, that the contrasting views of the HPC and the plaintiffs have the hallmarks of transactionality and relationality respectively. Second, that the structure and style of the policy-making process, as envisioned within each of the competing interpretations of the law, has distinctive weaknesses. It is important to note that although my arguments here are based upon differing legal interpretations, I am not assessing their respective legal merits, but rather I am assessing the character of the policy making process envisioned by the competing legal arguments. Let me start with the HPC side, followed by the plaintiffs.

The HPC placed an emphasis upon the fact that its involvement in the process is just the middle stage of a three stage policy making process. The HPC pointed out the policy is subject to scrutiny both prior and after it has been through the HPC. Afterwards it is subject to review and scrutiny by the legislature (Bircham Dyson Bell (2009b). The HPC seemed to contend that the parameters of the HPC's involvement is largely at the discretion of the Government in so far as whether or not it were to address the fundamental

‘whether and by whom questions’. The view that the Government had not asked the HPC to consider the ‘whether and by whom’ questions (but rather the more HPC-centred ‘feasibility’ study), and that this was perfectly legal, entails quite a sharp demarcation between high level policy-making on the one hand and low level policy making/administration on the other: the government issues the policy directive and the HPC administrates it. This sharp demarcation between high and low level policy-making, cemented by the HPC’s operational independence from government, arguably has a ‘transactional’ tone. This is in keeping with what Du Gay’s (2000) and King’s and Crewe’s (2013), to recall from Chapter Two, claim about the ‘next steps’ reform in the civil service back in the 1980s. The sharp demarcation is produced in order to increase what could be referred to as ‘democratic efficiency’: the minister makes the policy decisions and the civil service carries them out, thereby making the democratic ‘chain of command’ and responsibility from electorate to politician clearer. Political ‘meddling’ by the civil service in democratic decisions is thereby supposedly diminished. Drawing on the work of Du Gay (2000), and King and Crewe (2013), there are arguably two central problems emanating from this ‘structure’. One is that efficiency tends to be equated with effectiveness. In the political sphere of a plurality of competing interests, inefficiency may be a necessary component of effectiveness. For example measures to prevent corruption often introduce considerable inefficiencies (Du Gay, 2000). The second problem is that it fails to recognise the ‘iterative’ nature of the policy making process. To recall from Chapter Three, I drew on Derrida’s concept of iterative nature of the sign; that the sign is simultaneously the self-same and different when articulated from

one context to another. A sign will therefore connote and even sometimes denote different meanings as it makes its journey through different contexts. In short a policy directive becomes significantly modified (and either expanded or diminished) in meaning as it is 'translated' from one context to another and into more concrete measures, i.e. as it is 'administered'. [117] Indeed the legal struggle over the meaning of the policy directive statement about the HPC within the 2007 regulatory Trust and Assurance White Paper is a good example of the possible ambiguity and contestability of policy statements. There is also the wider issue of diminished creative interplay between higher and lower policy-making/administration whereby the former becomes modified in the light of the latter. King and Crewe (2013) also claim that such a sharp demarcation can diminish the sense of ministerial ownership of a project making meticulous early planning less likely. Also, the overarching character of policy becomes 'locked-in' early in the process. Although it can be overhauled further down the policy path, for example at the Parliamentary scrutiny stage, by this stage a lot of time, money and energy have been put into developing the policy; and the dynamics of an 'investment trap' are therefore more likely to be at play and may diminish the willingness of ministers and administrators alike to robustly look for significant policy weaknesses. Whilst I think the strong institutionalisation of the demarcation between the higher and lower policy making in this case – between the Department of Health and the HPC – did negatively impact the policy making process, the evident deleterious impact of deficiencies in how the 'pre-HPC'

[117] The tendency towards the transactional within this 'next steps' approach arguably takes 'administration' and its separation from 'policy making' too literally. It is a 'regulative' separation rather than an absolute one, and should be not institutionalised, as it has been, as if it were an absolute one.

consultations were conducted in relation to counsellors and psychotherapists should not be overlooked: for example the fact that the Foster Review (Foster, 2006b) paper did not even mention the regulation of counsellors and psychotherapists. And the Government's paper critiquing (Department of Health, 2007c) and rejecting the alternative proposal of the single specialist regulator – the Psychological Professions Council – was pitched at quite a generic regulatory level, rather than attending to the specific regulatory needs of the field. This of course folds into the analysis of the political dynamics of the struggle, and raises the question as to what extent the consultations within the policy-making process shaded into 'sham'. To recall from Chapter Five, a wide cross section of experts and their expertise within the field of counselling and psychotherapy seemed to be marginalised in order to push the HPC through to the Government's choice of regulator for the field.

Let me now examine the plaintiff's view that the HPC should have taken a fuller role - that it should have explored and recommended on the 'whether and by whom' questions. This would presumably have brought the development of higher level and finer policy detail into greater proximity, since the HPC would have had a greater role as regards both the general policy and the policy detail. But this vision, or interpretation, of the law on the policy process/structure arguably embodies heightened conflicts of interests, namely the potential financial rewards and considerable increase in jurisdiction, at stake for the HPC. This problematic also arguably to an extent applies to the HPC's capacity to conduct the narrower task of a 'feasibility' study as regards the capacity of the HPC to regulate the field. Indeed, to recall from Chapter Six, the HPC obfuscated the right of the Liaison Group to recommend 'no' to

the plans. Against this conflict of interests argument one could say that such a conflict of interests is present in government as such e.g. the Department of Health, as observed by 'public choice' theory on government bureaucracy (Dunleavy, 1991). All government departments could be said to have intrinsic self-interest in expanding their own jurisdiction, not least in order to increase career paths and rewards for individual employees, encompassing both financial and more cultural indexes of success. But arguably in the case of the HPC, as an operationally independent agency, this is more honed. A department of government obviously as a broader brief and remit of responsibility: it is 'bigger' and is better able to absorb 'losses' so to speak if it makes a decision not expand its jurisdiction in one particular direction, and [118] it is likely to be subject to a more diverse range of influences, not least proponents of competing regulatory ideas from a range of organisations and agencies (including the HPC).

Overall in relation to both the policy-content and the policy-making process the HPC tends tacitly to emphasise 'transactional' qualities. In policy-content the HPC Generic and Profession-Specific Standards of practice both continued to embody a strong 'treatment application' model. In policy-making the HPC promoted a strong image of itself as operationally very independent from government, yet simultaneously as loyal administrator of the Government's policy directive, encompassing a very sharp demarcation between higher and lower policy making, and therefore tending towards a

‘transactional’, ‘top-down’ model, as distinct from one in which there is more ‘to and fro’ between the different levels of government and policy making, not only between the three main developmental stages of the policy process (initial policy formulation by the government, development of the ‘nuts and bolts’ by the HPC, review by Parliament) but also *within* each of the stages.

Comments made in the exchange of legal letters about the extent of communication between the Department of Health and the HPC on the policy are illustrative of the competing expectations of the policy-making process at play, and ultimately of an apparent lack of ‘to and fro’ between the Department of Health and the HPC. Bindmans had requested that the HPC and their legal representatives disclose any instructions about the policy the Department of Health had given to the HPC. Bircham Dyson Bell responded that the only communication or instruction that the HPC had from the Department Health regarding the plans for counselling and psychotherapy was contained within the Trust and Assurance regulatory White Paper (Department of Health, 2007a) Bindmans were incredulous, responding in turn: ‘plainly your response is unsatisfactory. We assume your clients were provided with rather more than a copy of the White Paper before embarking on a piece of work of this magnitude’ (Bindmans LLP, 2009c). Bircham Dyson Bell replied:

> The clear implication of all this is the suggestion that the HPC has lied or sought to mislead you. It has done nothing of the sort. Your assumption is not only wrong but also offensive […] The HPC has never received any instruction or other document of the kind you describe. In fact, the HPC even purchased its own copies of the White Paper (Bircham Dyson Bell LLP, 2009d).

In summary of this section: we have essentially examined competing 'transactional' and 'contextual' assemblages of norms across different 'sites' or nodes, namely the policy-*content* of the plans, such as the HPC's new generic standards and the 'node' of the policy-*making* process itself. The Alliance, either expressly or tacitly, tended to contest the value and norm of transactionality, both within the policy-content and the policy making process. Transactionality is seen as malnourishing both practice and the policy making process by diminishing the possibility of work from the 'ground-up' reshaping the parameters and overarching character of the policy. The HPC for its part did not so much contest the desirability of greater 'contextuality' as contend that its approach enabled greater democratic control of the policy making process, and that vis a vis the new generic standards the HPC had enabled a shift in balance towards the profession-specific standards of proficiency and therefore greater 'context sensitivity' to each of the professions it regulates.

Now let us examine how the pro and anti-HPC camps sought to forward these competing characterisations. This includes, as seen during earlier periods of the struggle, strategies which seemed to occlude a forensic examination of the HPC plans altogether.

POLITICAL AND RHETORICAL STRATEGIES

As in Chapters Five and Six, the aim here is to understand the rhetorical and political strategies used by the pro and anti-HPC camps in their respective

attempts to install and derail the HPC plans. I focus here on the political dynamics of the events leading to the ‘fall’ of the HPC plans.

Drawing from the above outline of key events during this period, the following were the key areas of contestation contributing to the ‘fall’ of the HPC plans:

(i) The continued ‘intractability’ within the Liaison Group of the issue of differentiation between counselling and psychotherapy.

(ii) Increasing pressure within the professional associations from members opposed to the HPC plans.

(iii) The continued ‘noise’ from the Alliance against the HPC plans, including legal action, and the court decision to give the go ahead for a full Judicial Review.

(iv) A change in emphasis in government regulation ideology, following the 2010 General Election, the departure of New Labour, and the formation of the Coalition Government.

Let us look at each of these areas in turn, with a focus on the political and rhetorical strategies of the pro and anti-HPC camps.

As regards the ‘intractable’ issue of differentiation, the professional associations remained focussed on their concern about the potential impact of the structure of the register on the nodes of provision and distribution. The arguments from both camps continued to be couched in terms of the public interest, as expressed in Chapter Six. I will not reiterate these arguments again here; suffice to say, the fact that neither the PPAG nor the Liaison Group were able to come to a compromise on the issue of differentiation, was

a significant weakness in the HPC's recommendation to the Department of Health that HPC regulation of counselling and psychotherapy should go ahead. Malcolm Allen claims that the BACP 'lost the argument' [119] and therefore started to sway in tone somewhat against the HPC plans. But since the BACP are the largest professional association within the field and remained unpersuaded by the differentiation, it would seem a stretch to imply that the 'differentiation' camp had won the argument. Let us now look at the rhetorical and political strategies regarding the struggle within the professional associations.

Struggles within the professional associations

The rank and file within the BACP were becoming increasingly vocal. Letters to the BACP's magazine increasingly contested the style of BACP leadership and its continued support of the HPC plans. In his letter to Therapy Today, Paul McGahey for instance contended that the faltering HPC plans presented 'a window of opportunity available to strengthen the integrity of the organisation [the BACP] by providing a clear and decisive lead -- a rejection of a regulatory body (HPC) that is clearly unpopular and is simply not fit for purpose'. He called for the BACP to hold a consultation and referendum, 'only this way', he wrote, 'can the true meaning of democracy be re-asserted and the membership re-invigorated' (McGahey, 2009).

[119] Malcolm Allen (Chief Executive Officer of the BPC), interview by author, October 2014. See appendix A P 459.

The vocalisation of these alternative positions was heightened by the fact that the BACP does elect its Chair (though elections were not on the immediate horizon). It seems clear, however, that the most dislocating event emanating from internal wrangling within the professional associations was the election of Andrew Samuels as Chair of the UKCP.

The election of Samuels as Chair of UKCP

Andrew Samuels ran on an 'anti-HPC ticket' (as Paul Atkinson put it), and his subsequent election, was a significant juncture within the struggle. Both Samuels' candidacy and the election arguably exerted considerable influence on the struggle. To recall from Chapter Three, for the Laclauian post-structuralist approach, representation, constitutively speaking, does not simply represent that which pre-exists it but actually partially brings what is represented into being (Glynos and Howarth, 2007). Elections often help facilitate the production and deepening of 'agonistic' positions, encompassing the articulation of competing policy positions, acting in effect as a structured or planned 'dislocation' of the policy terrain. From this perspective it is easy to appreciate the significance of the relative absence and presence of the democratic norm among the professional associations. The norm was most at play within the UKCP during the struggle. In contrast the BPC does not elect its Chair. However, Lousada and Cooper (2010) did seem to be seeking to address sceptics of the HPC plans within the BPC through their intervention with their paper **'**shock of the real: psychoanalysis, modernity, survival' (more

on this below. As regards the significance of the election of Samuels to the UKCP Chair, Paul Atkinson expressed that:

> To have the Chair of the UKCP in on all the committees that the national organisations were discussing going into HPC arguing against, it was very powerful, very powerful. The 2 to 1 vote was very powerful. That shocked everybody, that really did alter the game, you know, because it had all been, this is inevitable, this is the way society is going. [120]

In his blog, the psychoanalyst, Christos Tombras, following Samuels election victory assessed that 'a new wind is blowing' (Tombras, 2009). The Chair election within the UKCP evidently helped engender the formal production of agonistic positions and the galvanisation of 'already existing' points of dissent, and helped to amplify and advance opposition to the HPC plans. The election of Samuels was a surprise (Atkinson interview), and was, to date, the sharpest rejoinder to what was hitherto supposed across much of the filed as the 'inevitability' of the HPC plans. Elements within the pro-HPC camp, however, made counter-offensive moves. Samuel's was subject, as noted above, to vociferous critique by the television producer Howard Martin**.** Let me now look at this in more detail.

Howard Martin's intervention

In examining Martin's intervention in more detail I do not primarily seek to assess the veracity of either Samuels' or Martin's claims and counter-claims, but rather to elucidate how Martin's narrative helps to further account for the 'affective grip' of the HPC plans.

[120] Paul Atkinson (Jungian Therapist, and member of Skills for Health group developing competencies for psychoanalysis), interview by author, June 2015.

In accusing Samuels of robustly and carelessly defending the practice of the much discredited practice of Derek Gale, both Samuels and the Alliance were sullied with the charge of being an abusive and reckless minority within the field, willing to close ranks and avoid accountability come what may.Samuels suggested that this was an attempt to sully his reputation through association:

> His [Howard Martin's] latest letter to the Trustees and Chief Executive of UKCP [..] accuses me(libellously) of 'supporting [Gale's] desire to carry on exploiting his clients'. Hence, I am alleged to be part of an abusive cult, as this is what Howard Martin alleges is what Derek Gale was operating (*ibid*).

Furthermore, Samuels contended that this was part of an attempt to discredit the campaign against the HPC plans for statutory regulation:

> You don't have to be a conspiracy theorist to grasp that, by now, the issue has much to do with finding a new avenue to attack those psychotherapists who have doubts about HPC as the regulator. Not surprisingly, common ground had been made between Howard Martin and the supporters of HPC in the profession' (Statement in Response to Howard Martin) (*ibid*).

Martin's public letter to Samuels in December 2009 is interesting for our purposes in one key respect. It embodies the drawing of a very sharp frontier between CBT and the HPC on the one hand and depth therapies and the Alliance on the other. The Alliance is dubbed a dogmatic and quasi-religious organisation, driven purely by self-interests (which are assumed to be entirely detrimental to the public interest) and the HPC characterised as 'flawed' but 'well intentioned' (Martin, 2009). Martin seems to take the Gale case and his largely discredited practice as representative of non-CBT therapies as such. He states for example that people like Gale can:

> Control and manipulate people into unnecessary very long periods of very expensive 'therapy'. The public can be very confused by the differentiations in modalities between a psychotherapist or counsellor who will give them a very limited focus on objective goals to sort their lives out like a CBT counsellor, and someone else who calls themselves a psychotherapist but who leads them on some infinite ill-defined quasi-

> religious journey with no perceptible objective other than some sort of greater self-awareness through a dictated life style and emptier pocket (*ibid*).

Martin goes on to describe the Maresfield Report (Arbours Association et al, 2009) as 'some sort of higher belief gospel on which to hang your selfish opposition to the HPC' (Martin, 2009). He claims that the 'Maresfield Report presents no corroborative evidence, no references, no original research, is factually inaccurate and offensive to victims of therapy abuse' (*ibid*). He mockingly suggests that Samuels and his colleagues within the 'anti-regulation cult' should be pleased to stop calling themselves psychotherapists ahead of HPC regulation, and operate completely outside of the HPC sphere:

> Where you would be happy to ply your unencumbered, untested, un-researched trade out there with the Tarot Card readers, psychics and other quasi-religious spiritualistic cults. Why don't you swear allegiance to Maresfield, put up your brass plate and start calling in the vulnerable, misguided and true believers (*ibid*).

