THE POLITICISATION OF CLINICAL PSYCHOLOGY TRAINING COURSES IN THE UK

"The goal is the creation of therapist-activists, who will diagnose presenting problems through a collective lens and use the client-therapist encounter to inculcate an ideology that fosters grievance and victimhood: the only solution offered to presenting problems will be a never-ending political activism."

Dr Val Thomas (2020)

THE POLITICISATION OF CLINICAL PSYCHOLOGY TRAINING COURSES IN THE UK

Implications for the profession, practitioners and patients

Carole Sherwood DClinPsy
Kirsty Miller PhD

The Authors

Dr Carole Sherwood is a clinical psychologist who has worked in the NHS specialising in sexual health, chronic pain, cancer and trauma. She was an independent practitioner until 2017 and is now semi-retired. Dr Sherwood has grown increasingly concerned about the incursion of Critical Social Justice into clinical psychology. These concerns prompted her to raise awareness about the potential for harm that this ideology poses to the profession, the NHS and, most importantly, to those who clinical psychologists serve.

Dr Kirsty Miller is an academic psychologist who has worked in a variety of roles within the education sector. She has acted as a consultant for a number of media programmes and been involved in outreach activities for several charitable and third-sector organisations. In recent years, Dr Miller has become very concerned about the encroachment of Critical Social Justice into health and education and is currently working to challenge its ideological takeover in our public institutions.

Declaration

The authors declare that they have no relevant material, financial or other interests that relate to the findings described in this report.

Acknowledgements

Val Thomas, Critical Therapy Antidote

Martin Seager, The Centre for Male Psychology

Dennis Relojo-Howell, Psychreg

Christine Sefein, Foundation Against Intolerance & Racism

Trainees in UK and the US who provided information

Introductory quote: Thomas, V. (2020, November 23). From Psychotherapist to Psychoactivist: How Therapy is Becoming Derailed. Areo. Retrieved 23 September 2022 from: https://areomagazine.com/2020/11/23/from-psychotherapist-to-psychoactivist-how-therapy-is-becoming-derailed/

Navigation

Throughout this report in PDF format text links and endnotes are shown in blue. Clicking on an endnote link takes you to the corresponding endnote. To return to the page, click on the endnote number.
Clicking on any other link takes you to another page or to an external web page To return to your previously viewed page within the document:

On a PC: press ALT together with ◄

On a Mac: press ⌘(command) together with ◄

For weblinks, leave browser and return to PDF viewer.

Report design: www.howard-sherwood.co.uk

Contents

1 Executive Summary

Background

In January 2022 a letter was sent to the Health & Care Professions Council (HCPC), the regulating body that sets standards for health professionals, raising concerns about the incursion of Critical Social Justice (CSJ) into clinical psychology. In that letter, the HCPC was alerted to the fact that CSJ ideology may contravene HCPC standards of conduct, performance and ethics for the following reasons:

- The politicisation of clinical psychology and the training of psychologists to become social justice activists is beyond the scope of clinical practice, incompatible with the scientist-practitioner model and a potential risk to patients.
- CSJ's rejection of objective scientific enquiry poses a serious threat to the provision of efficacious and evidence-based psychological treatments.
- The widespread adoption of CSJ has the potential for causing harm to the profession, to the NHS and other mental healthcare services.

Freedom Of Information requests

When the HCPC was informed about the risks of CSJ, the extent of its incursion into UK clinical training courses was unknown. Freedom of Information Requests (FOIs) were therefore sent to the 30 clinical doctorate courses in the UK. 21 out of 30 responded positively to our request, providing information about the role of ***social justice*** in their training, how they had addressed issues of ***Equality, Diversity and Inclusion*** and what steps they were taking to ***decolonise*** their curricula.

Responses were reviewed for CSJ-related terms, assessing whether words such as ***social justice*** and ***critical*** were being used in ways that correspond with CSJ principles. Commitment to CSJ was established by identifying the extent to which courses were introducing changes in line with its ideological principles and values.

FOI responses demonstrate that, without exception, across the 21 training courses who responded positively, CSJ ideology is already well established, with all courses showing commitment to its tenets. In some courses its ideological principles have been embraced with enthusiasm. In others, attempts are being made to try and combine standard practice and CSJ approaches, with little apparent understanding that these are incompatible. What is clear is that CSJ ideological principles are not only influencing the content of what is taught on training courses but also changing the nature, values, aims and practices of clinical psychology itself.

Structure of the report

In view of the high number of FOI responses, there was a large volume of material to process and several themes emerged that we believe worthy of consideration. For this reason, we have presented our findings in a series of chapters, starting with an account of external pressures on courses to adopt CSJ, followed by an overview of the extent of the problem. The remaining chapters focus on the effects of CSJ on clinical psychology as a scientific discipline and on its therapeutic practices.

Apart from the first two chapters, the same format is followed: firstly we explain the theme, then we present evidence from the FOIs, plus supporting material from other sources, considering to what extent the trainings

are consistent with the relevant HCPC standards and other professional criteria. The report ends with a discussion of our findings and implications for the future direction of training.

Summary of main points

Throughout the report, course responses are considered in the light of standard and established clinical psychology practice. Evidence is provided of the extent to which current clinical training courses have been captured by CSJ. Sources of external pressure to adopt CSJ principles are identified, including The British Psychological Society, hosting universities and NHS Health Education England. We name sources of grassroots pressure for political activism within clinical psychology itself and from movements such as Psychologists for Social Change. We also highlight the leading role of the American Psychological Association (APA) in politicising clinical psychology and disseminating CSJ's message to psychologists across the world.