Martin characterises Samuels and his colleagues as a throwback to a supposed period in the 1960s 'when gurus and cult leaders were respected as deities instead of being exposed as charlatans' (2009). To some extent echoing the position of Maltby (2008) in relation to critiques of audit culture, who, to recall from Chapter Two, claimed that Michael Power's 'the audit society' (1999) and its progeny are the 'stifled chorus of fury' of professionals at 'being made accountable' (2008:397), Martin comments that Samuels' putative anger 'does not stem from any justifiable doubts about the HPC but from a deep seated fear of loss of your power over your peers, clients and students' (Martin, 2009). The overall strength of invective evident within this intervention and narrative gives it a striking fantasmatic hue. The HPC tends tacitly to be cast as the position holder and guarantor and bringer of reason,

science and public protection, in a struggle with the 'horrific' obstacle of a cult of self-interested anti-regulators, mired in client and public harming dogma. This helps to account for the 'grip' of the narrative, as well as what is its rather 'black and white' character. Similarly to my argument within Chapter Six regarding the 'grip' of the HPC's claim that its standards of proficiency are universal and uncontentious, the 'black and white' narrative of Martin's here presents a rather grand Enlightenment-style narrative that unreason, self-interest, and the 'cultish' elements of extra-rational factors within social organisation have more or less been banished from public regulation and service, except for the concrete threat posed by an obstacle which can – the fantasy goes – be removed. Although Martin expressly concedes that the HPC is 'flawed', his discourse does not overall suggest that this is so. In fact, the fantasmatic narrative seems in effect to serve as a distraction, or actually prevent, a forensic engagement with the plans and competing concerns about regulation. Key nuances and points of commonality also seem to be missed. For example Martin mentions in passing Samuels' support of the practitioner full disclosure list system, and yet does not even raise, let alone critique or run with the possibility that this system may meet many of the demands of both the pro and anti-HPC camps. Furthermore, Martin's sharp demarcation between CBT/short focused therapies and open ended psychoanalytic approaches – which is to an extent an inverse mirror of Leader's mapping of this demarcation onto the Alliance versus HPC frontier – misses that a significant constituency within the Alliance, such as House (2003), also strongly critique long-term therapies as profession-centred and as deleterious to clients. Martin's intervention was an intensification of the HPC's 'narrow'

hegemonic strategy of focusing on a 'problem minority' (or perhaps problem professional oligarchy) in the field alongside the motif of safety.

Let us look at another tack taken by the pro-HPC camp.

BPC and 'the shock of the real' text

As noted in Chapter Six, the absence of routine elections within the BPC (a significant fact partially rooted in its point of origination, as briefly charted in Chapter Four) seems likely to have given less of a 'platform', and therefore less 'oxygen', to what Julian Lousada acknowledged to be concerns among some members of the BCP that the integrity of psychoanalysis was being excessively compromised. [121] Paul Atkinson also noted that there was considerable opposition within the BPC. [122] And perhaps Lousada and Cooper's (2010) intervention is also indicative of considerable concerns. This text was arguably an attempt to expand the HPC plans' socio-political horizon of meaning, thereby address the narrow, and arguably lacklustre 'problem minority' narrative, dominating the HPC's official approach. In short Lousada and Cooper's text provided what, in another context, Griggs and Howarth (2013) refer to as 'ideological cover '. In other words Lousada and Cooper say and claim things about the HPC plans that the HPC as 'administrator-regulator' could not say. The text is very difficult to decipher and oscillates

[121] Julian Lousada (Chair of the British Psychoanalytic Council, and member of the Professional Liaison Group for Counsellors and Psychotherapists), interview by author, September 2014.

[122] Paul Atkinson (Jungian Therapist, and member of Skills for Health group developing competencies for psychoanalysis), interview by author, June 2015.

considerably between various positions. I argue that this perhaps reflects ideological strategies and tensions within the wider BPC and pro-HPC position on HPC regulation. I look at it again below, but first let us look at how the struggle was shaped within the more 'neutral' arenas.

Taking the 'fight' to more 'neutral' arenas

The HPC were increasingly forced into policy arenas not of their own choosing; ones that were *outside* of the 'road map' so to speak it had set towards legislation. At the Confer-conference, at the offices of the Shadow Health Minister, and within the court, the HPC was unable to structure the debate or proceedings in the way it had hitherto done so. Given the Alliance tendency to engage and contest the HPC plans in considerable detail, compared to the HPC's tendency to eschew detailed debate (instead relying a lot on general assertion and a highly hortatory style), this shift arguably placed the Alliance at a distinct advantage. This increased the credibility of the Alliance, diminishing the sense that it was driven by 'left wing loonies' to borrow the phrase adopted by Samuels [123]. For example the High Court's decision to sanction a full Judicial Review made evident that the plaintifs had a credible case to be made and that the HPC had a case to defend. The serious reception that Anne Milton, the Shadow Health Minister, gave to the concerns of the Alliance was a far cry from the characterisation of the Alliance as a disreputable minority.

[123] Andrew Samuels (Chair of UKCP 2009-2011), interview by author, June 2014

HPC response to the Confer Conference

Similar strategies explored in Chapter Six were reiterated by the HPC. For example, in response to the Confer Conference, the Chair of the HPC, Anna van der Gaag, projected an image of the struggle as one caused by superficial misunderstanding in which the antagonists in fact have shared the same values and aims. Writing in the HPC blog she expressed that there was broad agreement among attendees of the Confer Conference that there was a need for some form of regulation that went 'beyond the status quo' and that 'whatever form regulation in the future might take, it must, in the words of Darian Leader, "respect the diversity which exists within the field"' (Gaag, 2010). She goes on to state:

> Overwhelmingly [ ] I felt the discussions highlighted to me the mis-understanding and lack of accurate information about HPC regulation and the desire for further discussion and dissemination of facts. If we are to achieve this, we must pursue the facts and work harder to build trust on all sides' (*ibid*).

Again the disagreement is tacitly conceptualised as existing along a single epistemological plain, the implication being that a simple ascertaining of the facts would resolve the whole problem. This, in my view, lacks credibility given the abundant availability of facts during the struggle, not least because of the HPC's laudable tendency to publish its policy documents, but also the Alliance's extensive documentation of its own position and concerns. We have identified some aspects which tended towards 'misunderstandings' – such as over the phrase 'evidence based practice'. But it seems clear that the conflict did not 'reduce' to such misunderstandings.

Anna van der Gaag claimed that another source of misunderstanding was ‘the somewhat confused and therefore confusing discussions about the application of the criteria used by the HPC assessing readiness or otherwise of a profession for regulation’. This presumably refers to the HPC’s acceptance criteria for new professions (Health Professions Council, 2004), as discussed within Chapter Six: to recall, the HPC’s position is broadly ‘quantitative’ in orientation as regards its ‘entry criteria’ for new professions. Furthermore, I argued that the HPC’s assurances about the autonomy of professions as regards how they test the efficacy of their practice does not square with the HPC’s strong levels of assurance, it itself provides, about the safety and effectiveness of practice. If discussions were confused and confusing, this seems like to have been partially due to the fact that the HPC’s position, quite aside from the regulation of counselling and psychotherapy, is considerably confused and somewhat contradictory.

Another apparent misinformation, Anna van der Gaag claimed, was ‘the suggested lack of a contribution from the counselling and psychotherapy profession to the drafting of the current version of the Standards of Proficiency’. She also asserted that there was ‘the mistaken assertion that “user groups” were denied access to the PLG [Liaison Group]’. She seems to have reduced the struggle to an effect of the dissemination of these half-truths and false hoods. The blog was arguably highly promotional, rather than analytic in this respect. The blog did not, for example, address the issue that only people predisposed to support the HPC as regulator (however reluctantly in many cases) were selected as members of the Liaison Group. The ‘corrective’ sharpness of Van der Gaag’s comment in relation to ‘user group’

access to the Liaison group was in contrast to a more complex picture in the light of Michael Guthrie's, Jonathan Coe's and Dianne Waller's later acknowledgement that user groups were partially, but not adequately, represented in the Liaison Group.[124] And the blog adopted a strategy used from early on in the struggle – the simple assertion that the HPC respects diversity - as opposed to a point by point or analytic engagement with the detailed critiques of the draft standards of proficiency presented to the HPC by Alliance members and organisations. One would perhaps not necessarily expect this level of detail in a blog, but it did not refer to places where this level of engagement, on the part of the HPC, occurred. Since there is, as far as I am aware, no place where this level of engagement did occur, any such reference could not be made.

This strategy of assertion and near stonewalling of critical views (whether conscious or unconsciously enacted), as opposed to analytic engagement with opposed views, tended to diminish the possibility of opposition values gaining traction. To recall from Chapter Three, a hegemonic regime becomes more vulnerable to dissolution or reform when opposed values of the regime are positively articulated, making the contingency of the regime, and possible alternatives, more visible. Apart from disjunctions in norms and values between the Alliance and the HPC plans we explored in the last chapter –

[124] Diane Waller (Chair of the HPC's Professional Liaison Group for Counsellors and Psychotherapists, interview by author, June 2014.
Michael Guthrie (Director of Policy and Standards, HPC), interview by author, June 2014.
Jonathan Coe (Member of Witness and PLG representative of service users), interview by author,

namely concerning the standards of practice and training – there were moments within the 'extra' policy debate where divergences became more explicit. For example Seale's reported statement, as noted above, that 'if a practitioner receives money from a member of the public and does not offer a predictable healthcare outcome, they just shouldn't be allowed to practise' (College of Psychoanalysts UK, 2009a). This was arguably a 'slip', and so such private and additional meetings did provide useful information and indications to the Alliance as regards the general character of the HPC plans**.**

Furthermore, the 'just a misunderstanding strategy' of the HPC, coupled with disavowal of differences between the position of the HPC and that of the Alliance, were increasingly challenged, however, within the more 'neutral' arenas. This was particularly so within the legal action, given the demand that points be addressed in some analytic detail. The HPC central strategy of 'it is just a misunderstanding' not only lacked credibility in factual terms, it was rhetorically also arguably rather negative and lacklustre. Lousada and Cooper's 'Shock of the Real' (2010) intervention was a novel one in the pro-HPC camp's repertoire of narratives. Let us have a look at the rhetorical dimensions of this before looking at the political dynamics of the legal action.

A new pro-HPC ideological narrative

Lousada and Cooper (2010) characterise the history of relations between modalities within the field as having the hallmarks of a social system of defence against anxiety in which psychoanalysts, rather than more fully confronting their inadequacies and failings, project them down the 'pecking

order' into psychoanalytic psychotherapists, who in turn project their anxieties about their own inadequacies into counsellors. Lousada and Cooper suggested that those psychoanalysts who opposed the HPC plans are stuck in the past, attempting to sustain an arrogant and hubristic relation to other modalities of therapy. They suggest that such a positioning is doomed to failure; 'many counselling trainings, whether psychodynamic or not, could not give a hoot about the British Psychoanalytic Society, or what its members might say or think' (Lousada and Cooper, 2010:4). There is some accord here with Andrew Samuels' claim, as mentioned within Chapter Six, that the 'sadistic hierarchy' (Samuels, 2009b) within the field would have been radically diminished by HPC regulation.[125] Lousada and Cooper also invert the placeholders of the Alliance's dichotomisation between socially responsible therapists and self-interested ones, arguing, as already stated above, that the HPC could help facilitate 'socially organised' provision of psychological help to a greater number of people. This is in contrast to the 'indulgent individualism' of those it is implied, opposed to the HPC plans. Lousada and Cooper's analysis tends to eclipse, or fails to address, two key aspects of the field, and thereby overly sharpen the demarcation between the Alliance and BPC position. First, Cooper and Lousada (2010) equate public provision with socially organised provision as such, thereby eclipsing a central argument and ambition of some Alliance members to grow community-built and organised talking therapy networks in order to address what they see as the 'scarcity' of psychological knowledge and provision caused by professions

[125] Andrew Samuels (Chair of UKCP 2009-2011), interview by author, June 2014.

(Postle, 2012). Lousada and Cooper seem to suggest that the HPC could be a figure head, or the pinnacle, of a 'free market of ideas' within the field (and that psychoanalysis should assume its place within the HPC among other therapies as distinct but equal); thereby tacitly adopting the HPC's claim to 'approach neutrality'. Cooper and Lousada reproduce the HPC's failure to demonstrate the latter, eclipsing the forensic critique of the HPC plans, offered by Alliance members, as imbued with healthcare norms, and which I have tended to re-describe as a calculative rationality i.e. transaction-based norms of practice. Cooper's and Lousada's position on 'evidence based practice' also seems somewhat ambiguous. They refer to other modalities having embraced the 'politics of evidence' and seem tacitly to take a sceptical position on the valorisation within NICE, and within government, of the empiricist approach to evaluating, providing, distribution and delivering 'treatments'; yet simultaneously they seem to say that political realism dictates that the game/politics must be played, and concessions be made in order to advance some form of psychoanalytic presence within the NHS. They seem to make a tacit political judgement that the valorisation of the 'empiricist paradigm' within government and NHS circles is not something that the BPC can do anything about, mirroring the position taken back in 1996 (as described in Chapter Four) by Fonagy in 'What works for Whom?, where he appears, or at least comes close, to fundamentally critiquing the validity the healthcare system's empiricist approach, whilst simultaneously accepting and promoting it. Cooper and Lousada (2010) therefore arguably continue what either is, or is perilously close to, political cynicism. This is articulated in conjunction with a tacit 'inevitability thesis' which tends to rhetorically render

the BPC (and the rest of the field of the talking therapies) as fully external to the discursive practices i.e. complex of decisions which cement the ‘evidence based practice’/empiricist policy as ‘inevitable’.

Let us now return finally to a more central aspect of the struggle – the legal action.

The public/private-interest dichotomy in the view on the policy making process

A strong dichotomisation between the HPC/public interest and the Alliance/self-interests, partially created, and was partially created by, the eclipse of possible private-interest motivations of the HPC in supporting HPC regulation of counsellors and psychotherapists. Possible private interests include increased jurisdiction and a large pool of practitioners from whom to collect membership fees. As noted above, personal careers, promotions and re-numerations are all interwoven with the fortunes of bureaucratic organisations. Again, the strong norm of operational independence of the HPC, and its role as low level policy maker cum-administrator, aided this eclipse. In short, as an independent, low level policy maker and administrator cum-regulator, it is simply not the HPC’s business to pass public comment on, or place into question, the fundamental parameters of its operation i.e. its political status. Having said that, however, according to the legal case made against the HPC, the HPC had abdicated from its legal duty – and in this sense had made a deeply political decision – to not extensively address the ‘whether and by whom’ questions prior to making any recommendation to the

government about the regulatory needs of the field. The HPC had illegally, according to the case made against it, curtailed both its own role, and that of other stakeholders within the field, including practitioners and service users, in the development of the policy on the regulation of counsellors and psychotherapists. Regardless of what the merits and demerits of the legal case may be, we can perhaps say at a minimum that neither the Department of Health, nor the HPC itself, at any stage of the policy making process publicly addressed the possible conflicts of interests in the position of either the Government, or that of the HPC, in their decision to pursue the HPC plans. It is perhaps not possible to entirely eradicate 'conflicts of interests' – a Government is never, and can never, be entirely external to the effects of its own actions. The government is not 'over and above' the rest of society. But it is striking that this tension is was not acknowledged at all by the Government and the HPC, in sharp contrast to the foregrounding of the possibility of the regulator being 'captured' by the professions it regulates. This rather adds to the sense that 'professional dominance' has tended to shift to 'regulatory dominance', where, in some quarters, where the idealisation of the professions has been supplanted by idealisation of the regulator.

The rather heavy reliance on parliamentary scrutiny for democratic input as regards the fundamental coordinates of regulatory policy tacitly construes both the values of democracy and pluralism as rather ad-hoc to the 'technical' determination of what the best policy, rather than a deeper involvement of stakeholders within the policy making process itself. The Government tendency to draw a sharp dichotomy between professionals (and one might add service users) on the one hand, and Parliament as democratically

representative of a far greater field of people, not only renders ‘democratic’ input into the development of policy rather broad, abstract, and nebulous, but also fails to address issues as regards the degree of political representativeness achieved by the British First Past the Post electoral system.

Before concluding this chapter, let us briefly examine the political logics involved in the Coalition Government’s decision to abandon the HPC plans.

The abandonment of the HPC plans

Ahead of announcing the policy ministers approached Andrew Samuels of the Alliance to see if a proposal of Assured Voluntary Regulation (AVR) would be acceptable as an alternative to the HPC plans. This was broadly though cautiously welcomed by the Alliance.

The Command Paper stated:

> Reducing regulation is a key priority for the Coalition Government. By freeing society from unnecessary laws, the Government aims to create a better balance of responsibilities between the state, business, civil society and individuals, and to encourage people to take greater personal responsibility for their actions (Department of Health, 2011:5).

Furthermore:

> For the overwhelming majority of occupational and professional groups which are not currently subject to statutory regulation and which are generally not considered to present a high level of risk to the public, but where recommendations that regulation should be introduced have been made (including those groups recommended by the

> HPC for statutory regulation in the past, but not yet registered), the assumption will be that assured voluntary registration would be the preferred option (*ibid*:18).

Nonetheless, in May 2011 the HPC made its somewhat ghostly final recommendations. Non-HPC members of the Liaison Group voted on each of the recommendations to be made. As regards the structure of the register, they recommended two protected titles for counsellors, one at level 5 and one at level 7, and one protected title for psychotherapy at level 7. The HPC noted that six members voted in favour of differentiation between counselling and psychotherapy, one voted against, and three abstained (Health Professions Council, 2011c), whilst everyone agreed that there would need to be further work on the Standards of Proficiency**.**

Following the 2010 General Election and New Labour's failure to form part of the Government, the broader political ideology changed significantly. The Conservative party, and to some extent the Liberal Democrats, were ideologically suspicious of the so called 'nanny state', instead preferring and emphasising personal responsibility and non-governmental solutions to societal problems. To some extent 'big government' was now billed as a key political enemy. More specifically, following the largest banking and economic crisis in the UK since the 1930s depression, 'profligate' government spending (however misleading this may be) was cast either as the main culprit or as a key problem. It was against this ideological background that the Coalition Government's decision to abandon the HPC plans, along with statutory regulation of other healthcare occupations, took place. The logic of cost-effectiveness, as well as the norm of personal responsibility, as distinct from government led solutions, was expressly present in the rationale of the 2010

Command Paper Enabling Excellence (Department of Health, 2011). However, the HPC plans to regulate the talking therapies entered the stage as part of a crowd of policies, and they left the stage as part of a crowd. The government formal policy rationale for dropping the HPC plans no more explored the specificity of the field of the talking therapies than did the consultation papers and the 2007 Trust and Assurance White Paper, as explored in Chapter Five, which announced the policy. This 'crowding' of the policy decision made this scant consideration of the specificity of the needs of the field less visible, leaving, however, what Guthrie and Coe, for example, pointed out, was the regulatory anomaly (as far as government policy is concerned) of no compulsory regulation of a field in which private practice is often conducted on a one to one basis without any employer to oversee it.

SUMMARY

In this Chapter we have covered the period in which the HPC came under pressure from October 2009 onwards on several fronts, including legal action, from an insurgence of opposition within UKCP and BACP, and from the sympathetic ear given to the Alliance by the Conservative opposition in Parliament. The competing policy imaginaries were reiterated from the Alliance Conferences and the HPC's initial statements. These were largely a reiteration of what we might call the HPC's 'have cake and eat it' stance in claiming that it was neutral and diverse friendly, whilst simultaneously enforcing threshold standards applicable to all and in its own name also strongly assuring that practice is safe and effective. The Alliance reiterated its claim that the thresholds standards were in fact not universal. A detailed

examination of the new generic standards and the new draft of professions-specific standard reveals that the ‘language game’ adopted is still transactional in character, adopting a form of ‘mastery’ incongruent with the more relational ‘language games’ adopted by many forms of talking therapy.

In the light of the legal action I also focussed on competing imaginaries of the policy-making process**.** Whilst the HPC interpreted the law in a way that was consonant with a sharp demarcation between the government and the HPC (between high and lower level policy making), the plaintiffs’ interpretation of the law tended to be in keeping with a softer demarcation between the government and the HPC. I have argued that the legal action illuminates structural tensions and deficiencies within the policy-making process, namely a predisposition towards failure to adequately subject policy parameters to an ongoing scrutiny.

I have also examined the key political and rhetorical strategies used by the pro and anti-HPC camps in their attempts to install, and defend their policy-content and policy-process imaginaries, and attempts to contest those of their opponents. Again, both sides tended to reiterate previous strategies as regards the policy imaginaries, namely, on the part of the HPC, a ‘just a misunderstanding’ approach, and a reiteration by actors on the periphery of the main stream policy arena of a vociferous ‘problem minority’ narrative: this was especially in relation to the election of Andrew Samuels to the Chair of UKCP. However, the Alliance orchestrated effective counter-offensives against these strategies by pushing the debate about the plans into more ‘neutral’ arenas, such as the Judicial Court, and the office of the Shadow Health Secretary within the House of Commons, thereby making the critiques

more visible. Cooper's and Lousada's text 'shock of the real' attempted to reinvigorate the HPC camp by broadening its political vision with an aim of greater societal equality and social justice, contra the Alliance, which they cast as an intellectually self-indulgent retreat from radical social provision. This text, however, was mainly directed at members of the BPC and did not seem to gain traction in the wider field.

As regards the frontier within the Professional Liaison Group, the question of differentiation remained intractable despite much work, undermining significantly the credibility of the proposals from 'within' the project. The Alliance perspective and arguments to an extent dovetailed with the ideological outlook of the newly formed Coalition Government following the 2010 General Election. This outlook included scepticism towards what the Government described as the 'nanny state', including New Labour's instinct, they claimed, towards over regulation.

Let me now bring the various strands of the thesis together within the concluding chapter.

CHAPTER EIGHT

CONCLUSION

In this final chapter I seek to bring together different elements of the thesis, clarifying my account of the HPC struggle, as well further drawing out how this account contributes to the literature on regulation, as well as drawing out the implications for policy advice, and hegemonic-strategy for achieving a better regulatory environment both within the field of the talking therapies and more widely. The account of the HPC struggle that has emerged is two-fold. First, I have identified and delineated competing characterisations of the HPC plans by the HPC and the Alliance – as a 'light touch' way of dealing with a 'problem minority' within the field, versus an 'imperialist' bid to reshape the field in accordance to consumerist and healthcare norms. Second, I have identified the key political and rhetorical strategies used by the pro and anti-HPC camps to forward their competing respective aims of installing and derailing the HPC plans. Broadly speaking this has been the HPC's strategies of marginalisation of opposition voices, and the Alliance's counter-strategies to make their voices heard.

The contours and contents of this account have been significantly shaped by the 'prism' of the poststructuralist logics approach, as outlined within Chapter Three. I have has also drawn significantly on literature, not only specifically on the HPC struggle, but also extensively from wider literature, which I reviewed

within Chapter Two. In this chapter the process of drawing out the implications of this case study for existing literature helps to further delineate the distinct dimensions of critique within my account, namely normative and ethico-ideological. The dimension of critique will also be foregrounded by another of my central aims within this chapter – to draw out the policy implications of my analysis. This will be in the form of tentative policy advice as regards the regulation of the talking therapies and to a limited extent the broader healthcare professions. Essentially this concerns the question of what kind of regulation we want for what kind of practice. Additionally it concerns what norms we want to govern the services and practices that are provided, and which norms we want governing how they are distributed. I also focus on the lessons that can be drawn from my account of the HPC's struggle as regards the policy making process. I echo the concerns made by Du Gay (2000) and King and Crewe (2013) about an overly sharp institutionalisation within government between policy-making and its administration.

Before providing a summary of my thesis account, I would like first briefly to reiterate the broad set of policy dilemmas that were at play both within the HPC struggle and within the wider context of the regulation of the healthcare professions in which the HPC plans were embedded. In doing so I seek to reiterate the broad set of policy and practice problematics that my account speaks to.

KEY POLICY CONTOURS AND DILEMMAS

The HPC struggle was driven and animated by a range of policy dilemmas and discourses within the talking therapies and wider professional fields. Accountability of practitioners and the safety and effectiveness of their practice is a key concern. Another key concern is sustaining diversity within the field and therefore public choice. In so far as these concerns can, and are, expressed as a dichotomy, there is a dilemma between the right of clients to protection and 'quality service' on the one hand, and both practitioner and client rights to freedom from unwarranted intrusions of the state on the other hand. As regards the issue of quality and public protection, a central problem identified in recent decades is that of 'professional dominance', including the tendency of professions and individual professionals to be often overly paternalistic, 'arrogant' and excessively cloistered, manifesting in a tendency to 'close ranks' when one of their members makes serious mistakes. Within the field of the talking therapies, understandings of the phenomenon and concept of client transference to the therapist seems, at times, to have been deployed to shore up the idealisation of traditional conceptualisations of professional expertise, rather more than contest them. Concerns about professional dominance are consonant with Malcolm Allen's caution against looking back at the 'heydays' of professional autonomy and self-regulation within the statutory professions with rose tinted glasses. In my interview with him Allen stated:

> I grew up in the fifties when there was no audit culture. And what it meant, right, leave it to the professionals: rampant old boys networks in the medical professionals: Untouchable canteen culture in the police service while they could fuck over everybody in site, whether they were gay, pakies, or whatever, leave it to the professionals […] No

> bloody lights shone in on them. But that was the lack of an audit culture in the 50s and early 60s. So leave it to the professionals doesn't quite cut it with me [126]

The central policy response to the problem of professional dominance within recent decades has centred largely on challenging individual and collective professional autonomy. This has largely been done through by contesting professional 'shelter' from the market, as well as the degree of professional independence from government. A raft of regulatory measures, coupled with the introduction of 'market logics' have sought to make professions more responsive and accountable. Though perhaps most theorists and professionals recognise the problem, or at least potential problem, of professional dominance, many view the current dominant approaches to dealing with it as counter-productive in many respects. In relation to the talking therapies and healthcare, for example, to what extent have the government, quasi-markets and the regulator become the key sources of dominance? There is, for example, a concern that government, in the hunt for 'magic bullets' to define and resolve key societal problems is fostering a tendency towards hubristic promises and assurances about what talking therapies and healthcare practices and services can do for both clients and society at large, whilst simultaneously and paradoxically – and therefore somewhat tragically - actually diminishing the substantive effectiveness of professional practice and services, lowering their 'attunement' (to borrow one of Mol's terms) to the voice, so to speak, of the client or patient. It is arguably also diminishing the attractiveness of many public service professions to

[126] Malcolm Allen (Chief Executive Officer of the BPC), interview by author, October 2014. See appendix A transcript P 461.

workers, contributing to quite severe retention and recruitment problems, even where pay is very good, across many of the public service and healthcare professions.

Many professionals and theorists advocate more reflective, contextual, and relational ways of underpinning practice. The government drive for more ‘acontextual’ forms of practice – for a heightened calculative rationality – within services often presents a strategic dilemma for those with a more ‘relational’ and ‘contextual’ imaginary of practice and regulation. What do they do? Do they, for example, seek to avoid joining and/or extricate themselves as far as possible from such regimes? For some statutory professions, like medicine, which are regulated by ‘function’, this is not an option: but for other professions and practices, like the talking therapies to an extent there is the possibility of greater autonomy, which rather like Freud, one could somewhat romantically caricature as ‘splendid isolation’, in which a field, or at least some strands within it, can develop with less government interference. . The downside of this strategy is of course the possibility of the diminishment in wider influence and power, and the depletion in resources. Or, do the critics and sceptics seek to consolidate their position ‘within and against’ (to use Lousada and Cooper’s phrase) such regimes? These are some of the specific dilemmas faced by practitioners and institutions involved in the HPC struggle, and, to a significant extent, across the professions. My account of the HPC struggle has to extent been framed by these concerns, but it has also placed them under scrutiny. Let me now draw this out further.

SUMMARY OF THESIS ACCOUNT

Approaching the HPC struggle through the 'prism' of the 'logics' theoretical research approach my account of the struggle emphasises both the social character of competing policy imaginaries – namely a transactional versus a relational one - through which the struggle was constituted, as well as the fundamental contingency of the struggle, identifying and foregrounding the political and rhetorical strategies used by the pro and anti-HPC camps in their attempts to make their respective policy imaginaries 'win out' in the battle to hegemonise the regulatory and practice terrain. The HPC plans, if they had been implemented, would have assimilated the talking therapies into a transactional healthcare and consumerist frame across the nodes of education and training, provision and distribution, and delivery within the field. The HPC contended that it had established universal standards of practice, and claimed that adherence to these by training schools and educational establishments, and by practitioners, would ensure that only safe and effective practice would be provided, distributed, and delivered, where any HPC registrant counsellors and psychotherapists are deployed. There is an overarching tendency within the HPC plans to view practitioners and practice as rendered safe and effective via a 'top-down' process of governance and regulation. The HPC, together with elite factions within the field of the talking therapies, established universal standards of practice, which the HPC were then to 'police' – a term used by the Department of Health (2007c). This mirrored the structure and governance within IAPT and the SfH programmes,

as well as the wider healthcare regime. I have identified significant divergences between the HPC plans and its associated projects. This is namely that IAPT, SfH and the wider healthcare regimes are all strongly predicated on empiricist research/random controlled trials. In this sense they have a more sharply defined transactionality. IAPT especially articulates a strong 'predict and control' discourse. However, the projected HPC regime embodied a regime with similar contours and logics. Professions regulated by the HPC are for example expected to demonstrate their effectiveness and safety through quantifying research methodologies. Drawing on wider literature and critical accounts by the Alliance, I have argued that this transactional regime tends towards hubristic and illusory assurances about the safety and effectiveness of practice. The plans are situated within a broader tradition, namely the so called classical/scientific strand of the Enlightenment, with an emphasis upon 'prediction and control' **(**Woolfolk R.L and Richardson F.C, 1984:778). The plans were also rooted within the so called rise of the regulatory state, coupled with 'de-regulation' across sectors of the economy, and the introduction of logics of the market within the professions. A framing of practice in terms of technical rationality – practice as an application of general scientific claims to particular cases – dovetail with a consumer ethos in which treatments are tacitly seen as 'products' with contractually guaranteed properties and outcomes for the client-consumer. As Mol (2008) notes, the logics of the market is one way of attempting to democratise expertise.

In contrast, the more ‘contextual’ and ‘relational’ regime articulated by the Alliance, contends that practice poses inherent risks, and articulates a view of expertise, insight and knowledge as constituted within the therapist-client relationship, rather than as sanctioned from above – in a sharply differentiated node of governance and regulation, and/or realm of research. It is the practice itself which produces understanding. Broadly speaking the Alliance perspective is rooted in the more ‘romantic’ strand of the Enlightenment, placing an emphasis upon feeling, the irrational (Woolfolk R.L and Richardson F.C, 1984). It is also rooted within the history of field of the talking therapies where many traditions within the field have developed in counter-distinction and opposition to medical and psychiatric approaches. As suggested by Malcolm Allen the IAPT, SfH and HPC plans constituted a new ‘zeitgeist’ within the talking therapies; an attempt to nudge all quarters of the field towards a more calculative and consumerist rationalities. This new zeitgeist was co-constituted by existing elements within healthcare, namely an array of practices captured by the concept of ‘clinical governance’ and the evidence based practice movement, factions within the field of the talking therapies, namely clinical psychology – especially its cognitive constituencies, including the BABCP, and factions within psychoanalysis associated with the BPC, namely Peter Fonagy and Anthony Bateman, and by the Government and , namely its ‘high modernism’ and its search for cost-effective interventions to improve social justice as well as its mission to address inefficiencies and the problem of professional dominance and poor practice within public services.

My account has sought to highlight how the HPC proponents and opponents are protagonists within a struggle which is merely an epiphenomenon of an unfolding historical telos. Rather, I have sought to identify key ways in which the struggle was contingently constituted. The HPC plans were advanced largely through a complex of strategies which marginalised opposition concerns about the fundamentals of statutory regulation of the talking therapies – the so called 'whether and by whom' questions. Initially the plans were 'swept along' with wider regulatory reform of the healthcare professions. A strong top-down relation between empiricist research and a managerial elite on the one hand and 'rank and file' practitioners on the other was already significantly established and legitimated within healthcare professions. This position was consolidated by strategies which made the particularity of the regime less visible. For example the fact that the reforms were in effect deepening the contestation of more 'contextual' forms of healthcare practice is made less visible by rhetorical commitments to the importance of 'patient-centred' care, and comments which valorise the majority of 'extraordinary' healthcare professionals in contradistinction to a problem minority. To an extent the relative consensus around the healthcare reforms (apart from a few specific issues, such as the planned change from a criminal to a civil standard of proof within fitness to practice cases) smoothed the early stages of the HPC's route to statute. The government's strong confidence in the so called evidence based practice movement, and its overall 'standards approach' seems to have made it confident that its new programmes – IAPT, SfH, and the HPC plans – would neutralise division and acrimony within the field of the talking therapies and bring the whole field of the psychological therapies up to

speed, so to speak, with the rest of the healthcare regime, helping to better utilise psychological expertise, protect the public, and meet its commitment to create greater parity within public services between physical and mental health. In Chapters Five and Seven I identified fantasmatic narratives in which both the evidence based practice movement and the regulatory state seem to be invested with quasi-religious meaning, somewhat paradoxically, in the form of a tacit belief that they are a total Enlightenment break from dogma, tradition and self-interest: power is seen as finally supplanted by truth. This fantasmatic narrative provides the HPC and evidence based practice movement with 'affective grip', namely by quelling anxiety associated with recognition of the fundamental and often very concrete 'undecidability' and precariousness of professional expertise and practice. This is where the motifs of safety and effectiveness come strongly into play. These narratives also seemed to have diminished the possibility of a more open conversation and debate, including forensic engagement with the arguments. These fantasmatic narratives, paradoxically, served to promote the HPC as the pinnacle of reason – of Enlightenment – whilst helping to shield from view, not only the HPC's state of being 'mired' in relations of power, as well as in the 'muck' of culture. Neither the HPC, SfH, nor the IAPT programme engaged with the Alliance or other bodies on concerns about the scientific approach and the philosophy underpinning these projects, despite the empiricist philosophies and scientific approach being contentious across much of the social sciences and humanities. Following widespread consternation within the field over the empiricist designs of IAPT and SfH, the HPC sought to distance itself from IAPT and SfH, foregrounding the HPC's independent

status. The HPC adopted a narrow hegemonic approach, focussed on the motif of public protection, dealing with a small minority of practitioners. Additionally the HPC tended to claim that the dispute was fundamentally predicated on a misunderstanding – that the HPC plans are in fact 'neutral': only practitioners who abjectly fail would be challenged by the HPC.