In the main body of the report, we demonstrate the many ways in which CSJ is incompatible with clinical psychology and how it contravenes HCPC standards. A summary of the points made is listed below, in which we contrast the aims, values and practices of clinical psychology with those of CSJ:

Clinical psychology is a scientific discipline whose applied practice is underpinned by rigorous scientific enquiry. Over time, an extensive knowledge base of psychological theories, methods and treatments has been established. Clinical psychologists are scientist-practitioners with research and clinical skills that enable them to draw on this scientific knowledge base for the benefit of their patients. Their research skills allow them to evaluate the effectiveness of their practice. Clinical psychologists collaborate with patients to create and implement evidence-based therapeutic interventions designed to help restore mental health and improve quality of life.

In contrast:

CSJ rejects Western science and aims to dismantle the existing knowledge base of clinical psychology through the process of ***decolonisation.*** CSJ prefers unscientific *ways of knowing* that have no evidence to support them and which often include methods that are political in nature such as *Liberation Psychology*. CSJ prioritises ***social justice activism*** over therapeutic practice. It requires clinical psychologists to abandon scientific principles. Clinical psychologists must become ***change agents*** whose aim is to dismantle existing societal values, structures, policies and practices. In their work with patients, ***change agents*** facilitate ***consciousness raising*** in those considered *marginalised* and provide them with the tools to bring about revolutionary social change.

Clinical psychologists focus on the unique individual. Their therapeutic practice is based on compassion, empathy, non-judgement and acceptance. Clinical psychologists do not make assumptions about their patients or impose their values or political beliefs on them. Their practice is required to be ethical and non-discriminatory. They aim to develop trusting and respectful relationships with their patients and take account of their wishes and needs.

In contrast:

CSJ rejects the notion of the individual in favour of ***identity politics*** and *intersectionality*. People are divided into groups and labelled *oppressed* or *privileged* based on their immutable characteristics**.** This leads to stereotyping, shaming and 'us-and-them' thinking. Those in ***minority*** groups are expected to conform to CSJ beliefs about oppression and are subject to criticism if they dissent. Those in ***majority*** groups who are white, male or heterosexual are blamed for racism, sexism and homophobia. The needs of vulnerable or disadvantaged individuals in ***majority*** groups may be dismissed or overlooked, such as in the case of men who account for 75% of all suicides in the UK.

Clinical psychologists develop clinical, professional and personal skills that enable them to manage the demanding emotional work required in their profession. They draw on existing scientific evidence that identifies ways of thinking and behaving that maintain good mental health and those that lead to distress and difficulties. Knowledge of this literature enables them to help others, while assisting them in understanding and reflecting on their own behaviour and biases.

In contrast:

CSJ encourages behaviours such as blaming,shaming, judging, avoidance and hypervigilance for threat that would, in standard clinical practice be considered detrimental to mental health. CSJ devalues the notion of expertise and promotes the idea that only those with *lived experience* of *oppression* can judge what is in a patient's best interests. Concepts such as *microaggressions* are promoted, despite evidence of their scientific limitations and the requirement to make interpretations based on impact rather than intent. Uncharitable interpretations are often made based on feelings rather than facts. This fosters grievance and intolerance.

Clinical psychologists are empathic and flexible in their thinking, open to alternative perspectives and interested in the complexity of human nature while acknowledging common humanity and the universal aspects of experience such as fear and loss.

In contrast:

CSJ requires conformity to its beliefs and world view. It is authoritarian in nature and rejects alternative perspectives. Those who do not conform to its views must be re-educated and are expected to engage in ***correct thinking.*** CSJ's view of human nature is simplistic and divisive. Its preoccupation with difference and division ignores the universal and shared aspects of experience that help people develop empathy for others and facilitate social cohesion.

Clinical psychologists have a range of clinical skills that enable them to help patients. These include challenging beliefs and assumptions that may be affecting a patient's quality of life or interfering with recovery of mental health. They have the training and expertise to manage risk when patients are in danger of self-harm or suicide. This level of clinical competence is essential for safeguarding purposes. Clinical psychologists have a duty of care to ensure that patients' needs are met.

In contrast:

CSJ insists on the adoption of an affirming stance premised on ***lived experience*** which is interpreted purely through a CSJ lens. Patients' beliefs are validated without question, regardless of whether these are based in objective reality or detrimental to their mental or physical health. Objectivity is viewed as *oppressive***.** The Cass Review Interim Report on the Tavistock Gender Identity Development Service (GIDS) illustrates how such ideological approaches can lead to safeguarding issues and harm distressed and vulnerable patients. [1]

HCPC standards

To put this in context, here is a brief composite of relevant HCPC standards that we believe courses and clinical psychology registrants may be contravening if they follow CSJ principles: [2]

- The HCPC requires courses to support and develop evidence-based practice. Their curricula must remain relevant to current practice.
- HCPC registrants must keep within their scope of practice, using the knowledge and skills relevant to that practice and be able to engage in evidence-based and informed practice.
- Clinical psychologists must use their professional and research skills, based on a scientist-practitioner and reflective practitioner model. They must understand a range of evidence-based and theoretical models and frameworks.
- Clinical psychologists must treat all patients as individuals, acting in their best interests at all times, obtaining informed consent and taking account of their needs, wishes and goals.
- Clinical psychologists must not discriminate against their patients The safety and well-being of patients must always come before any professional or other loyalties. They must be able to practice within the legal and ethical boundaries of their profession, exercise a professional duty of care and maintain fitness to practice.

Implications

In the report's concluding summary, we express concern that clinical psychology is at serious risk from the incursion of CSJ – a political ideology that aims to dismantle the profession as a scientific discipline. We note, as mentioned above, that the Cass Review Interim Report has already highlighted problems arising from CSJ gender identity ideology within the Tavistock Gender Identity Development Service (GIDS), with children and vulnerable young people found to be at risk of harm.

We suggest that students currently in clinical training may graduate either unable or unwilling to engage in evidence-based and evidence-informed practice while using CSJ approaches that are untested and political in nature. If this is the case, it will have serious implications for those who require help from mental health services. Since the Covid-19 pandemic, clinical psychologists have never been in greater need, with a 25% increase in anxiety and depression reported worldwide. [3]

In our conclusion we call upon both the HCPC regulator of clinical psychologists and the Secretary of State for Health to take urgent action to halt the incursion of CSJ ideology into clinical psychology training courses. This is essential to protect vulnerable patients with mental health difficulties from harm as a result of clinicians adopting a political stance in their work and using untested methods beyond the scope of their professional remit. We also call for an urgent review of Health Education England's Action Plan which has played a major role in establishing this ideology in clinical training courses.

2 Introduction

The subject of this report is the findings from an investigation into the politicisation of clinical psychology training in the UK. This is a complex and far-ranging issue. In this introduction we will be clarifying the scope of this report, setting this topic into a wider historical/cultural and professional therapy context and giving definitions of key terms. We will begin by defining the category of therapy professionals with which this report is concerned: clinical psychologists. [4]

The Scope

Although inferences can be drawn from our report regarding other therapy professions, it is important to be clear about the scope of this report from the onset. We are focusing solely on clinical psychologists and the university courses in the UK that provide clinical psychology training at doctoral level. [5]

The Bigger Picture

No one in the third decade of the 21st Century would dispute the general perception that Western cultural/political and social systems are experiencing a period of tumultuous change. During a time of social turmoil, it is to be expected that individuals, no longer sure of their footing, would seek external sources of help and guidance. Historically, this role would be fulfilled by doctors, priests and respected elders: in more recent times, it is more likely that people would consult professional therapists such as clinical psychologists.

Over the last few decades, the services provided by those therapists have become increasingly regulated: professional associations and government regulatory bodies have performed the necessary functions of maintaining ethical standards within the professions. However, due to the increased importance of the therapist role, it is incumbent on all of us within those professions – not just those operating in a regulatory capacity – to make sure that our services can adapt effectively to the needs of contemporary clients and that we can preserve and transmit our expertise and knowledge to future generations of therapists. This ethos of individual and collective responsibility for ensuring professional standards informs our report.

Wider Context

It is important to acknowledge that psychology does not operate in a vacuum: it is affected and shaped by larger social/cultural and political forces. For example, clinical psychologists are trained within universities and often work within the NHS and other statutory agencies: the policies operating in these wider contexts influence and place constraints on training and practice. Of course, this has been the case for decades, so why is it particularly important now to consider this wider context? Mainly because a new world view – one that is collectivist, explicitly political and authoritarian – has increasing purchase on our cultural institutions. This world view identified as Critical Social Justice (CSJ) is shaping the wider health and social care professions, their institutions and their practices.

Social Justice v Critical Social Justice

Until very recently, CSJ and its radically different world view has been able to establish itself unchallenged in UK institutions. The reason this has happened so easily is due to confusion about definitions. The term *Critical* Social Justice does not mean the same as the term ***social justice***. The latter is generally accepted to mean the pursuit of a fair and just society for everyone. While clinical psychologists might be expected to favour ***social justice*** in its generally accepted sense, it would be surprising to find them automatically accepting and

advocating for ***Critical*** Social Justice which is a postmodern concept informed by Marxist Critical Theory.

In order to understand the context of this report, it is important to determine the differences in meaning of these two terms. To clarify, we will briefly explain what each term means:

Social Justice

In the recent past the term ***social justice*** would have been understood as a classic liberal notion of moving steadily and incrementally in the direction of a society that was fair and just for everyone.

Critical Social Justice

Although it sounds very similar to the classic liberal term, this concept is radically different. ***Critical*** Social Justice (CSJ) is a political ideology, with utopian commitments, whose origins are in Marxist thought and postmodernist theory. [6] CSJ is an umbrella term that includes critical race and gender ideologies that adopt a specific theoretical approach to addressing issues of prejudice and discrimination on the grounds of characteristics like race, sex, sexual orientation, gender identity, dis/ability and body size.

CSJ aims to disrupt and dismantle Western political and social systems which it regards as systematically oppressive. Its goal is continuous revolution. CSJ claims that knowledge is not objective but culturally constructed to maintain oppressive power systems. As such, it poses a serious threat to clinical psychology which draws on scientific knowledge to help people experiencing psychological distress.

Once this distinction between the two different versions of ***social justice*** is fully grasped, it then makes it clear that when, in this report, we quote a training course referring to ***social justice*** while stating that they wish trainees to engage in ***activism and social change***, this means that the training course is informed by CSJ.

What does CSJ look like in practice?

In the wider society wherever CSJ gains control, its key characteristics become very clear: it is authoritarian; dedicated to the dismantling of societal norms; hostile to any opposing viewpoint; hostile to evidence and reason; and its goal is the hijacking of everything for political ends.

The therapy professions have not been able to protect themselves from the encroachments of CSJ. Activists have been able to establish themselves in the professional bodies and activist scholars have been able to change the established narratives of therapy. Below are some examples:

- The adoption and normalisation of CSJ gender identity ideology has permeated all professional bodies and institutions. Those publicly holding different viewpoints have been silenced. For example, in 2021 James Esses [7] was expelled from the Metanoia Institute, where he was training to be a counsellor, after raising concerns about safeguarding young people with gender dysphoria

- Contested ideas such as *microaggressions, intersectionality* and *decolonisation* of curricula have been widely accepted and adopted without debate or discussion

- Concerns raised about the lack of evidence-base and incompatibility of CSJ with standard clinical practice have been dismissed and those raising concerns subjected to twitterstorms of protest and denunciations by the British Psychological Society and its members. [8] , [9]

- Acceptance of insulting pejorative characterisation of the majority population, for example the Moss, D., (2021) [10] paper on whiteness as a form of parasitism and the use of terms such as *toxic masculinity* and *white fragility*.