The route of the HPC plans towards statute was also aided by a policy making regime and process which is marked significantly by transactionality. The sharp institutional demarcation between the Department of Health and the HPC, based on the latter's operational independence from Government, diminishes 'to and fro' between higher and lower levels of the policy making process, and also seems to have intensified institutional investment – in terms of time, resources, and culturally – in the HPC as the regulator to be.
The Alliance, in contrast, challenged the 'inevitability thesis' partially by framing the policy dispute as a struggle over norms and values, often adopting a strong talking therapy exceptionalism argument, drawing an absolute difference between the talking therapies and healthcare practices. In a wider hegemonic strategy they cast the HPC plans as a metonym of wider forms of regulatory and market dominance within society. The Alliance, constituted by people from a wide range of traditions and schools within the lfield, were able to unite around the HPC plans as a 'common enemy', and around a broad notion of the talking therapies as relational rather than healthcare/transactional orientated (pertaining to the node of delivery), as well as the contention that the field is, notwithstanding this broad

conceptualisation of much of talking therapy practice, deeply pluralistic. This pertains to the node of provision and distribution.

As regards the node of regulation, the Alliance was broadly united around the positive alternative programme of the practitioner full disclosure list system. This allowed for deep pluralism within the field, and therefore did not raise anxieties between competing schools of thought and practice about whether the system predisposed towards some more than others. The Alliance position was supported at times by a David and Goliath style fantasmatic narrative in which the HPC plans were an existential threat to the field, the HPC often characterised as representing a wider totalitarian threat. Largely excluded from the policy making process – at least as far as the parameters of the policy was concerned – Alliance members made their case in other institutional arenas, namely the Parliamentary offices of the Opposition Party, and the law courts. The 'noise' around the HPC plans generated by the Alliance, as Guthrie put it, the initial victory in the early stages of the Judicial Review for members of the Alliance, and the fact that the HPC's Professional Liaison Group fell far short of full agreement on the 'nuts and bolts' of the plans, all dovetailed with the change of Government and its general political scepticism about what it called the 'nanny state' – including excess regulation, to provide conditions ripe for the Coalition's decision to shelve the plans.
Now let us look at this account in relation to existing literature.

REVISITING EXISTING LITERATURE

Given that my account of the HPC struggle delineates between description, normative evaluation, and ethico-ideological critique, I structure the following discussion in relation to these facets. To recall from Chapter Three, description and evaluation attend to what *is* and *ought* to be the case, and ethico-ideological critique focusses on how it *became* the case, and how it might therefore be otherwise. Descriptive and normative policy analysis, without ethico-ideological critique, can often be either excessively idealistic or fatalistic; and ethico-ideological policy analysis, without express normative critique, can tend, at times, to be rather lacking in purpose or 'mooring'. Let us begin with the descriptive and normative elements.

Descriptive and normative analysis

My account of the HPC struggle has drawn upon, and to an extent supports, aspects of Moran's (2003) description of a shift towards 'high modernism': the contention that government has not been in retreat, but has in fact sought to extend its reach. This analysis has broad commonalities with House's (2003) conceptualisation of regulation as a rejuvenated form of modernism. My account has also drawn upon, and to an extent corroborates, the restratification thesis (Chamberlain, 2010), and its description of increased differentiation within professions between managerial and research elites on the one hand, and 'rank and file' professionals on the other. This was evident to an extent within the projected HPC plans. The HPC draft Profession-Specific standards were set by an elite faction within the field, in conjunction

with the HPC and its Generic Standards, and would have been owned and enforced by the HPC through regulatory practices. In the IAPT and Skills for Health projects this differentiation was sharper because the projects were based on empiricist research evidence.

As regards normative critique, my account of the HPC struggle, however, is less consonant with Moran's (2003) broad evaluative judgement that the rise of the regulator state is a form of democratisation to be celebrated. My account is more in keeping with Power's (1999) view that the regulatory state tends towards creating 'false assurance', diminishing 'public curiosity', and is to an extent, consonant with Postle's (2012) and House's (2003) characterisation of the HPC plans and professionalization of the talking therapies more broadly, as a form of domination. To recall from Chapter Two, Moran (2003) and Maltby (2008) claim that the regulatory state is broadly conductive to the public good, challenging professional oligarchies through a raft of regulatory technologies such as the codification standards and competencies. This purportedly contests professional dominance by bringing an end to professional 'mystique' (caused for example through the use of language unfathomable to 'lay' people). Another key norm of the regulatory state is that of transparency – such as within the holding of fitness to practice hearings in public, thereby making it, they argue, more difficult for professionals to 'close ranks'. There is one key way in which the HPC plans would likely to have been 'democratising', however. This concerns the contention, made by both HPC proponents and detractors (Samuels, 2009), (Lousada and Cooper, 2010), alike, that the plans would have challenged the

informal ‘sadistic hierarchy’ (Samuels, 2009) within the field of the talking therapies. Indeed this rather unofficial discourse was arguably a key attraction of the HPC plans for many within the field.

However, a claim that the HPC plans would have been a challenge to professional oligarchies as such (rather than only some) would surely have to be predicated on the contention that HPC regulation would have been universal and objective in character: that is to say above the political ‘fray’. My account clearly does not support such a claim. The HPC plans were orientated as a regime of transactionality, and within its draft standards of practice, in its standards of education and training, and within its broad collective criteria for aspirant professions, projected the norms of heightened calculative rationalities, including healthcare and consumerist norms, across all nodes of the field. Moran (2003) and Maltby (2008) would perhaps regard transactionality and market logics as an effective way to democratise the professions, even if recognised as distinctive political programmes with some sectional interests (more on this below).

But my close reading of the HPC and Alliance arguments, and immanent critique of them, and my view of the ontological ‘grain’ of practice as fundamentally relational, contextual, and iterative, as well as my importation of critiques of the evidence based practice movements, and, finally, my prior normative commitment to pluralism and democracy, have all guided me towards the view that market logics and heightened forms of transactional practice and regulation tend, in the round, to be damaging and ineffective

models for the democratisation of expertise. This is in keeping with Mol's (2008) Schon's (1983), and Fooks (2000) arguments against market logics and/or technical rationality as the predominant model basis for the professions.

The HPC to an extent seem to have proffered a myth that the regulation can intervene without impacting practice. The projected likely impact of the HPC Standards of Proficiency is consonant with literature which highlights how regulatory technologies can reshape and distort services and practice (Power, 1999), (Traynor, 1999). Indeed, in the case of the HPC plans, the planned imposition of a 'universal' set of standards – with a distinct transactional and consumer orientation – implied a process of standardisation. My analysis suggests that Alliance concerns that the HPC plans would have diminished diversity within the field are broadly credible, contra the relative confidence of Cooper and Lousada (2010) that HPC regulation would have provided a more level playing field for different modalities of therapy to take their place, side by side, and make their distinctive offers within the competitive market place.[127]

Overall a close analysis of what would have been the likely impact of the HPC plans suggests that they could have exacerbated problems associated with transactional ways of framing and governing practice. The central one is the tendency towards contextual insensitivity and eschewal of the perspective

[127] This also seems to be in tension with Andrew Samuels' contention that HPC regulation would have challenged the 'sadistic hierarchy' within the field. Perhaps HPC regulation would have tended to cement an inversion of the existing cultural hierarchy within the field which Samuels (2009) and Lousada and Cooper (2010) refer to in which psychoanalytic orientated therapies project their own inadequacies down a perceived hierarchy of modalities, supplanting it to an extent with a consumer and transacational orientated therapies at the top tier.

and experience of both the practitioner and the client in each new 'case'. My analysis of the HPC struggle suggests that, in one sense, strong proponents of the rise of the regulatory state such as Moran (2003) and Maltby (2008), and strong proponents of the random controlled trial, such as Chalmers (Hammersley, 2005) as above the 'fray' are correct: the regulatory state has made much of professional organisation and practice, across the nodes of governance and regulation, training, provision and distribution, and delivery, *more true to* what has often been taken to be the basis of their legitimation: that is the view that universities develop the knowledge and science – the general principles – which practitioners then apply in their practice to particular cases. To recall from Chapter Four this is how the professions originally won their position within the universities (Schon, 1983). The effective help given to clients by professions, in so far as they are helped, arguably is often significantly due to the fact that professionals, in practice, often tend to divagate from technical rationality. Furthermore they arguably tend to stray from, or reject, technical rationality outright because it just does not fit very well with the realities of the problems they face and address. Technical rationality in other words tends to *cut against* rather than *with* the ontological 'grain' of social reality. Furthermore, a range of work, such as Mol (2008), Corfield and Leader (2007), and Glynos (2012) suggest that, within the field of healthcare for instance, technical rationality and dominant biomedical perspectives do not fully capture or exhaust illness. Rather the biological closely intersects with, and both shapes and is shaped by, interpretative activities i.e. by social meaning. [128]

[128] See Glynos (2012) for example.

I would like now to briefly focus on how the more ethico-ideological dimension of my account relates to the broader literature. .

Ethico-ideological critique

A key aim within this thesis has been to foreground the contingency of the struggle, whilst also understanding why particular regulatory discourses ‘grip’ subjects. My analysis of the HPC struggle has drawn upon, and accords with, key aspects of the restratification thesis (Chamberlain, 2010).This is particularly the case in the claim that segments of a field are co-opted by government and its agencies in order to assist it in pushing through organisational reform. In the HPC struggle itself the Government co-opted elite factions within the field to push through the Government’s regulatory agenda. These co-opted elites did not fully ‘play ball’ in the way the HPC might have hoped however - Antrican’s decision, for example, to allow the ‘dissenting voice’ section within the UKCP’s submission to the HPC Call for Ideas consultation, or Julian Lousada’s quelling of some attempts within the Professional Liaison Group to caricature the Alliance as the simple villain of the piece, and, most serious of all, the refusal, or incapability, of those around the Liaison Group table to come to an agreement about the ‘nuts and bolts’ of the plans. To an extent this observation of a degree of ‘push back’ is not entirely inconsistent with the restratification thesis. However, Chamberlain’s contention that medicine has retained its collective autonomy through

restratification does not apply to the field of talking therapies. This is partially because the talking therapies were, and are not, constituted as a statutory regulated field. In this sense the field does not enjoy the autonomy and power of this: rather individual segments within the field each enjoy levels of autonomy within a field which is more loosely, in so far as it is at all, constituted as a collective. But I also contend that the analysis of IAPT and SH tend to suggest that the restratificaiton thesis overestimates the retention or gain of collective autonomy. In the case of medicine the increased domination by the pharmaceutical industry, as evidenced by Healy (2013), seems to be substantially underplayed within the restratification account. Part and parcel of this, is the restratification thesis's failure to address the significance of the changes in medical practice i.e. diminished contextual practice, concomitant with restratification. My analysis of the HPC plans and associated projects suggests that not only were the plans set to significantly restratify the field but that this would broadly diminish conditions conducive to robustly contextual and relational forms of talking therapy. In short the restratification thesis tends to focus on the changes within the formal relations within the node of governance and regulation, and somewhat neglects changes to the node of delivery i.e. the character of the treatment provided. The restratification thesis usefully helps to identify what we might call a discursive practice i.e. increased differentiation within the field – perhaps akin to the 'logics of difference' within the approach of Laclau and Mouffe (1985) and Glynos and Howarth's (2007). However, Chamberlain (2010) does not identify these new relations as discursive practices, or as discourses. This leaves the theory vulnerable to the charge that it tacitly posits the changes as

‘over and above’ the rest of society – as driven by linear and progressive developments within medical science. Indeed there is a sense that the approach provides only a description of events rather than itself also being an intervention. There is within the writing of this tradition a tendency not to offer an adequately clear stance on the normative value (i.e. whether desirable or not) and of the ontological status (i.e. whether contingent or necessary) of the regulatory changes it describes. Consequently there is arguably a tendency towards tacit prescriptive endorsement of the changes masquerading as mere description. This is also, to recall from Chapter Two, a tendency within Waller and Guthrie’s (2012) account of the HPC struggle – where prescriptive policy advice masquerades as mere description of policy ‘trends’. Similarly there is a tendency within many accounts to render the emergence of particular regulatory technologies as necessary responses to fundamental changes within the social and organisational environment, such as public scandal, globalisation, fiscal crisis and the increased educational attainment of the population (e.g. Moran, 2003). They tend to eclipse the fact that regulatory policy and regulation are a complex of interpretative actions involving ‘problem definition’ (Bachii, 2012) as well as the contingent forging of particular regulatory solutions – rather than others – to these problems. The HPC plans for instance were one possible contingent response out of any number of possible ones to what was construed to be the problem of public protection in relation to counselling and psychotherapy. The notion of regulatory changes being a necessary response to fiscal crisis or ‘external’ economic change is arguably a particularly powerful one (Hay and Watson, 2003). This did not come expressly into play within the HPC struggle and the

associated projects, though such discourses tended to underpin them: for example the discourse of globalisation partially underpinned the shift towards multiple-professional teams within public services and the concomitant shift towards multiple-professional regulators. The rolling out of IAPT – especially its preference for short-term and focussed therapies, as well as its 'stepped-care' approach – was partially legitimated through the concept of cost-effectiveness, alongside side the concepts of 'early intervention' and prevention. Drawing on critiques of the evidence based practice movement, however, assessing the cost-effectiveness of a programme, or treatment, is evidently a highly interpretative, difficult and contentious task. To recall from Chapter Two, Healey (2013) claims, for example, that a colossal amount of tax payers money goes into the huge profit making pharmaceutical industry, in the purchase of new and patented, and therefore expensive, drugs, for which there is frequently very weak evidence of their effectiveness; or, worse, there is often considerable evidence that they cause harms to patients. This throws the constructed and often misleadingly ideological nature of the concept of 'cost-effectiveness' into sharp relief. My analysis of the healthcare reforms, along with the HPC plans, IAPT and SfH, as promoted by an Enlightenment narrative, often marked by fantasmatic narratives, is consonant with elements of Du Gay's (2000) and Newman and Clarke (2009) analysis of the rhetorical strategies adopted to promote institutional reforms, namely the quasi-religious belief in a new organisational form to bring unparalleled success. This includes a tendency as Clarke et al put it to 'collapse spatial differences into time' (Clarke et al, 2007:12)**.** This is where organisational and cultural difference across companies, for example, or even

within the same company, are rhetorically temporalized, so as to construct one set of norms as 'with the tide of history', and the other as rendered defunct by the tide of history. My account has shown that this strategy was evident within the HPC struggle to an extent. My analysis of the fantasmatic narratives involved within the HPC struggle has theorised why such denial of the contingency of the HPC plans, and possible alternatives, at times, affectively 'grip' subjects. My analysis is consistent with, and supplements, literature which highlights the significance of 'dramatic' narratives within regulatory and professional struggles: for example Shedler's (2015) identification of a 'master' narrative within the evidence based practice movement: 'In the dark ages, therapists practiced untested, unscientific therapy. Science shows that evidence-based therapies are superior' (2015:47). My account also arguably supplements Postle's (2012) notion of 'trance induction' as well as Power's (1999) foregrounding of the affect of anxiety. Through the 'prism' of the 'logics' approach and its adaption of elements of Lacanian psychoanalysis I have deepened the theorisation of the role of affect within what we might refer to, rather generically, as fantasmatic Enlightenment narratives.

Let us now briefly draw a few pointers from this analysis regarding policy advice. This helps to bring further to the foreground the evaluative and more prescriptive elements that are to an extent inscribed within my analysis.

POLICY ADVICE

A key policy question which this case study speaks to is: how is it best to 'frame' regimes and practice so as to tackle, diminish or avoid the problem of occupational or professional dominance, including lack of responsiveness to clients? Another related question is: what are the most effective ways of regaining, retaining and improving broad public trust in the field of the talking therapies and the public professions more broadly?

Regulatory policy

As regards the node of governance and regulation my analysis suggests that the Government's shelving of the HPC plans was a good judgement call. If it were decided that statutory regulation of the field of counselling and psychotherapy was again to be pursued, the practitioner full disclosure list, as advocated by Postle (2003), the Maresfield Report (Arbours Association et al, 2009), should, in my view, be given serious consideration. Its key advantages are that it allows deep pluralism, and does not seek to shape or structure the field or practice in accordance to any particular norms. In fact the system can encompass heightened transactional forms of therapy just as much as relational or contextual oriented therapies. It also has the advantage of bringing a practice of 'audit' into play in so far as it would institute a legal obligation for a practitioner to disclose any complaints held against them. And as the Maresfield Report suggests, the government should concentrate on making the law more accessible to individuals, rather than create a poor quasi-legal substitute of it through the HPC-style complaints system, which

affords less protection than the court system to clients and practitioners alike. I do think, however, that there are question marks over the practicality and the political desirability of regulation by function within the field of the talking therapies – though these are questions that have been largely outside the scope of this thesis. Another important advantage of the practitioner full disclosure system is its emphasis, as its name suggests, on the disclosure of information, including practitioners' way of working, rather than on providing assurance about the safety and effectiveness of practice. This helps avoid the HPC's tendency towards false assurance, to borrow Power's(1999) phrase, and to help, in its place, foster greater public curiosity (again as Power puts it) about practices and services. An educational programme to make the public more aware of the character and inherent risks of different kinds of talking therapy, as suggested by the Maresfield Report (Arbours et al, 2009) would enhance this. This would arguably make the node of governance and regulation more congruent with more relational and contextual ways of framing practice, which, in turn, are more consonant with the ontological *grain* of practice - that each therapy is contextual – has unique elements, and is therefore experimental. This is in a similar sense to how Mol (2008) conceptualises medical practice as experimental. A process of trial and error is therefore seen as intrinsic to the process.).The HPC tendency to foster conditions ripe for a fantasmatic narrative in which a 'problem minority' of practitioners is imagined to be the only obstacle – and a merely empirical one - to fully assured and effective practice, not only seemed to provide the HPC plans with considerable affective 'grip' in some quarters, but it also simultaneously leans the regime towards the making of rather illusory claims

about the safety and effectiveness of services and practice. As Parker (2010) puts it:

> There is an illusion of safety guaranteed by equally illusory attempts to predict and control innovative human activity. The HPC website offers posters and window stickers which proclaim 'you're in safe hands: I'm regulated by the HPC', and the message is that once you are with a practitioner on a register you will be safe and sound. This is a dangerously misleading message (6).

Furthermore, the fantasmatic narrative which supports the HPC-style system means that in one sense if the abusive, ineffective and unsafe practitioner did not exist – if the 'problem minority' did not exist - then they would need to be invented. The prevalence of actual abusive practice, perhaps what we can refer to as abjectly or aberrantly bad practice (though this is ontologically always subject to historical and cultural definition and construction), has not been a focus of this thesis. The point I am making here is not that it does not exist, but that if it did not exist, then the HPC would need to invent it. There is therefore a risk that the heightened 'assurance' system ,and the fantasmatic narratives which support it, and which perhaps also help give rise to it, create conditions in which the emergence of abject forms of abusive practice are more, not less, likely to emerge. In short the abjectly abusive practitioner is required to take the role, in the fantasmatic narrative, of the contingent empirical obstacle to what is otherwise imagined to be the fully safe and effective practitioner and system. In reality, however, the regime is desperately dependent upon the notion of the abjectly abusive practitioner: it is that which 'guarantees' the 'beatific' HPC-registrant practitioners who are 'safe' and 'effective' and free from contestation and uncertainty. This is arguably problematic as it is more likely to foster unconditional client or patient trust in practitioners, rather than a conditional trust based on curiosity

of the client or patient in the practice of the practitioner. [129] The node of regulation and, within organisations, the node of governance, should therefore be geared towards challenging such narratives. In order to do this a regulatory regime could seek to robustly set both practitioner and client expectations in the direction of what Schon (1983) refers to as reflective practice, and House (2003), and Fook (2000) refer to as postmodern practice, and which Mol (2008), within a medical context, as 'attunement' and 'doctoring'. These are ways of democratising expertise which not only acknowledge the precariousness and limits of expertise – including its ultimate inability to fully assure safety and effectiveness –, but also more robustly conceptualises, and finds room for, the client as an active agent within the process. This active role is not seen as limited to having a 'consumer-style' choice between different practitioners and different treatments, but extends to an active role in shaping the actual 'treatment' and relationship. In one sense many talking therapies may be characterised as a 'prototype' of such an approach given the tendency within the talking therapies to make the relationship between the client and practitioner the pure 'instrument', so to speak, of the 'treatment'. Ideally therefore the direction of influence between the healthcare regime and that of the talking therapies should arguably be more from the talking therapies to healthcare, rather than, as currently the case, the talking therapies taking on the more empiricist and heightened acontextual style and system of practice currently dominant within healthcare. This would mean for example that within the professions more

[129] See Janet Haney's book 'Regulation in action' (2012) for an examination of how HPC style regulation can tend to overly dichotomise between safe and unsafe practitioners to the detriment of effective practice and regulation.

broadly the regulator should seek to soften the demarcation between the nodes of governance, provision, distribution and delivery, so that questions of 'standards' and 'quality' – the character of the professional-client relationship, and the treatments produced, made available and delivered – becomes something shaped, at least to a greater extent than currently the case, by the client and the professional within the specific context and set of exigencies in which they find themselves. Schon (1983) suggests that both the professional and the client need to give up the 'mystique' of expertise and move into a 'reflective contract' in which the uncertainties of the work the client and the practitioner do together are acknowledged. The promise of hardened outcomes and of excessively standardised treatments, should, to an extent, be regarded as a threat to the capacity of the practitioner and client to experiment their way to an effective set of responses to the unique problems and challenges which present themselves. To be congruent with and to help facilitate such an approach to practice, regulatory practice should also place an emphasis upon reflective regulatory practices, in which the regulator is more contextually 'attuned' and has a 'fuller' conceptualisation of the practitioner (and of their clients) and/or organisation being regulated. This would help avoid 'subsumptive' tendencies, where regulators try to fit square pegs into round holes so to speak, as well as reduce the tendency of organisations becoming arbitrarily distracted from their main tasks (noted by Power, 1999, and Traynor,1999, for example), and thereby also help avoid excess homogenisation across organisations which diminishes the pluralism of expertise required for a pluralism of problems and issues. Innovation in practice can therefore, to a greater extent, occur from the 'ground up', where

expertise emerging in practice feeds, in a more organic way, into the more abstract theoretical body of knowledge within a profession, as well as decisions at a more organisational level and political decisions at the policy level.

In drawing this conclusion, I am not suggesting that audit practices should not be used at all, but that they should be used sparingly, and as an aid to more contextual and reflective forms of regulation, rather than seen as a straight forward 'technical fix' to the problem of professional dominance and accountability. They should also be used, I would suggest, with greater awareness of, and careful scrutiny of, the ways in which they are significant interventions within a field. The notion of 'light touch' regulation arguably tends towards being a myth. It is perhaps encouraging, in this frame at least, that there has been a shift towards the concept of 'right touch' regulation (CHRE, 2010).

This leaves the node of provision and distribution – the norms governing which treatments and services are available and how they are distributed – left to be considered. As noted within Chapter Five, one of the attractions of a highly technical and standardised approach to governance and practice is that it addresses the problem of the so called 'post-code' lottery, and helps to objectively delimit and legitimate the provision and distribution of some treatments and services over others. However, the literature suggests that within IAPT, as well as medicine and healthcare more broadly, the NICE and empiricist system of controlled trials tends to be rather more objectifying than objective. It seems quite clear that the weight of empiricist evidence i.e. the

evidence from controlled trials, even when taken on its own terms, does not support the Government's tendency to promote particular forms of talking therapies over others. This diminishes public choice, whilst simultaneously fostering hubristic expectations about psychological expertise. In a welcome development the evidence based medicine movement is currently reviewing its valorisation of the random control trial (Stirling, 2017). Scarcity of resources, and the apparent need for 'cost-effectiveness', and the need to constrain costs within an increasingly harsh competitive environment of the globalised world is a compelling reason often given for why the democratisation of the node of provision and distribution must be very limited. But to note, again, Healey's (2013) critique of the pharmaceutical industry is a clear instance of where this is perhaps shown to be an over-simplistic and misleading framing of the problem, motivated at least in part by powerful institutional and economic interests. The dominance of medicine by the pharmaceutical industry, as noted by many, even by those quite favourable to the inherent qualities of the random controlled trial approach to research (for example see Goldacre, 2013), needs urgent attention. Within medicine it is perhaps the biggest barrier to both more evenly available and deeper forms of contextual practice, or, as Mol (2008) describes it, 'doctoring'. My account of the HPC struggle suggests that, in some respects, attempts within the field of the talking therapies to ape the 'hard' science of medicine, and to adopt its valorisation of the controlled trial, contributed significantly to the impetus behind IAPT and SfH, and, albeit to a lesser extent, the HPC plans.

For a key strand within the Alliance, namely the humanistic, anti-professionalisation tradition within the field, as manifest for example in the

IPN, and the work of Postle (2012) and House (2003), Mowbray (1995), (as explored within Chapters Two and Four), it is important that the node of provision and distribution does not, as far as the talking therapies are concerned, involve bureaucratic or professional organisation. This is because they contend that such forms of organisation are inherently contrary to the ethos and practice of the talking therapies, largely because they encompass hierarchy within the organisation. This issue not been a strong focus of this thesis, as the focus on the struggle over the HPC plans does not afford the opportunity to directly 'test' the theories concerning the differentiations between voluntary/community organisations on the one hand, and bureaucratic and professional ones on the other. But, with Schon's (1983) critique of sharp demarcations between anti-professional and professional forms of expertise, and Mol's (2008) and Healy's (2013) critique of what I refer to as highly transactional ways of doing medicine, and their exposition of more contextual ways of medical practice, in mind, it is my sense that the NHS can and should play an important, though not all encompassing, role within the provision of talking therapies, where a more contextual system of governance and regulation is in place. Concerns about both the system of practice and influence of other stakeholders, such as the pharmaceutical industry's influence on medicine, should to an extent be within the remit of the professional regulator, in conjunction with other stakeholders. This is particularly so because regulators do tend (and be seen) to 'vouch', not only for individual registrants, but for the profession or field as a whole. Indeed the HPC, as noted within Chapter six, has a legal responsibility to itself ensure that practice is safe and effective. In my view the latter requirement should

either be taken away, and a practitioner full disclosure system style system adopted, where decisions about what treatments are made available, are made at more localised levels, or, the HPC, and regulators like the General Medical Council (GMC), should carry out a more robust 'meta-evaluation' of how the professions they regulate determine what practices are deemed to be safe and effective enough to provide. Any such meta-evaluation should encompass the wealth of research evidence from both within and outside the empiricist tradition. It is perhaps through a much more robust inclusion of 'practice based evidence', and through mechanisms by which the experience and knowledge of reflective practitioners and clients – as conceptualised by Schon, in which a client or patient is strongly seen as 'active' within the treatment, that professional dominance is best addressed, and the emergence in recent decades of a new 'regulatory dominance' addressed and avoided. It is beyond the scope of this thesis to consider the various practices and organisational innovations which may make an institution more reflective, but the innovative governance and regulatory practices adopted by the Independent Practitioners Network – even though they tend to eschew such terminology – as well as the additional voluntary schemes that some therapeutic communities, funded and regulated as public services, participate in – such as the Royal College of Psychiatrists 'Community of communities' for therapeutic communities [130]- are perhaps good resources to draw upon.

[130] A description can be found at the following link: https://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/therapeuticcommunities/communityofcommunities.aspx

My account of the HPC struggle has focussed considerably on the policy making process, including, for example how the policy process both encompassed, and was shaped and supported by, rhetorical strategies of marginalisation. Now let me briefly draw from this account advice about the policy making process and structures.

Policy making process

One key way in which the HPC policy was arguably a 'fiasco' is that there were sufficient grounds for a legal case against it. To what extent was this a failure in individual decision making, and to what extent does it reflect more systematic or structural problems in the policy making process?

There are a number of things that could reduce the likelihood of a similar policy fiasco. We can reasonably say that my account of the HPC struggle suggests that the (initial hearing of the) Judicial Review was the result of the HPC's and Department of Health's failure to robustly secure the legality of the policy-making process, along with the determination of a group of psychoanalytic organisations to challenge the legality of the process. The origins of the somewhat 'foggy' legality of the way that the policy making process was conducted can, to a significant extent, be located in the shift, which, to recall from Chapter Two, began with the 'next steps' civil service reform programme during the 1980s, and the sharpened institutionalisation of the division between policy making and its administration, consequently tending to diminish the 'to and fro' between them, and therefore the

effectiveness of the process. As Du Gay (2000) noted, this helped foster a 'can do' attitude within the civil service, in contrast to a tradition of the civil service offering 'frank and fearless' advice on policy proposals. The sharp demarcation between higher level policy making and low level policy making/administration helps to account for why the HPC development of the policy seemed so technocratic: divorcing the administrative arm of government from the democratic/political arm meant that the HPC was seeking a rational cum-technical, rather than a political, solution to the competing demands of different stakeholders. My account has of course suggests that this constitutes a political strategy – making the political decision to make the talking therapies more transactional orientated apparently a mere technocratic and rational process. It is a remarkable feature of the struggle that the HPC in effect insisted that a rational consensus – embodied with the supposed 'universal' threshold standards – underlay all the 'surface' conflict. The 'success' of this approach to political strategy and to the policy making process, however, as I have argued in the case of the HPC struggle, is predicated on excessive occlusion of diverse perspectives, especially those of many clients and practitioners, on the policy in question; a 'blockage' which, in the case of the HPC plans, helped to bring about a near-implementation of policy I have argued would likely have been broadly detrimental to the field of the talking therapies and the public interest. This case study therefore adds to the body of literature (e.g. Du Gay, 2000 and King and Crewe, 2013), which raises concerns about the impact of the sharp demarcation between policy and its administration, including its tendency to impoverish the political and democratic character of the policy

making process in which relatively narrow and factional political interests tend to masquerade as techno-rational solutions to the problem at hand.

Politico-hegemonic strategy

A key suggestion as regards hegemonic strategy is intrinsic to my analysis and partially follows from the post-structuralist contention, as explored within Chapter Three, that research as such is an intervention of sorts. My suggestion is for a more middle path to be found between the Alliance tendency to adopt a position near to talking therapy 'exceptionalism' in its struggle to fend off being subsumed by transactional orientated and dominated healthcare regimes, and the supposedly more pragmatic embracement of the evidence based practice movement and more transactional ways of framing talking therapies practice and services of others in the field.. In one sense the position close to talking therapy exceptionalism may be deemed the most politically pragmatic because strong transactional ways of framing healthcare are so powerfully embedded, the best chance of keeping the talking therapies from such a regime is perhaps to forcefully foreground the differences between the talking therapies and healthcare practices: demands for significant reform of the whole healthcare and pharmaceutical system raises the political stakes significantly, and therefore also the political and institutional barriers. The trouble with the talking therapy exceptionalism strategy, however, is arguably that, by creating a strong dichotomous relationship between healthcare and the talking therapies, it

helps to shore up the position and identity of highly acontextual/transactional discourses within healthcare, reinforcing the sharp frontier between healthcare and the talking therapies, which then poses a heightened 'imperialist'/scientistic threat, from the 'outside', to the more contextual orientated talking therapies. Another strategic possibility is that a more open stance within the field of the talking therapies towards what arguably are significant family resemblances between the talking therapies and more contextual and relational imaginaries of practice within healthcare may help grow alliances across the fields between those members of each that want greater depth in the contextual and relational framing of practice and its regulation. Given the strength with which a highly transactional regime is currently cemented within medicine, this is admittedly probably a Herculean task and these are strategic dilemmas to which there are no easy answers.

The HPC's, IAPT's and SfH's attempt to reshape the field of the talking therapies in accordance with consumer and transactional norms is perhaps indicative of how strongly hegemonic - that is to say 'naturalised' – these norms are within contemporary culture and society. This is perhaps most evident in the apparent incredulity of the HPC, and some supporters of the plans, that the desirability of the contractual consumer norm and standards approach could be placed in question. In fact, even more than that, the HPC seemed unable to recognise these norms as forms of particularism to which there are credible alternatives. Simultaneously, however, the case study suggests that these logics are not invulnerable, and that more contextual and relational conceptualisations of practice can, and often do, motivate

practitioners, especially (though not only) within the field of the talking therapies, and that it is possible for practitioners to organise and mobilise in the name of more relational and contextual norms of practice and regulation.

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APPENDIX A

TRANSCRIPT OF INTERVIEW WITH MALCOLM ALLEN

Jon: You became Chief Executive Officer of the BPC in

Julian was saying that that was the first appointment and was part of the professionalising of the BPC

Malcolm: Yes I think that's right. The BPC had existed for about ten years prior to my appointment but had bumped along with a couple of administrators, so I was its first sort of you know high level kind of professional appointment in that sense. But I think, you've probably worked this out but I think it's just worth knowing that I think the BPC as organisation emerged out of the whole thing around potential psychotherapy regulation. So it all goes back to the rugby conference. I think without impending statutory regulation, as it was thought to be impending at the time, wrongly of course [laughs], but you know, probably the BPC would never have existed. So it came about because, on the whole psychoanalytic organisations, love nothing better than to be gloriously insulted. And probably would have stayed that way, so you'd have had the British Psychoanalytic Society just staying where it was. I think what generated them was a realisation that the profession might be statutorily regulated and thoughts that it had to organise itself to be in the best position to do that. So there were all sorts of conferences kicking around, way before my time. The famous one was the Rugby Conference. You'd need to check the facts on this. I may not get the facts dead on right, but I think there was this larger organisation that basically became the BABCP, the British Association for Counselling and psychotherapy. I think UKCP decided to separate itself at about the time of the Rugby Conference.

Jon: The BPC was a breakaway from the UKCP?

Malcolm; The UKCP was I think, but you'd have to double check this [...] was a sort of breakaway from the broader thing, which became BABCP, which was first the BAC, I think. It may have been messier than this. Anyway the first differentiation was the BABCP and the UKCP with the UKCP standing for something called psychotherapy as distinct from counselling. And then the BPC split from UKCP because it felt that psychoanalytic psychotherapy should be recognised as a distinct profession.

Jon: And when you were appointed was that around the time of the psychological professions council proposal?