What is happening in training?

The examples given above raise major questions: Are these indications of a short-term 'fad'; are they merely outliers; or are they suggestive of a much deeper and long-term change? Or, to put it bluntly, is established traditional clinical psychology in the process of being changed from a therapeutic practice into a political one? The best place to start to answer this question is to look at what is happening in the training field as this holds the key to the future of the profession.

Focusing on the training aspect has also been prompted by considerable anecdotal evidence particularly from North America, where CSJ is already well-established, from students who are unhappy with the focus on advocacy and political activism in their counselling training programmes. There are also instances of professors speaking up who have then either been cancelled or have been forced to resign. [11] .

Clinical Psychology Courses in the UK

In view of these worrying developments, we believe that this report is timely. We hope that its findings will help to clarify what is happening in clinical psychology training courses in the UK. It is also our hope that steps will be taken to halt the incursion of CSJ ideology into those courses before it causes damage to the profession, to the NHS more widely and to the many people in need of its services.

3 Method

As noted earlier, the Health & Care Professions Council was alerted to the incursion of CSJ into clinical psychology in January 2022. At this time there was limited evidence of the extent to which CSJ had been embedded in UK doctoral training courses. It was decided that sending FOIs to these courses would be the most straightforward and effective way of obtaining evidence of CSJ incursion, as universities are obliged to respond to FOIs, except in cases of cost or commercial interest.

Between April and May 2022, FOI requests were sent to the 30 courses providing doctoral level clinical psychology training in the UK. The requests were sent by email and in accordance with Government guidelines, providing each course with a named applicant, address and a description of what was required. There was no obligation under the Freedom of Information Act to provide a reason for our request and we chose not to do so in order to encourage open and direct responses.

27 out of 30 courses responded over the course of the following five months and, of these, six declined to provide information on grounds of cost or commercial interest. Three courses did not respond. This report is based on information provided by the 21 courses who chose to respond favourably to our request: a response rate of 70%.

FOI Questions

FOI questions were chosen carefully to elicit evidence of CSJ teaching. We asked courses to provide information about the subject areas of interest to us while ensuring that our questions were 'open' and neutral in nature rather than designed to encourage courses to respond in a particular way. Here are the three CSJ-related themes we chose and the reasons why:

Social justice

The incursion of ***social justice activism*** into courses is one of our main concerns. Our aim was to establish the extent to which ***social justice*** was explicitly endorsed and whether this represented a liberal or CSJ form of ***social justice.***

EDI (equality/equity, diversity and inclusion)

The term EDI is often indicative of the presence of CSJ principles. Our aim was to assess the extent to which courses had adopted these principles and what effect they were having on course content.

Decolonisation

Decolonisation is now a widely adopted method of removing or dismissing existing scientific literature both in universities and other institutions. Our aim was to determine whether courses were decolonising their curricula and to what extent.

FOI request

The following request was made:

Please can you provide information* on the following:

- The role of Social Justice in your course teaching & research
- How you have addressed issues of Equality, Diversity & Inclusion
- What steps you have taken to decolonise the curriculum
- Any other steps/commitments you've taken to ensure the inclusivity of your course

For example: training materials, slides, handouts, trainee projects, research, surveys, working- groups etc.

FOI responses

When reviewing the responses, we highlighted all references to CSJ-related concepts and noted the extent of commitment made to CSJ principles, paying particular attention to ***crossover**** words and terms. We then identified common themes appearing throughout the FOIs which were incorporated into the chapters of this report. We found that material relating to Critical Race Theory (CRT) – a major branch of CSJ – was most predominant in the responses but there were also several references to Gender Identity Ideology/Queer Theory and evidence of CSJ Feminist Theory. Finally, we identified the relevant HCPC standards that courses and registrants should be following and may be contravening.

The full FOI responses can be seen at: save-mental-health.com/training-courses/

Interviews

To gather more background information we arranged informal interviews, through Critical Therapy Antidote [12] , with Professor Christine Sefein [13] previously of the University of Antioch and two clinical psychology students in the US. We also corresponded with two trainees on doctoral courses in the UK. Our rationale for the US interviews was to gain insight into the ways in which CSJ has influenced training courses and affected trainees there, as CSJ incursion is further advanced. In this way, we hoped to provide a sense of what to expect once CSJ establishes a firmer hold in the UK.

It is important to note that the views expressed by those we interviewed are not necessarily representative of all clinical psychology practitioners or trainees. We have discovered, through the process of evidence gathering, that there is a great deal of enthusiasm for political activism within clinical training courses and trainees themselves are often the most vocal and committed supporters.

Preamble

Please see Appendix B for a table listing all the UK courses contacted with FOI requests. The full name of each course is provided, together with a shortened version which will be used throughout the report.

To provide some context for the FOI responses, when presenting the findings we will refer to relevant research, articles, books and include quotes from clinicians.

When citing quotes, certain words or phrases have been emphasised to assist understanding or to highlight a point.

Endnotes are used to clarify points made and provide research references.

We refer to 'patients' throughout the report rather than 'clients' or 'service-users'. We hope this serves to remind the reader that those seeking help for psychological difficulties are often in a state of vulnerability and that health professionals have a duty of care to protect those patients from harm.

*We often refer to ***crossover*** words or terms in the text. [14] What we mean by this is a word or term such as ***critical*** or ***social justice*** that has a different meaning in CSJ than it does in 'normal' or accepted usage. ***Crossover*** words or terms are often used by CSJ proponents as a 'Trojan Horse', enabling the introduction and consolidation of ideas that may otherwise be considered too controversial to be adopted. Please see Appendix D for a list of ***crossover*** words that appear in the report.

4 Findings

External pressures

In this chapter we discuss the finding that pressure is being brought to bear on training courses, from several sources, to adopt CSJ ideology. FOI responses reveal that these sources include the British Psychological Society, Health Education England and hosting universities. Learning about these pressures helps us understand why the profession of clinical psychology, that was once required to be neutral, is now adopting a political agenda.

The British Psychological Society (BPS)

The BPS has become increasingly more orientated towards CSJ ideology [15] . This has manifested not only in the society's priorities and outputs, but also in their course requirements. Some of the FOI responses reflect this:

> **Edinburgh:**
> *The overarching approach to social justice in Doctorate in Clinical Psychology is reflected in the British Psychological Society's standards for clinical psychology programmes.*
>
> **Sheffield:**
> *The programme is designed to meet the BPS 2017 accreditation criteria, which requires trainees to understand the impact of social inequalities on mental health and their implications for clinical practice.*

While several concerns have been raised about the BPS' political agenda [16] , these have either been dismissed or disregarded and courses are required to adopt CSJ ideology in order to receive accreditation.

NHS Health Education England (HEE)

FOIs also identify HEE as one of the driving forces behind the introduction of CSJ ideology into courses in England:

> **UEL**
> *… we are aligned to Higher [sic] Education England's (HEE) recent EDI Action Plan and they have supported our programme like all other clinical psychology programmes in England to further this work*
>
> **Essex**
> *As part of the HEE initiative, we have appointed an EDI lead who has set up a mentorship scheme for prospective and current trainees*

HEE has achieved this by providing substantial funding to each of the courses which in return, are expected to enact nine action points. HEE requires courses to introduce a CSJ version of anti-racist [17] education for course staff and supervisors and to decolonise their curricula. We were unable to establish whether courses in Scotland or Wales are subject to similar requirements from their HEE equivalents [18] . Nevertheless, evidence of CSJ is clearly present in these courses.

While HEE's plan to increase the diversity of the clinical psychology workforce and improve access to psychological help for people from ethnic minorities is commendable, the methods being used to bring these changes about are political in nature and incompatible with the aims, values and methods of clinical psychology, as will be demonstrated in the following chapters.

Universities

FOIs reveal that clinical doctorate courses are also under pressure from their hosting universities to adhere to CSJ principles:

> **C&W:**
> *A key goal of Coventry University's 'Curriculum 2025' strategy is for* ***every course within the Coventry University Group*** *to be able to* ***demonstrate*** *that they are inclusive and* ***decolonised****….*
>
> **Glasgow:**
> *We are* ***committed to*** *enacting the commitments and initiatives expressed by* ***the wider University of Glasgow community***

Reinforcement of CSJ principles

The BPS, HEE and universities also reinforce the adoption of CSJ ideology through awarding praise for 'good practice', continued accreditation or funding, meaning that courses have little option other than to adopt and maintain CSJ principles:

> **IOP:**
> *The Diversity and Inclusion Sub-Committee (D&I), which was* ***identified as an area of good practice in our recent BPS accreditation visit****…*
>
> **Leeds:**
> *Decolonial pedagogy will be recognised and highlighted through the creation of a* ***Leeds' Decolonising Mark***
>
> **Exeter:**
> *The University of Exeter has* ***developed successful bids for funding from HEE in 2020 and 2021 for EDI actions*** *that demonstrate our sustained commitment and action to reduce inequalities and eliminate discrimination*
>
> **UEL:**
> *Staff Member Professor Nimisha Patel… has recently developed,* ***with funding from the BPS****… a framework…* ***which examines the influence of assumptions of 'whiteness'***

Grassroots movements

In addition to external sources of pressure, interviews with clinicians and trainees in the UK and US suggest that much of the pressure to adopt CSJ comes from students in training who wish to be activists. In the UK there is evidence of grassroots pressure from Psychologists for Social Change' [19] ; the BPS Minorities in Clinical Psychology Subcommittee [20] ; qualified clinicians [21] , clinical doctorate tutors and students [22] . Clinical tutors and trainees from the University of East London, for example, have been working in consort with the BPS to impose CSJ principles across clinical psychology training courses [23] .

Wider influences

It is also important to recognise the role played by The American Psychological Association (APA) [24] . The APA is a leader in the advancement of clinical psychology as a scientific discipline, whose research and guidelines are followed by psychologists worldwide.

However, in recent years the APA has been captured by political activism with worrying results [25] . Despite its claims to apply ***"the best available psychological science to benefit society and improve lives"*** [26] , it has published a racial equity action plan [27] in which one of the priority actions for clinical psychology training is to:

> *"Reimagine graduate training curriculum to promote epistemological justice by centering diverse, non-Western cultural perspectives in U.S. based training programs."*

Examples of these non-Western cultural perspectives include:

> *"indigenous healing, eastern medicine and faith-based practices"*

There is an inconsistency here that is often found in captured institutions. On the one hand the APA claims to be applying the "best available psychological science" to benefit society and improve lives while on the other, it has committed itself to "centering" non-Western cultural perspectives that are unscientific by their very nature. These two claims are contradictory. However, where the APA leads, the world's psychologists follow. This does not bode well for the future of clinical psychology.

Summary

Our findings show that the BPS, HEE and universities have all played their part in embedding CSJ principles into UK training courses, encouraged by grassroots movements and students eager to become activists for political change. Meanwhile, the APA leads the way in politicising clinical psychology worldwide. As we will demonstrate over the course of the following chapters, training courses in the UK run the risk of breaching current HCPC Standards for education and training if they follow CSJ principles and no longer support or develop scientific and evidence-based practice.

Extent of the problem

In this chapter we consider the extent of the incursion of CSJ into courses, giving examples from FOI responses to demonstrate the level of commitment to CSJ principles.

Please note that wherever the word *"critical"* appears in these FOI responses, it is being used in the CSJ sense of the word.