Malcom: OK absolutely I came in in September. That proposal emerged around about then. Now I can't remember exactly but it more or less emerged that autumn. And one of the very first things that I did was to go to a meeting where the proposal was launched.

Jon: And that was a meeting with UKCP and the British psychological society, and the BABCP? I think I read an account, think it was Dennis Postle, I think he complained that it had been presented without consultation and that there was also a very short window before it was submitted to respond to it. What's your view of that?

Malcolm: I don't quite know what that means. My memory is all but a bit vague about it to be honest. [pause] You know, at that point there was no, because after the rugby conference everybody had split, there was no unified forum, everybody was doing whatever they were doing. So there was no natural means of anybody consulting anybody else. To be honest. You know, somebody came up with this idea for basically, the notion of self-regulation. If we're going to be regulated let there be a psychotherapy specific regulatory body, so it wasn't self-regulation is was... if there is to be statutory regulation let it not be the health professions council, let it be, a profession specific body, statutory body like the GMC and the others, and like the HPC itself, but let's have our own body. That was the argument. Now I simply can't remember the sort of logistics of who wrote the proposal. It was presented. I don’t' remember there being some kind of time issue.

Jon: And in what way was the BPC involved in it?

Malcolm: Well funnily enough, I was new to all of this. I'd worked as an arts manager. This was a whole new world. I knew bugger all about any of it. So I went along to this meeting. It was like one of my first meetings. I thought bloody hell. When the proposal was presented, and I can't remember who presented it/. I think the work had been done primarily within the British Psychological Society, I think. I thought well ok, this seems quite sensible idea. So I took a report back to the BPC, and said well look this is all of the other bodies, BPS, BACP, UKCP, all seem to be up for this idea, sounds sensible doesn’t it I don't know. And actually to my surprise the BPC didn't want to play with the idea. My executive, I was the chief executive, I

Jon: When you say executive do you mean a board?

Malcolm: A board yes. There were two, it wasn’t called a board but it was effectively a board. There was a council meeting that met every whatever I don't know, several times a year. And there was an executive which met monthly, a and I think this was the executive, but I really can't remember> I think what was going on is that, I think when the BPC split from UCKP, it very much felt it could define a sort of quasi separate profession of psychoanalytic psychotherapy. The BPC thought this. I mean to be quite frank. At the time I joined, it was a very arrogant organisation.

Jon: IN what way?

Malcolm: It was it was rather contemptuous of everybody else within the field. I mean it, it was it had a kind of go it alone, and thought it had its own hotline to the department of health. All the world and its mother had a hotline to the department of health and felt that they were going to have their special place in the sun, and the BPC thought that to.

Jon: And did they to an extent?

Malcolm; No [laughs].

Jon: Has it been the case previously

Malcolm: no

Jon: In some accounts that I've read there's perception that BPC members are more likely to have contracts within the NHS. There is more involvement within the NHS with the BPC members?

Malcolm: I don't know that that's the case. It may have been more the case then than it is now. These days' psychoanalytic psychotherapists feel totally marginalised in the NHS. I think this was probably true that at that time, in the mid-2000s, you know, there was still the kind of fag end of a kind of historic reality, but it was the fag end of it. And the reality of it of which was a fag end was probably during the fifties, sixties, during the sort of 50s 60s 70 80s right, there were quite a significant number of, very eminent psychiatrists who were also psychoanalysts.

Jon: IS that not the case now?

Malcolm: no, so in that sense it's probably true that there was a perception that the psychoanalytic profession had a kind of level of seniority but within the psychiatric profession within the NHS. I think that was probably true. But by 2000 we were at the fag end of that. All sorts of things had happened by then. (a) the psychiatric profession itself was under the cosh, so frankly psychiatry totally lost out to clinical psychology within the NHS. Psychiatrists were seen as bloody pill prescribers, not fit for much else [laughs]. Clinical psychology had become the more ascendant profession.

Jon: Because previously clinical psychology had been seen as almost assistants to psychiatry.

Malcolm: Yes and that was changing. Increasingly more work and scope was given to clinical psychology. Psychiatrists were losing out basically; they were just seen as prescribers. What else were they fit for [laughs].

Jon: And that's mainly the case now then is it?

Malcolm: Yeah, I think it's in a sense there was a sort of retreat of psychiatry from the sort of prominent place it had, I think it's probably retreated to a place where, it's held its own, obviously I think here, it's recognised that psychiatrists have a role to play. They're not god. Or some kind of special weird, mystical knowledge, but they've got a level of expertise.

Jon: it's almost double edged then is it - there are positive aspects to it as well. There was an arrogance there - people or psychiatrists thinking that they're god sort of thing, but also a loss

Malcolm: Yes. I think psychiatrists don't think that they think they're god anymore but think they're the bottom of the shit pile [laughs]. They do all this training for years and years and years.

Jon: And clinical psychology is increasingly dominated by CBT

Malcolm: yes, I mean, yes, guess generally that's probably more complicated than that

Jon: There used to be an analytic strain within in it

Malcolm: I think there still is. I don't think it's simple. I don't think that clinical psychology is a totally gun hoe bastion of CBT. I don't think it's true at all but probably. It's probably the case that as a profession clinical psychology has been more, has embraced the CBT thing more so than probably psychiatry did.

Jon: You were saying that when you joined that the BPC was still a narrow organisation

Malcolm: It didn't feel the need to create a broader alliance between the psychotherapy bodies. It didn't. And in fact what I made it my business to do, but we've, you can't [laughs]

we're not big enough. BPC was 12 hundred members, you're not big enough to make any impact in the world and to be honest psychoanalysis now, ok it still holds sway in film studies, it does not, it is no longer seen as the great, the primary model for mental health treatment.

Jon: Was it your view that one of the best ways of doing that was to engage with the proposal for the Psychological professions council?

Malcolm: Ok, I personally, oh personally, I [pause] personally I probably wasn't sure, I think to be honest. I mean it felt generally a sensible proposal. The BPC I think, what they were adverse to wasn't the proposal as the proposal, it's that they just didn't want to be in an alliance with all this other lot. I remember the phrase used was some guy at the BPC executive said 'I think we should be just in with the dentists' - [laughs] -

Jon: Who was that?

Malcolm: I can't remember. OF course the reality was, what he was meaning is that I would rather be regulated by a sort of body like the HPC; this is what he meant by the dentists, because the dentists have their own regulatory council. So he got it wrong. But it was a sort of way of saying, look, let's not fuck around with all this politicising, this is all just a political pissing about. There is a regulatory body. If we're going to be regulated, let's just keep it simple. - along with other health professions and don't fart arse around with all this politicking. And that's how they saw it. These were all, it's not that psychoanalytic psychotherapists were not political animals, and most of them were sort of you know 68ers and all the rest of it, but they saw this as just fucking around.

Jon: And what was so horrendous about the idea of being regulated alongside other kinds of psychotherapy?

Malcolm: I don't think it was the fact that it was horrendous, is I think, err [pause] I think there was just a suspicion that this was just all gunning back to the politics of the rugby conference. I think that was probably it. We just don't want to be in rooms arguing the toss with all these UKCP, BACP people.

Jon: As if it would have been an attempt to undo as split that had been made in the first place?

Malcolm: Yeah, I'm not even sure it was as thought out as that. I think it was just a general aversion to what people saw as a kind of amateur politicking.

Jon: And was it your sense that this view was shared by most of the membership of BPC?

Malcolm: I think that's hard to estimate because I'm not really sure that the bulk of the membership of the BPC was very engaged with the whole question of it. I think the fact is that, the executive and the sort of leadership had to be everybody else just got on with their lives really. Now they knew that it was an important issue. I mean don't get me wrong, I think people saw it as an important issue but just weren't interested enough to get engaged with all the finer points of it. Well, you know we've got to be regulated; we'll leave it to the executive to sort out the best possible thing. So we were alone, the BPC in not supporting the psychological professions council. Now the fact was that this was all very short lived anyway. Because what happened in February 2007 if my memory is right is that the labour government produced a green paper, I think it was a green paper.

Jon: Do you know what's called because I have [....he means the white paper] [.....]

Malcolm: [...] February 2007 there was the white paper. And the white paper following the foster review, very definitively said that psychology, psychotherapy and counselling should be statutorily regulated as a priority and that it will be HPC. So now, by this time, we had formed a little working alliance. And I was quite influential in this., it was all, it was what I wanted to do, build bridges, and I said look, despite the fact my organisation didn't support the psychological professions council we were keen to be involved in a kind of cross body, working together.

Jon: what was it called?

Malcolm: it was called

Jon: was it called the psychological professions action group.

Malcolm: I didn't think it was called that> I thought it was psychological professions alliance group. It may have been alliance group. Yeah I can't remember. But it was basically BACP, UKCP, BPC and for a time the BPS. Now later on, I think that the BABCP also joined in. Now the problem was that the situation with the psychologists was a bit complicated, Because what had happened is that statutory regulation sot of prior to all this was on the whole came about through the professions themselves wanting it. So the way HPC worked they didn't got out and grab professions they sat around and waited for professions to knock on their door we want to be statuary regulated please. We didn't have government's saying here we're going to statutorily regulate - it was the opposite, so all the professions that HPC had brought under their statutory regulation were effectively professions that wanted it, and indeed had to prove to HPC that they were worthy of statutory regulation and there were criteria like they were a single profession, they were articulated standards, all this sort of thing. Now, the BPS

had put in an application to HPC to be statutorily regulated. [laughs] And they changed their minds

Jon: did the government have any intention of regulating them?

Malcolm: What happened is that this had gone on bloody since the 70s, so there was, in the late 70s this was all started by another Foster Report, which was the report on Scientology,

Jon: And Sieghart

Malcolm: And Foster in passing mentioned that psychotherapy which had a huge potential impact on people, didn't seem regulated, and this didn't seem to be a good idea. And various people pursued it, include John Alderdice who was himself a psychiatrists and psychoanalysts who basically promoting the idea of statutory regulation for psychotherapy. So the whole thing gained a bit of traction. I think at some point the DofH had been persuaded that it should be statutorily regulated, there was a woman in the Department of Health up in Leeds who was trying to make sense of it all, it was driving her completely around the bend,

Jon: Who was that? Was it Rosalind Mead?

Malcolm: Yes, and she was just [laughs] she was just like, everyone but everyone was going to bend her ear, and she was charged with the job of trying to come up with sensible proposals, where no matter what you said nobody was going to be happy. It's an impossible job and obviously she was just floundering and didn't know what to do about any of it. So of course everybody, including the BPC, was Rosalind Mead, Rosalind Mead, were ringing up every fortnight, saying how's it going. [laughs]

Jon: Do you know why the BPS changed their mind?

Malcolm: No, I don't really; I think there were different factions within BPS, and there was obviously a lot who thought it was a smart thing to do. [laughs]. Put an application in with the other lot not really knowing, though I'm probably exaggerating, but I don't really know, but then the other lot got the upper hand what fuck this then and asked for it to be withdrawn. This was all in the middle of the foster review going on, the HPC said, we're not sure you can withdraw your application. In any case we're all waiting for the Foster review; nothing's going to happen until the foster review says what it says, so let's just leave it. So it was the whole period of time where everyone was waiting for the foster report.

Jon: Did the BPC actually contribute to the Foster Report prior to it actually coming up with the report?

Malcolm: Do you know I think we may have done, we may have put a submission in, probably saying that as far as we were concerned the HPC was as good a regulator as it might be. So basically we probably said we weren't particularly in favour of the PPC, I think.

[....]

Jon: Who do you think I should approach to get copies of these submissions?

Malcolm: of our submissions, you could, ask the BPC office. The logistical reality is that, they were on my computer and, assuming they haven't thrown the computer away which they may have done. Obviously Gary is the chief executive so he won't know. Janice is one of the administrators.

Jon: One of the things I'm trying to work out when the, because the HPC, the regulation of the talking therapies isn't even mentioned in the Foster Review.

Malcolm: Ok, no, it is mentioned in the White Paper. I think you may be right. So what the foster review was designed to do was to. What the foster review was looking at the overall architecture of health regulation so there were nine statutory health regulators, GMC, the dentists, the nurses, blah blah blah, down to the HPC. So he was looking at the question is there a more efficient, this all seems a bit of a bit of mess, that was the general perception, I mean nine. There was also this kind of meta regulator called CHIRPY which actually became what is now the PSA

Jon: I've not heard of that

Malcolm: It's what CHRE was before. CHRE itself was called something which people called CHIRPY. IT was the regulators of the regulators, you had the regulators and then you had the regulators of the regulators [laughs slightly]

Jon: But it seems that it was widely known that there was an intention ... was it known by word of mouth that there was a government intention for HPC to regulate the

psychotherapies. In terms of official documentation is appears out of know where in the white paper.

Malcolm: That is a good question. I think that the perception probably, the months leading up to February 2007 I think that the general sense was the HPC was a possibility but not necessarily a given or even the most favoured option, it was definitely an option,

Jon: By government

Malcolm: I think by the profession generally. To a certain extent it was the simplest option. HPC was the odds and sods regulator, psychotherapy and counselling was clearly an odd and sod, so clearly a simple option for any government was to say, give it to the HPC. In a way it was sort of an obvious one, in a sense for no other reason that had to be an option because it was an obvious option not because governments had hinted that that's what it's going to do. It was keeping mum; Rosalind Mead didn't have a bloody clue about very much at all. I don't think it was a reading of the government's mind it was just that the HPC was an obvious option.

Jon: The responses to the Foster Review, there were a lot of psychotherapeutic organisations that expressed opposition, and then the government's own responses of summaries acknowledges that but then go ahead with the HPC plans anyway.

Malcolm: Ok, so, basically, in the months leading up to February 2007, you obviously had, this sort of group pushing for the psychological professions council and I think genuinely believed that it might be a goer. So I think whilst that was on the table, probably that contained what later become the anti-regulatory opposition. I think I'm right in thinking that the anti-regulatory opposition hadn't crystallised yet as a force. I mean it was probably there bubbling around. I think the proposal for the stand alone profession specific probably kept people happy enough I think. I may be wrong but that's my memory of it. The white paper came along, we're going to do it, it's a priority and it's going to be the HPC. So I think that was the moment, so the psychological professions council people didn't quite know what to do then. So of course it made my job much easier because I was able to say, well look guys whatever we all think the government's planned its position it's gone through a review, this and that, now let's just get on and work with the HPC. Ok. So that was our position. Let's stop fucking around, government knows what it wants to do, it wants the HPC, let's make it work with the HPC. Of course that aligned very neatly with what the BPC wanted to do.

Jon: I get a sense it was mainly the BPC that didn't want to be involved with the Partnership, rather than hesitancy or wish to exclude from the UKCP.

Malcolm: I was very keen that we did have an alliance grouping but not organised around a demand for a psychological professions council. I was for the grouping but not for the demand

Jon: For what purpose for that group then?

Malcolm: well [laughs slightly] that's a good question. To [pause long pause] I think at that point because there was a difference of view around the demand it was probably just to keep the dialogue open between us and we broadly speaking, all professional bodies including UKCP were formally of the view that they supported statutory regulation, and that they wanted the best possible form of it. Now we had a different view from everyone else about what the best form would be. But look we, had the psychological professions council proposal been taken up, BPC wouldn't have gone to the wall against it, we'd have probably have said at that point, well ok, we'll go with that then. I think we had a sort of pragmatism about it.

Jon: And you don't think the BPC in not joining initially was instrumental in the government not accepting the PPC proposal, the government was already... /

Malcolm: Absolutely, yeah. I don't think at that point anybody had huge. I think the profession was such a bloody pig's ear and so obviously a pig's ear that no section of it really was taken seriously by government. I honest think that that was the case.

Jon: A pigs ear in a sense of there being no...

Malcolm: It just looked like a bloody shambles, I mean we were.

Jon: IN a regulatory sense?

Malcolm: In any sense. I don't think any section of the profession had the ear of government because we looked like a bloody shambles. That was the truth of it.

Jon: Were there any positive reasons why the BPC, more positive reasons why they wanted to be regulated by the BPC?

Malcolm: Not really no. I think you know, I think it was, it was just sort of, if this is going to happen let's just have the simplest the most elegant, the most clean cut version of regulation.

Jon: But it was seen that is was just going to happen

Malcolm: Oh I think everybody but everybody assumed that there would be statutory regulation of one form or another at that point, absolutely yes. The working assumption was that it was coming, it was taking years and years and years to work out but sooner or later it would come. I think everybody thought that.

Jon: And there's a general perception that BPC would try and create a monopoly through the skills for health and...

Malcolm: it's just ridiculous. The BPC, I know that there were people around that thought the BPC had some magical access to the levers of power. We had no, we had nothing. We were as hopelessly un-influential as everyone else. Now we did have Alderdice. We had the ear of Alderdice, lord Alderdice, psychiatrist, psychoanalyst and was earlier on a real player, in an attempt to get through statutory regulation as a private members bill. But frankly by 2007, to be honest whilst Alderdice, I'm a great fan of John had all but no influence on this debate actually.

Jon: I'm thinking mainly in terms of BPC's influence on the SfH project which was supposed to influence the process of the HPC PLG,, and

Malcolm: Well it didn't. This is absolute illusion.