Widespread CSJ

We found that all the courses who responded to our FOI request demonstrate a commitment to CSJ to a greater or lesser extent. What is clear is that course structures, curricula, research, supervision, placements, staff training and recruitment are all undergoing significant and far-reaching changes based on CSJ ideology.

FOI responses suggest that some courses are trying to combine traditional therapy teaching with CSJ approaches:

> **Essex:**
> *We seek to balance the pragmatic content-based approach to therapy teaching (reflecting services as they are) and a more* ***critical values driven approach****. This is work in progress and we are needing to continue to appraise, modify and adapt the approaches we are taking*

In such cases, there appears to be some confusion, or lack of understanding, that CSJ beliefs and values are incompatible with traditional approaches [28] .

Other courses explicitly choose to adopt a CSJ world view. In such cases, all aspects of training are designed to encourage trainees, tutors, supervisors and, in the case of Coventry & Warwick, guest lecturers, to view their work purely through a CSJ lens which favours a political interpretation of traditional approaches:

> **Newcastle:**
> *The education and training of psychological professionals has been* ***built on a structural foundation of Eurocentric epistemologies****. This foundation* ***privileges certain forms of evidence and ways of knowing*** *and is implicated in how dominant models of curricula and healthcare practice position concepts of knowledge, equity and social justice*
>
> **Hertfordshire:**
> *The introductory module ("Understanding Distress across the Lifespan")* ***replaces traditional teaching on 'psychopathology', explicitly focusing critical attention*** *on social, contextual and inequality-related aspects of psychological distress across the lifespan* [29] .
>
> **Liverpool:**
> *We have* ***integrated anti-racist practice into foundation supervisor training*** *as part of a half-day session on Equality and Human rights in supervision: this includes inviting supervisors to* ***critique the existing evidence base and theory base for clinical psychology supervision through an antiracism, decolonising lens***
>
> **Manchester:**
> *An ability to* ***critically*** *appraise the historical, social and cultural context which [sic]* ***psychological theories and models are grounded.***
>
> **Teesside:**
> *We will take a* ***critical approach*** *to clinical psychology* ***as a profession***
>
> **Bangor:**
> *Development of the research component of the programme to highlight racial injustice and discrimination as a valuable area for research and for* ***research teaching to include critical appraisal of the Euro-centric and white-centricity of research culture***

Responses often give the impression that there is a moral imperative and an educational obligation to adopt this world view rather than acknowledge that CSJ is just one of many alternative theoretical perspectives that explain human behaviour.

Pressures on students and staff to demonstrate a commitment to CSJ principles is also evident in measures such as compulsory training, contractual obligation, recruitment or grading:

> **UCL:**
> *Staff development:* ***Compulsory participation*** *in power and privilege training*
>
> **Surrey:**
> *The wording on all placement contracts is being updated to more explicitly state that* ***responsibility lies with supervisors and trainees*** *to create an environment that supports and* ***promotes anti-racist and anti-oppressive practice***
>
> **IOP:**
> *We are piloting amendments to rating criteria (in trainee recruitment) that would* ***privilege EDI and/or antiracism awareness/experience***
>
> **Exeter:**
> *Trainees are* ***expected to address*** *inequality and power in their assignments, with* ***marks awarded*** *for addressing contextual factors e.g. patient context and culture/diversity*

Summary

In this chapter we have reported findings from FOI responses that indicate widespread adoption of CSJ principles across training courses. While levels of commitment vary, significant changes are being implemented across all courses, based on CSJ ideology. These ideological principles are not only influencing the content of what is taught on training courses but changing the nature, values, aims and practices of clinical psychology itself. If, as FOI responses suggest, courses are removing current evidence-based theories and practices, in favour of ideological teachings then it is questionable whether those courses will remain fit for purpose.

Social Justice Activism

In this and the next chapter we consider how clinical psychology's position as a scientific discipline is being undermined by CSJ. Here we describe the scientist-practitioner model and the threats posed to it by ***social justice activism*** and ask whether the adoption of an activist approach meets with HCPC standards.

The Scientific Study of the Mind

The BPS describes clinical psychology as "The scientific study of the mind" while NHS England describes the role of clinical psychologists as one in which "you will draw on your scientific knowledge to bring about positive change," and "work in partnership with service users to design and implement interventions to overcome their condition or improve their quality of life". NHS ENGLAND ENDNOTEThis is a description of the scientist-practitioner model which has, for many decades, formed the basis for training clinical psychologists

Scientist-practitioner model

This model encourages clinicians to use empirical research to influence their applied practice while, at the same time, drawing on their clinical experience to shape future research questions. In this way, clinical science is advanced and refined. Training in accordance with the model ensures that clinical psychologists have the necessary research and clinical skills to conduct assessments, create individual formulations, intervene appropriately and evaluate their practice. These skills are the cornerstone of clinical psychology practice.

The scientist-practitioner model is designed to produce competent and knowledgeable clinical psychologists, well versed in objective scientific enquiry and trained to use evidence-based interventions for the benefit of their patients. Clinicians are required to evaluate their clinical work to ensure they are using effective treatments of benefit to their patients. However, clinical skills such as evaluation are incompatible with CSJ which rejects the concepts of objectivity, scientific enquiry and evidence-based interventions, viewing these as ***oppressive***, ***unjust*** and supportive of ***dominant*** and ***marginalising*** power structures in society.

Social Justice Activism

In contrast to the scientist-practitioner model, ***social justice activism*** calls for psychologists to become ***change agents*** who are sensitive to injustice and who can, through their political activism, bring about major societal change. Goodman et al., (2004, p795) [30] describe ***social justice activism*** as "professional action designed to change societal values, structures, policies and practices" with the aim of enabling "disadvantaged or marginalised groups" to "gain increased access to tools of self-determination".

Goodman et al., consider certain principles, informed by multicultural and feminist theories, to be "essential to providing dedicated training in social justice advocacy". These include "facilitating consciousness raising" [31] and "providing and leaving clients with tools to work toward social change". In other words, clinicians are required to use political activism in their work and to motivate their patients to become political activists in order to overcome their ***oppression*** [32] .

This is a long way from the scientist-practitioner model in which clinicians "work in partnership with service users to design and implement interventions to overcome their condition or improve their quality of life".

In the FOI responses, we note a clear shift away from the scientist-practitioner model and towards ***social justice activism***. In the quotes that follow, please note that when references are made to ***social justice*** what is meant in all cases is ***Critical*** *social justice****:***

> **Essex:**
> *We would like trainees to consider the role of activism and social change*

Liverpool:

Social justice is integrated into our teaching and research in a variety of ways. In particular, the Liverpool programme has ***embedded social justice principles*** *through using a human rights based approach (HRBA), for which we were commended by the BPS in 2019*

Hertfordshire:

Social justice is an ***underpinning theme stressed throughout the course teaching, in all modules and small group work (including problem-based learning topics)***

Social justice forms a key part of a Community Psychology module…. it will now become a core part of the curriculum. This includes… ***participatory action****…*

Lancaster:

We have a commitment to promoting equality, inclusivity and social justice and we encourage trainees' and teachers' exploration of these issues.

Trainees are to approach issues of inclusivity and social justice

UEL:

(Social Justice) is ***woven through the whole programme.***

As social justice is so integrated it is not feasible to send materials for relevant sessions: there are over 280 three-hour teaching sessions across the three years

HCPC Standards

The shift away from a scientist-practitioner model and towards ***social justice activism*** raises important questions for clinical psychologists: are they still meeting HCPC standards that require them to work within their scope of practice, using appropriate research skills, based on a scientist-practitioner model?

HCPC standards require all registrants to:

3. Work within the limits of your knowledge and skills

Keep within your scope of practice:

3.1 You must keep within your scope of practice by ***only practising in the areas you have appropriate knowledge, skills and experience for.***

Maintain and develop your knowledge and skills:

3.3 You must keep your knowledge and skills up to date and ***relevant to your scope of practice*** through continuing professional development.

HCPC standards state that practitioner psychologists must:

1. be able to practice safely and effectively within their scope of practice

2. be able to practice within the legal and ethical boundaries of their profession

2.2 ***understand what is required of them*** by the Health and Care Professions Council

12. be able to assure the quality of their practice

12.1 be able to engage in ***evidence-based and evidence-informed practice, evaluate practice systematically*** and participate in audit procedures

14. be able to draw on appropriate knowledge and skills to inform practice

14.30 be able to use professional and research skills in work with service users based on a ***scientist-practitioner and reflective practitioner model that incorporates a cycle of assessment, formulation, intervention and evaluation***

Summary

The scientist-practitioner model is in alignment with HCPC standards for registrants. It employs the knowledge and skills that are required and relevant to a clinical psychologist's scope of practice. ***Social justice activism***, on the other hand, requires clinical psychologists to abandon scientific principles and become change agents whose aim is to dismantle unjust societal structures and values. It is important to consider the ethical implications of adopting an ideological stance in clinical work that is designed to encourage patients to become political activists. Courses must consider how trainees who are motivated to adopt a ***social justice activist*** approach, will develop and maintain the necessary clinical knowledge and skills relevant to their practice in order to meet HCPC standards.

Decolonisation

In this chapter we consider how clinical psychology's existing scientific knowledge base is being dismantled through the process of *decolonisation*. We report evidence from FOIs which shows that alternative and untested *ways of knowing* are being introduced into course curricula. We then present HCPC standards which require clinical psychologists to understand the knowledge base of clinical psychology and use a wide range of theoretical models, frameworks and psychological approaches to inform their practice.

Decolonising the curriculum

Evidence-based knowledge is considered by CSJ to be ***dominant and oppressive,*** only benefitting the power systems and hierarchies of Western societies. Scientific endeavour is described as ***WEIRD:*** **W**estern **E**ducated **I**ndustrialised **R**ich and **D**emocratic. CSJ's negative view of scientific enquiry and determination to dismantle it, presents a serious challenge to clinical psychology whose applied work [33] , as we saw in the last chapter, is underpinned by objective scientific research in the pursuit of evidence-based psychological interventions.

FOIs give a clear indication of courses' resolve to ***dismantle*** western or ***Eurocentric*** scientific endeavour. For example, The University of Newcastle provided us with a presentation, titled "Dismantling the Master's House: Building the Foundations for an Anti-Racist Clinical Psychology" [34] .

In this presentation, a paper by Wood and Patel (2017) [35] is cited, in which it is stated that "the workforce, models, practices and services" of clinical psychology are "Eurocentric, ignoring racism, disadvantage and oppression".

According to FOIs The University of Newcastle's aim of '***dismantling power***' is widely shared across the courses, all of which are decolonising their curricula. For example:

> **Manchester:**
> *Thorough curriculum review to* ***decolonise our curriculum*** *(HEE, A3) which will include introducing more diverse content, enhancing anti-racist teaching practices, promoting reflection about race and whiteness and ensuring that issues of equality, diversity and inclusion are considered throughout the programme*

> **Bangor:**
> ***…decolonise the curriculum*** *such that there is a commitment to understanding* ***and teaching non-Eurocentric psychological theories, models and interventions*** *which is embedded throughout all elements of the programme*

In some cases, external consultants such as representatives from Black Lives Matter, have been invited to advise on how to achieve this aim:

> **Liverpool:**
> *Reviewing/ decolonising the curriculum (2019 to present – ongoing): Academic team + teaching unit co- ordinators.* ***Merseyside Black Lives Matter*** *and Black Curriculum working group agreed to consult on this through workshops with staff and trainees*

Implications of decolonisation

Hellowell and Schwerdtle (2022) highlight the risks of ***decolonisation*** in undermining confidence in scientific knowledge [36] . Author Olúfémi Táíwò claims that decolonisation is *"seriously harming scholarship in and on Africa".* He argues that it is a *"cure-all that cures nothing"* and points out the irony that the very idea of decolonisation originates from Western thought [37] .