Jon: Peter Fonagy and Mike Cooper primarily devised the draft standards of proficiency

Malcolm: Ok you've leaped on a bit, so where are we, February 2007. So what then started to crystallise in the weeks and months after February 2007, it took a few weeks if not months for the people who were in favour of the psychological professions council to realise it was a no goer. It took a few weeks for that to sink in, but gradually it did. So in a sense, pragmatically people had lined up with the BPC position, not because they wanted to, but they realised that the only show in town was now the HPC. And that it was better rather than pissing around with other proposals that no one was going to take up, was to constructively engage with HPC, as our potential regulator, and that was our position, and became BACP's and indeed UKCP's position. Also, during those weeks and months, whilst the leaderships of those bodies basically decided it was time to constructively engage with HPC, the opposition to statutory regulation crystallised as a force. Now, the opposition, in my mind had two completely contradictory arguments. One argument was that we oppose statutory regulation completely. Basically, there were in its statements that effectively said we are against any form of statutory regulation. To a certain extent that was probably the heartbeat of the opposition. The way that the argument was actually constructed though wasn't that, it was a sort of moderate version of it, was that we are opposed to regulation by the HPC. Implying that if there was something else, that was, that, where did that leave another possible body like the original proposal, which would have been potentially a statutory regulator. Would they have then been happy with that or not?

Jon: They made a distinction between state and statutory regulation didn't they?

Malcolm: Well, what does that mean?

Jon: There argument is that a specialist, based on the model of the GMC, a statutory regulation, whereas with the HPC, there actually in control of what the standards are set for a profession.

Malcolm: I can't see any structural position between the HPC and the GMC

Jon: With the GMC isn't it the profession itself that is primarily still in control.

Malcolm: well yes, alright but frankly these days, the pressure was on all regulatory bodies to have majority lay members, Ok I can accept that basically the provenance of the GMC, yes this was a self-regulatory body, underpinned by statutory regulation. But the actual reality was that over time, they took on lay members and all the rest of it. Also the HPC, you say, that the things were imposed, but they set up, the way the standards of proficiency were to be worked out, was to set up a professional liaison committee. No one else arguing the toss around the standards of the proficiency other than members of the profession. So yes, alright I can see that in some vague, originating way there was a difference between the GMC and the HPC, but to say that this was some deep structural difference between state and statutory regulation, and statutory regulation is just bloody verbal, it's just linguistic [..] magic. In effect in any kind of operating level there is no distinction between the two.

Jon: So in your view that's one wrong argument of the opponents?

Malcolm: It was wrong, it was incomprehensible. To me it was, it doesn't make sense [laughs].

Jon: What about the argument that psychotherapy is not a healthcare practice?

Malcolm: Well, I mean, it's not that that claim is incorrect, it's just kind of what do you do with it. Governments have, governments chop themselves up in certain ways, they have departments on the whole do education do military things do health food this that and the other. At the edges there are different ways of cutting it up, and you know, sometimes they do cut it up differently. Sometimes they give universities to the business department [laughs], other times they give universities to education. So you can chop things up in different ways,

and all governments have to decide about how you chop things up. Yes it's true that psychotherapy has dimensions to it which, probably in the main overlap with health concerns and operates in ways that sometimes, doesn't. I wouldn't' want to go to the wall and say no psychotherapy is definitely our thing. But if you accept statutory regulation is either a good thing, or a necessary thing, or an inevitable thing, then it's going to sit somewhere and probably in the round health is about a sensible place as it can sit anywhere else. Where else would it sit the ministry of defence [laughs].

Jon: One particular way of looking at it would be through. When I interviewed Andrew Samuels, he said that in one of the standards of proficiency, there was a passage that said the psychotherapy should make a diagnosis and then devise a treatment plan and then follow it... he actually suggested that you might have written that.

Malcolm: This is what happened. When we got into the detail of working out the standards of proficiency, the big battle within the professional liaison committee wasn't about for or against statutory regulation, it was between BACP on the one hand and UKCP, BPC, and BABCP together on the other, and the argument was this. The BACP wanted complete non-differentiation between counselling and psychotherapy whereas BPC, UKCP, and BABCP believed these were distinct professions with distinct standards of proficiency, and this was the big battle line within the standards, within the professional liaison group. The battle around for and against statutory regulation was going on somewhere else. So there were two battles going on if you like. So there was a battle against statutory regulation or against HPC regulation, and that was being fought by Andrew and the comrades. Within the PLG there was another battle going on about whether counselling and psychotherapy were to be merged or kept distinct. Ok. So this was the thing. Many of us don't forget BACP, ha 33 thousand members, it leaves everyone else looking like nothing. But its numerical preponderance was not represented, and basically they didn't have very smart people operating in that committee. Neither did UKCP but that's another story. We had Fonagy [laughs ever so slightly]. And our other person was Julian, although Julian often didn't go and I went instead to quite a number of those meetings, and played a very active role. What we argued was. There was really quite a passionate debate around all this, with us saying, no these are distinct, the BACP saying no no they're not blah blah blah. And there was a sprinkling of people from the HPC and other committees who were members of the profession, who looked on with kind of fuck [laughs]. So what we agreed to do was we asked BACP to organise a meeting with whoever they wanted there to come up to define their own standards of proficiency. And we proposed that we convene a group to define, or to come up drafts standards of proficiency for psychotherapy. When those two drafts had happened to put them side by side and then to conduct the debate on the extent to which they were different.

Jon: This is the BACP doing their own and the BPC doing their own.

Malcolm: No, the BACP who led on drafting standards of proficiency for counselling and a combination of BPC, UKCP, and BABCP, together tried to draft standards of proficiency for psychotherapy, ok. Now, if you try to do that exercise, even UKCP realised this, but they would never acknowledge it, the only words and concepts, that ultimately distinguish

psychotherapy from counselling, are words and concepts that one one way or another derive from medicine. Clinician, pathology, treatment, and so we had what's her name, Joanne thingy Black.

Jon: Carmen

Malcolm: Carmen, yes, who was against the medical model, but when. So Carmen came up with any concept that distinguishes clinician. Carmen clinician, where does that come from. So you know, you try and do it, and try and, as soon as you try and eliminate any form of medical concept from psychotherapy you're left with something that's very hard to distinguish from counselling. Now does that make psychotherapy a purely medical model? No I don't think it does, but it's hard to say that it has, that is doesn't have commonalities with, if you like, with the tradition of healing, that goes back to hypocritise.

Jon: Another dimension, it's quite interesting, responses to the call for ideas, and also draft standards from people in the profession, there was a disjunction between the organisations and individual members, and individual members didn't want to have a distinction between counselling and psychotherapy. Is that driven partly by many psychotherapists not wanting to be identified as psychotherapists that have a strong medical model?

Malcolm: Well, ok, the trouble with people, of course, within the BPC, there are Jungians. Jungians would be the last people, or they'd be the first people to say, you know, it's not a medical model. So it's not like the BPC is full of medics, It absolutely isn't. So if you had a debate within the BPC, is psychotherapy, you know, is psychotherapy based on the medical model, you would probably get a majority of BPC people voting no. Ok, similarly within UKCP, would say no no no, we're not about medical model. But they are also adamant that they are not counsellors. But the only way, what I'm saying, the only way ultimately, you can differentiate counselling from psychotherapy is by some reference to the tradition of healing. Now whether you call that medicine, or whatever, whatever, whatever, you end up using words like clinician, pathology, words that in one way or another are connected to the tradition of medicine.

Jon: And so did you approve of that draft that said about the treatment plan?

Malcolm: You have to get hold of what happened. There was a ferocious debate within this group of people. They included UKCP, BABCP, BACP, and us; they are the draft standards of proficiency for psychotherapy. I honestly can't honestly remember whether that phrase ended up in it. It may have done, it may not have done. But it was a compromise and Carmen as much as anybody argued for as much elimination of medical concepts as was possible. Equally, she also had to have in mind, if we had in mind something that was too indistinguishable from counselling she would have lost the argument she was much more passionate about, that there was still a distinction between psychotherapy and counselling.

Jon: And why was she passionate about that?

Malcolm: Because UKCP people are passionate about that - they profoundly believe that they are psychotherapists, and that psychotherapists are not counsellors.

Jon: And do you think that's linked to conceptual and philosophical differences as well as issues of social closure -, concerning markets I suppose. The reality finding markets - that seems to be at play as well.

Malcolm: Yeah, although you know, BACP will produce research saying that much more people are drawn to somebody that is called a counsellor than a psychotherapist. But whether that's true or not. But I think it's more of a status thing than a hard market analysis drive [laughs]. People are trained in psychotherapy think they are psychotherapists and they are not going to be called a counsellor. Or you know, said to be the same thing as a counsellor. I think it is to do with self-identity in very large part. Interesting though, BACP, commissioned a study. A public questionnaire about the difference, about whether there was a difference between counselling and psychotherapy, and the vast majority of people they surveyed said there was a difference. And I didn't get to learn about this until after the debate. Never once did they produce this report for us.

Jon: Who didn't?

Malcolm: the BACP

Jon: Wow, right.

Malcolm: The BACP own survey of the public, demonstratively showed that in the public mind over sixty, I can't something like over sixty percent of the public believed there was a difference between psychotherapists and counsellors. But they kept very quiet about this report.

Jon: Why do you think there is that disjunction between member organisations and membership?

Malcolm: I don't know if I buy that. What happened is that BACP galvanised their members to write in as individuals to say there is not distinction. I think that BACP, sorry start again. So BACP successfully galvanised their membership to write as individuals saying that there was no distinction. Now, BPC, UKCP, BABCP, were less successful in galvanising. I think that UKCP probably more than others. I doubt very much whether the UKCP membership would

have written in saying there's no distinction. I just don't believe that. Their membership will have said loud and clear there is a distinction. So I don't buy that, I think the reality was, that a very large number of individuals wrote in to say that there was no distinction, but that was BACP mobilising its membership. And the other organisations were not as successful in getting their individual members to write in. So I think there was a numerical disparity, but it wasn't that our memberships were saying different things from the leaderships, on that issue.

Jon: Can you say something about the membership of SfH and PLG? You said that there wasn't some kind of hotline to government, but there is the question of the BPC dominating the membership.

Malcolm. I don't believe there was. Ok, so, ok, what there was a kind of zeitgeist, ok? So I think what there was, is probably for the first time, in a very long time, the notion of psychological therapies was, had a much higher profile within governmental circles, than it ever had had. That was going on. OK. So you know, psychological therapies was a hot topic. Not as hot as the Falklands war, or you know. But in the scale of things, and this is in large part due to Richard Layard, and the whole IAPT thing. So all of this was going on. Nothing to do with statutory regulation. So psychological therapies kind of had a positon on the stage within this sort of broader, governmental, policy making framework, ok. And because of that, there were all sorts of overlapping committees and there was stuff going on you know. So for example IAPT, there was an expert reference group. There was an education training committee. There were various committees going on around IAPT, and we were all arguing the toss around, the predominance of CBT - all the rest of it. There was a whole number of individuals, and I was one, you know, Sally Aldridge of BACP was another, who were turning up at all these bloody committees. All arguing our corner. So that I think was the, the context for all of this, ok. Now, many of us believed that this was a, an opportunity to really to put the sort of profile and status of psychotherapy as a profession firmly on the map, or you know, firmly in place. That was an ambition. It was an ambition that Peter Fonagy had, an ambition that I had. It was an ambition that various people had. There was IAPT going on, there was statutory regulation. I think a number of us believed that together, if we played this right, we would establish psychotherapy as an important valued modern profession. There was an ideological project going on if you like, of which Peter was very much a part and I was very much a part. It was to seize an opportunity to, yeah, to really place a modern profession of psychotherapy at the heart of things. So, yeah, there was an ideological project, and statutory regulation was part of the package.

Jon: You could argue though that it was an attempt to make a certain form of psychotherapy into a well-established modern profession

Malcolm: And what form of psychotherapy would that be?

Jon: More manualised forms that Peter Fonagy developed.

Malcolm: Well, you know [exasperated, sighing].

Jon: Or would the argument be that one gets a foot in the door and then develop more ...

Malcolm; The trouble is that, I think, Peter will be the first to recognise that this kind of, you know, deeply finely grained [inaudible] of competencies, I mean, lead to this encyclopaedic thing that became the sort of official SfH. What happens to it? Who reads it? It sits on a shelf. Has anyone read it in the last ten years?

Jon: is it used at all?

Malcolm: No [emphatically].

Jon: One of the intentions was that it would be used to help develop job descriptions.

Malcolm: That's bollocks. It doesn't work like that. You know, I, I wouldn't mind, I might be wrong, but I'd be amazed if more than ten people looked at those skills for health competencies in the last six, seven, eight years. I would be amazed.

Jon: national occupational standards

Malcolm: Yeah

Jon: wow, Ok. What do think is motivating that then?

Malcolm: Well, I don't honestly know how it came about, but as I say, it's part of the zeitgeist. OK right, ok, I do vaguely remember how it happened. Right, as part of the IAPT thing, right, part of Layard's argument which was successful is that, in order to combat, mild to moderate anxiety and depression we need to use evidence based therapy. Basically this is CBT. And you know if we spend loads of money. Or if we spend in his view a modest amount of money, then you know, it would all be paid for having not given out so many benefits, that was the Layard argument. Give people treatment, go back to work and save on benefits.

Jon: Skills for health was supposed to support that?

Malcolm: No, no, no. Well, there was a connection; I'm a vague about this. The whole IAPT thing went ahead. And Layard was saying we need thousands, thousands of CBT therapists, we haven't got them, and so we need to put training in place. And so the IAPT the commissioned all this CBT training for high intensity therapists, and what were then called low intensity therapists, which became well-being practitioners. So this is all commissioned, and that lead to a need for defined curricula for these trainings. Now, I think what then happened is that someone in the DH commissioned UCL, and particularly the bit that's the Pilling ones, to define sets of competencies for CBT, and that fed into the national curricula for the IAPT-CBT training. Now, obviously then what happened, and this I really just don't know how it came about, but obviously conversations happened with SfH, who decided to commission a wider body of National Occupational Standards around psychotherapy.

Jon: So they were overlapping.

Malcolm: Now, so who had those conversations, how they came about, why SfH decided it was the right time, I don't know. I don't know. But, you know, the main contextual point is the zeitgeist point, psychotherapies were very much, centre stage, and so, I mean, there may have been all sorts of nudging and conversations, going on. I really don't know. But anyway, SfH decided to commission these NOS around four modalities, which were basically psychoanalysis-dynamic, family systemic, humanistic something or other, and I suppose it was CBT. I think that was it.

Jon: I don't know if you've read the Maresfield report, and its account of SfH. Even though, they documented the SfH actions and quite clearly it seems that SfH were quite underhand in how they went about making appointment or justifying them. They actually acknowledged that it wasn't representative enough and they would do something about it and then they didn't do anything. There were lots of things, SfH seem to have failed to do what they claimed that they would do, and that was to, for better or for worse, to make those groups representative of different groups within the field.

Malcolm: Yeah, I don't know, I won't, I mean, you know, that may be true. I think certainly that the exercise was led be Lord Alderdice and Peter Fonagy, and I think they probably, you know, had a fairly tough and impatient stance on it, that. I think they did take a bit of a view that there was a job to do. They were fucked if they were going to be arsed around with, you know, a whole bunch of people who were just against the whole exercise. They just wanted to get it. So I think they were probably a bit, you know, [laughs] kind of, they probably aired on the side of an unparticipativeness. Because they had a certain impatience to get the job done. They just knew what would happen, they'd end up arguing the toss and going around in circles with a bunch of people who actually didn't want this exercise to happen, and they were buggered if they were going to plisse around like that. I mean, you know, so possibly the process was not, was less than, perfect, in that sort of participative, democratic, representative way, but it was born out of an impatience to get the job done.

Jon: Were you and Julian invited to join the PLG or did you apply? Did people apply?

Malcolm: Err, [long pause], I can't remember, obviously there was a working assumption that the, I mean, what. As I remember the HPC was very clear, that people were there as individuals and not as representatives. I think that's the theory. However, I think there was a kind of pragmatic acknowledgement on the part of HPC that certain organisations had to be around the table because it couldn't work in any other way. So I think there was a bit of fudge between you know where they there as individuals or were they there as representatives sort of thing. And I think broadly speaking, though strictly speaking; you couldn't be there, as it were, representing an organisation. The pragmatic reality was that all of the organisations were in in fact in quotes 'represented' around the table.

Jon: It's hard to understand how they would be able to select without..

Malcolm: yeah, I'm pretty sure that the BPC, would have been asked who they wished to, but probably nominate. I think the most we could do was to have nominated, we weren't there as a right. I think.

Jon: And in terms of the PLG, do you think, you were close in reaching an agreement as to whether, if it hadn't been for a change of government and judicial review?

Malcolm: I think, ha, yeah, by agreement, I have to say, agreement it wasn't a consensus. It was a majority agreement. And what happened is that the differential lobby to call it that won the argument. And BACP lost it. Simple. They lost it, they knew they lost it. They hated losing it, possibly, had it gone forward, then BACP might as an organisation have come out against HPC Registration because they had lost the argument around differentiation.

Jon: The BACP position seems to be very variable. Not very long before - they actually made a statement that they were withdrawing their support.

Malcolm: But I think it was because they lost the argument around differentiation. It was all to do with that, nothing to do with anything else. After the demise of psychological professions council their position was to be very supportive of constructive engagement with HPC. Absolutely they were, totally in favour of statutory regulation, they were happy, or broadly happy with HPC as the regulator. It was only when they lost the argument around differentiation did they start to get more critical.

Jon: were there any specific criteria that BPC would have withdrawn support?

Malcolm: Yeah, we hadn't articulated a sort of checklist but you know but by and large we took the view that, in the scheme of things seemed to be a sort of decent enough body, its

processes were. I actually, the process were some of the best I've seen in terms of transparency, openness, the way they published minutes. I thought they - as a body,

Jon What about their fitness to practice and the fact that you can't have fitness to practice before the findings of a hearing?

Malcolm: Err, well, it's true that HPC didn't have a formal mediation process. I think when that argument started to be put to them they acknowledged that and said, yes ok that's not an area they'd thought about, and I think had said they would be happy to think about it. And I think that they said that credibly, so yeah, you know, it probably was an area of weakness of whatever.

Jon: Another area that opponents highlighted was the case of the psychologist, I'm not sure, David Cross [Malcolm Cross] who was, he was put through a very lengthy fitness to practice hearing on the basis of his behaviour at a private party.

Malcolm: Oh ok, i vaguely remember that.

Jon: And they actually found in their behaviour, but it didn't seem particularly like a victory to him because he'd gone through an awful ordeal.

Malcolm: Well, [long pause].

Jon: isn't there a danger that could lead to defensive practice, if the HPC is active in that sense, widely publicises, almost vilifies somebody just through publicity - it would lead to defensive practice.

Malcolm: Well, you know, if you, ok if you have a complaints procedure, now the BPC had its own complaints procedure, and nothing about it was public at all. It took the view that it shouldn't be. Basically to protect the reputation of a practitioner until the dict, to call it that, had been reached. And that was the BPC's own way of doing it, and you know the HPC as a public body took a different view, which is that if you get a complaint. There's a stage one process to decide whether or not there is a case to answer. As I remember it that is not public. And that is protected. If it is decided there is a case to answer it goes to second stage, and at that point it is public.

Jon: Is there any attempt of mediation in that first stage?

Malcolm: No, I don't think that there was. But I think this is the thing that the HPC is - took on board - that they would look at. I don't know if they ever did. But there was an issue there. Now, HPC would say as a public body, European legislation and all the rest of it and that has to be a sort of transparent publicly scrutinised process, and of course the down side of that is that it leaves a practitioner going through that process who might then be found not guilty or similar. Or the complaint is not upheld as has been publicly exposed. And that is I suppose the price of a regulatory system. Induvial practitioners subject to complaints.

Jon: Opponents argue that it's very damaging to the complainant as well. They're very exposed, and are pushed into a very adversarial system.

Malcolm: I mean, there are down sides, there's a price to pay for this what you might call public scrutiny. But there is also a price to pay for a kind of leave it to the professionals, we know what we're doing closed shop - too. And I, I know people bang on and on about the so called audit culture and all the rest of it, but I grew up in the fifties when there was no audit culture. And what it meant, right, leave it to the professionals, rampant, you know, old boys networks in the medical professionals. Untouchable canteen culture in the police service while they could fuck over everybody in site, whether they we gay, pakies, or whatever, leave it to the professionals. They knew what they were doing. No bloody lights shone in on them. But that was the lack of an audit culture in the 50s and early 60s. So leave it to the professionals doesn't quite cut it with me.

Jon: So with the audit culture there is an element of meritocracy in challenging the old boy's network?

Malcolm: Well, how do you let the light in on self-interested professions? You know, you have to bloody well insist upon it. Sorry, we're opening the doors here. We are going to hold you accountable to the public for what you do. Now, that, it's not easy to get that right. And of course there is an opposite danger that making professionals overly accountable in a kind granular detail way, of course there is an opposite danger that they feel un-disrespected, you know, just a kind of a cog in a machine. This is a terribly difficult thing for societies to get right, I think. But just to sort of bang on about an audit culture, forgetting what a non-audit culture looks like is just too simplistic in my book. I mean look at the bloody bank crisis, where was the audit culture when we needed it.

Jon: Well it was supposed to have been there wasn't it; arguably it shows that it was for who. And some people do argue that HPC trials are show trials really. And that the HCP doesn't regulate everyday practice as much as professional associations do.

Malcolm: well, ok, it, I don't, I left the BPC when I left it, so. I'm an empiricist, if one looked at it over time, and found that, you know, really as a system of regulation is really just wasn't cutting it, then I would say, ok, then we judge this outfit not fit for practice. I wouldn't want to take a sort of non-empirical view on it and say, I've mad my mind up about HPC that it's

alright and I’m bloody well going to stick to it. But against the evidence, if the evidence is in that round that it really doesn't seem to be working, and there are case after case of ridiculous decisions and it's not really getting at the heart of where the problem is then of course but I would want to look at that against the evidence, not against a sort of fixed prior view against an ideological view of the HPC.

Jon: A couple of questions if that's alright?

Malcolm: Yeah.

Jon: There was an account where Mick Cooper was reported to have said within the PLG I think, that service user views need to be taken into account. And that there was a major omission there.

Malcolm: Yeah I would agree with that. I would utterly agree with that.

Jon: So when people talk about service users, through mind...

Malcolm: Well, whoever, there's loads of different ways of doing it, but I think basically the mental health profession and this organisation itself. We're working to change that, but have a very poor history of involving with lived experience of services and mental health issues, as co-designers and co-constructers of solutions, and I think the composition of the PLG reflected that, long standing structural weakness, it is absolutely true.

Jon: And do think it's because it would seem to complicate the matter too much?

Malcolm: no I think it was the default potion of most organisations at that point in time. There wasn't culture and tradition of involving service users. People just hadn't thought of it.

Jon: So it's a very recent phenomenon then?

Malcolm: It, its differential, it's been better in other fields, certain places. Certain organisations have bene much better at it than others. At the Tavi [Tavistock] we've been very poor until quite recently.

Jon: And would you say that Jonathan Coe represented service user's views at all?

Malcolm: Well, Jonathan, [pause] you know, I mean, Jonathan had set up what was effectively an advocacy group on the part of people who had suffered abuse at the hands of psychotherapists. I always thought that Jonathan was a decent guy and he was coming from where he came from, he felt that he significant abuse had gone on and had effectively been covered up. And I thought he, he had an important voice. I wouldn't say, in a sense, represented the diversity of service users. But I think he represented a particular voice. And I always found Jonathan a very decent, thoughtful guy, who had important things to say.

Jon: What like? What was he contributing that was distinctive?

Malcolm: I don't think he was perusing a line. I think Jonathan believed passionately in statutory regulation. He thought that it wasn't necessarily the ultimate answer to historic questions of abuse by professionals, but he felt it was an important part of the jigsaw, and so that, but in a sense we were all signed up to that then. He wasn't generally; I think he wanted to see in place a fairly robust system of statutory regulation.

Jon: There was that conflict between him and Darian Leader about the Manchester stakeholder meeting where Jonathan had introduce a former patient or client or whoever, and Darian later made the argument that there was something being replicated in the way that Jonathan was almost forcing her to represent - I can't remember the exact details...

Malcolm: I think I was in Manchester. I think this is the sort of Darian view that any patient that is put in front of an audience is going to enact certain or play out some kind of psychoanalytic scenario. The fact it - I can't remember the details of that specific thing. I couldn't see anything wrong with somebody that had obviously suffered abuse and coming along and bloody well saying so. [laughs] We had this debate in the BPC, all organisations. All psychotherapeutic organisations have a natural tendency to pathologise complaints. That's what they do. So someone has complained that their pathologising. And it took a long time to change the culture within the BPC to say, actually, some of the complaints are real and legitimate and the psychotherapist has been at fault. It's not all pathology guys. Sometimes psychotherapists do wrong things. And people are right to complain. Now the shift for the BPC was introducing lay members on panels. And out chair of ethics himself, who, to a certain extent was a bright guy, he was a brilliant Chair of ethics, himself said do you know Malcolm, I've come a long way because, whilst I wouldn't have been the kind of people that would have said that all complaints are pathology, nevertheless we all have a tendency to put complainants in that pathological box, and we all do it. And the big difference that was made when we had lay members, because they don't buy that shit. Lay members come along and say, and he. Actually the big difference is not necessarily what the lay members say but what the psychotherapists say because they realise that they can't get away with their bullshit in front of a lay member. His journey was a very interesting one. He believed that the introduction of lay members to complaints panels was the single most effective thing it did to make them more, fairer and saner. Just more grounded in reality rather than this psychotherapeutic fantasy world, where that anybody complains has pathology.

Jon In that particular case Leader wasn't saying that the abuse didn't happen but that it was being replicated by...

Malcolm; Yeah but I think that's a classic form of a psychotherapist trying to pathologise away a confrontation with a reality that needs to be heard. So I think that's exactly the sort of old bollocks that therapists often come up with.

Jon: A final question, though a broad one. I was wondering. Your background is in arts management isn't it. And my understanding is that there's an increasing instrumental philosophy in that. And that the arts, when they commission, they need to be shown to be adding something for the government achieving its broader policies.

Malcolm: Yeah, I think that's by and large true. You know, now up until - to a certain extent many of the arguments came from the arts themselves. It wasn't some imposed thing. The arts have always struggled for money. Ok, so sometime in the, when was it. Kind of in the 80s really, a lot of artists, realised that, there was money around, […..]

[Ends]

APPENDIX B

INTERVIEW GUIDE MALCOLM ALLEN

Biographical Information

Dean of Postgraduate Studies

Tavistock and Portman NHS Foundation Trust

January 2012 – Present (2 years 9 months)North London

Strategic responsibility for postgraduate education and training programme

Chief Executive Officer

British Psychoanalytic Council

September 2006 – December 2011 (5 years 4 months)North London

UK-wide professional association for psychoanalytic & psychodynamic psychothotherapists

Director, Capital Programme

Arts Council England

July 2004 – August 2006 (2 years 2 months)London, United Kingdom

Managing National Lottery-funded capital investment programme

Head of Assessment, Capital Programme

Arts Council England

July 1999 – June 2004 (5 years)

Senior Lottery Officer

Arts Council England

January 1997 – June 1999 (2 years 6 months)

Director

The Studio

June 1992 – December 1996 (4 years 7 months) Beckenham

Arts and media centre, incorporating multimedia studio

Director

Birmingham Media Development Agency

August 1989 – May 1992 (2 years 10 months) Birmingham, United Kingdom

Project consultant

Broadway Cinema & Media Centre, Nottingham

September 1987 – July 1989 (1 year 11 months)Nottingham

Feasibility work and set up for the media centre

Structure and Key Questions:

Position and background:

1. What's the difference between the role of the Chair and the Chief Executive of the BPC?

Pre-White Paper:

2. What was BPC's response to the Foster Review on The regulation of non-medical healthcare professions? Why was the BPC not involved in the so called Partnership Group (UKCP, BPC, BACP) and the Psychological Professions Council Proposal? Was the BPC already in support of the HPC?

3. Why did the BPC support the HPC plans? Why did the BPC support the plans and SfH project to map National Occupational Standards, in contrast to its refusal to participate in project during the early 1990s to devise NVQ standards for

psychotherapy? The BPC actually took a lead in resisting these. The BPC had stated that the system was 'flawed' and the language of 'competencies' inappropriate for the process of analytic psychotherapy (see Balfour and Richards). If it is matter of pragmatism or realism – was there something more pressing or overwhelming about the HPC plans? Or did the BPC lack pragmatic attitude during the 1990s – was it simply stalling the inevitable? If it was inevitable – doesn't the abandonment of the HPC plans demonstrate that in fact it wasn't inevitable?

What's the BPC's response to the charge of opportunism? Was it seeking to establish a monopoly within the field? Is it a 'survivalist strategy'? One of the key attractions to many people within the field of the HPC plans was the view that it would contest a perceived hierarchy within the field with the BPC and psychoanalysis as superior. Given this, it seems reasonable to surmise that the BPC dominance of SfH and its links with HPC contributed considerably to the derailment of the plans. What's your view on that?

Skills for Health Project to map NOS for Counselling and Psychotherapy:

4. Were you personally involved in the SfH project?
5. What is the influence of SfH in the provision of mental health services? What uses have the NOS been put to?
6. As you'll know, the perceived dominance of the BPC on the Skills for Health project created a lot of anxiety not only about that but also the HPC regulatory plans. Strong complaints were made to and against SfH about impropriety in the way they handled the section of members of the groups. What's your view on that? (see 'Skills for Health Impropriety' sheet).
7. When Denis Postle from the Independent Practitioners Network met with Marc Seale of the HPC, and expressed concerns about the relationship between SfH and the HPC plans, Marc Seale reportedly stated that […….insert the quote – see therapy futures book]. Do you think that this assertion, repeatedly made by various people in favour of the HPC plans, was a very credible view? – especially also given that Peter Fonagy had such a prominent role in devising the definitions of psychotherapy and counselling for the PLG in the HPC.
8. What is your view of 'manualised' forms of psychoanalytic treatment? In keeping with arguments that you and Cooper develop in 'Borderline Welfare' aren't manualised treatments partially a retreat from disturbing knowledge and the complexities of in-depth relationship? (See quote A and Quote B).
9. When I interviewed Nick Temple he described manualised psychoanalytic treatments, e.g. those developed by Peter Fonagy as 'watered down versions of psychoanalysis' and characterised them primarily as a necessary, if somewhat regretful, survival strategy for psychoanalysis i.e. to ensure that there is at least some form of psychodynamic treatment available within the NHS. Do you share that view?

Professional Liaison Group (PLG)

10. Am I correct in thinking that you attended some of the PLG meetings? How would you describe your overall experience of the group? The impression created by external accounts was that it wasn't a very creative group?
11. What in your view is the difference between counselling and psychotherapy? You were reported to have reluctantly accepted a definition of counselling as 'mental health well-being'. Is that right? What is your objection to that?
12. Mick Cooper is reported to have said that service-user views need to be taken into account in the process – and that this was a major omission. Were service-user views taken into account? Do you think that service users and the public generally want a regulatory system like the HPC?
13. In responses to the HPC call for ideas as well as consultations on the PLG recommendations regarding the structure of the register – there were significant differences between the responses of individual practitioners and those of training and professional organisations. For example most individual practitioners were against structuring a distinction between counselling and psychotherapy in the register.
14. [add question about the final recommendations and structure of the register].
15. How instrumental do you think the Allliance and opposition to the HPC plans from within the field instrumental in leading to the dropping of the plans?
16. What's your view of the current system of assured-voluntary regulation? Is it adequate?

The HPC Generally

17. What is your view of the fact that HPC fitness to practice hearings only allow mediation after the conclusion of a hearing? [draw on some of the critiques and figures drawn out by Haney].
18. Do you wish that the HPC plans had been successful?

IAPT and more general: Have you any dealings or specific knowledge with IAPT and public mental health services more generally?

19. What is your view of IAPT? Is this a positive development in the provision of mental health services? How is it viewed within the field? How is moral in the mental health service field in relation to policy developments?

20. Has IAPT taken resources away from already existing mental health services, and psychotherapy services?
21. What is the 'New ways of working' project and what impact has this had within the field?
22. What kind of employer regulation or governance of counsellors and psychotherapists is current within the NHS and public services? Nick temple said that the system of revalidation of doctors and psychiatrists is largely a paper exercise that is more about creating the impression that the public are protected from another Harold Shipman, but that in reality someone like Shipman would probably be able to pass revalidation with flying colours.
23. What's the Savoy Partnership?

Arts Council: I understand that previously you have worked for the Arts Council. It's often claimed that funding for the arts has in the last few decades shifted towards an instrumental philosophy in which programmes must demonstrate how they will contribute to the aims of government policy –such as greater inclusion - in order to achieve funding. Is this true in your experience? If so, do you think there is a similar logic at play in the arts sector as there is in mental health service provision and the HPC regulatory plans of private psychotherapeutic practice?

APPENDIX C

SAMPLE RESEARCH INITATION LETTER

From: Jonathan Wildman

To: Linda Mathews

Dear Linda Mathews,

I am writing to invite you to take part in a research study. As a part-time Ph.D. student in the Department of Government at the University of Essex**,** I am currently conducting research, under the supervision of Dr Jason Glynos, on the regulation of the talking therapies. The focus of my research is on the 2006-2011 political and professional struggles around the attempt to institute the Health Professions Council as statutory regulator of the talking therapies.

In the research I seek to illuminate the plurality of perspectives of different stakeholders involved within the struggle. Participation within the study would involve taking part in an in-depth interview, by telephone, which would explore your views on and involvement within this struggle and policy domain. I am particularly interested in your involvement with the PLG for Counselling and Psychotherapy, your experience of this group, and in the BABCP's position on regulation, both then and currently.

If you agree to participate, I shall send you an 'interview guide' (and accompanying consent form), in advance of the interview, highlighting potential areas of interest and discussion. You would, of course, be free to withdraw your consent to participate at any stage prior to the completion of the research.

Please contact me at the above email address, or on the above telephone number, to let me know whether or not you are interested in taking part in the research, or if you have any questions about the study. I plan to send you a follow-up e-mail invitation too in a few weeks, in case this makes things easier. An interview would be arranged at a time that is convenient to you.

Yours Sincerely,

Jonathan Wildman