In clinical psychology ***decolonisation*** may have serious implications for evidence-based treatments. For example, Cognitive Behavioural Therapy (CBT) has benefited many patients and its psychological interventions are recommended by the National Institute for Health and Care Excellence (NICE) [38] . However, CSJ advocates [39] criticise CBT, question its scientific methods and accuse it of *epistemic violence*. While Mindfulness approaches that evidence shows can help reduce chronic pain [40] , are criticised for *cultural appropriation* [41] .

What replaces decolonised therapies and methods?

The widespread introduction of CSJ ideology across courses means that trainees, course staff and supervisors are expected to use models that reflect the CSJ world view, regardless of whether there is any evidence to support them. For example, several courses are now using the ***Social GGRRAAACCEEESSS*** (Burnham, 1993) [42] model:

Birdsey & Kustner (2020) [43] explain that the ***Social Graces framework***:

> *"Is increasingly used within training institutions, as a means of encouraging learners to **critically*** explore issues of social difference. Attending to issues of power and diversity is believed to help trainee family therapists become more alert to any biases that may impact on therapy"*

**Crossover word*

However, the authors acknowledge that further research is needed to "explore practitioners' application of the social graces framework in practice" and that "even less is known about how this impacts on clinical practice".

Other courses have introduced a wide variety of CSJ-related topics for trainees to consider in their clinical practice. Many of these are political in nature, as we can see below. Also, as CSJ rejects scientific enquiry, they are unlikely to be supported by evidence:

Hertfordshire:

- *Discomfort, Disembodiment & Deconstructing Whiteness in Clinical Psychology*
- *Intersectionality and black feminism in the therapy room*
- *Colonialism & Clinical Psychology*
- *Liberation Psychology*
- *Gifts from Queer Theory*
- *Applying liberation psychology and social action projects in practice*

According to the American Psychological Association ***Liberation Psychology*** "challenges traditional Western-based psychology by offering an emancipatory approach to understanding and addressing oppression among individuals and groups." It draws on Marxist, Feminist and Critical theories [44] .

Queer theory aims to disrupt and dismantle what society considers to be 'normal' and views heterosexuality as oppressive. Proponents of Queer Theory have been criticised for promoting the sexualisation of children [45] . Concerns have also been raised about attempts to normalise paedophilia by using the concept of Minor Attracted People (MAPS) who are seen as an oppressed group [46] .

FOIs also show that existing psychological treatments such as Cognitive Analytic Therapy, Systemic Family Therapy and CBT are either being adapted to reflect a CSJ world view, by adding concepts to them such as intersectionality and power dynamics, or their usefulness for minorities challenged:

Liverpool:

- Cognitive Analytic Therapy (CAT), ***Race & Diversity lecture***
- ***CAT and Power*** – Considering ***CAT in relation to minority groups and power dynamics*** as part of clinical supervision

South Wales:

Reading list:

*Butler, C. (2015). **Intersectionality in family therapy training:** Inviting students to embrace the complexities of **lived experience**. Journal of Family therapy, 37(4), 583-589*

*Moloney, P., & Kelly, P. (2004). Beck never lived in Birmingham: **Why CBT may be a less useful treatment for psychological distress than is often supposed***

Traditional teaching on 'psychopathology' is given ***critical*** attention and replaced without any apparent consideration of its potential benefit to patients:

Hertfordshire:

*The introductory module **('Understanding Distress across the Lifespan') replaces traditional teaching on 'psychopathology'**, explicitly **focusing critical attention on social, contextual and inequality-related aspects of psychological distress across the lifespan***

This narrowing of focus to solely social factors and dismissal of biological and psychological aspects of mental health, has serious implications for clinical psychology and for patients. The biopsychosocial model [47] has, for many years, provided clinicians with a useful way of helping patients make sense of the relationship between the physical, psychological and social factors that often underlies distress. Limiting attention to social factors alone means that trainees will not develop the skills to assess, formulate and intervene appropriately. They will be ill equipped to work with patients whose difficulties have a biological origin or psychological component such as head injury, obsessive compulsive disorder or chronic pain.

In other developments, trainees are no longer required to demonstrate their skills in administering well-established neuropsychological assessments:

Liverpool:

***We have removed the requirement to 'pass out on the WAIS'** [48] in favour of a broader emphasis on demonstrating skills in complex neuropsychological testing to reflect concerns about the history and use of IQ testing*

Trainee Research Projects

FOI responses also show that CSJ themes are reflected in trainee research projects and doctoral dissertations. References are made to such research being conducted to find or 'support' certain outcomes or groups, although this is antithetical to the scientific method of open enquiry whch starts with a hypothesis that can be refuted, is falsifiable and can be replicated.

Liverpool:

*In terms of research, **themes of social justice**, either related to class, social identity or marginalised groups in clinical services are well represented in the topics chosen for the major thesis component of training.*

A preference is shown for qualitative over quantitative research. In one case, a lack of experience in quantitative research is highlighted, despite an HCPC requirement that clinicians have skills in both:

Essex:

*With regard to research there is a **strong tradition of qualitative study** …*

Lancaster:

*The group (a research sub-group for trainees **specifically focussing on social justice** led by the Dep Prog Director) **does not currently have the experience to support quantitative research***

HCPC Standards

The widespread decolonisation of curricula and replacement with unevidenced and often politicised content which focuses predominantly on factors relating to ***social justice***, appears to contravene several HCPC standards.

In relation to Education and Training programmes:

Programme governance, management and leadership:

3.1 the programme must be sustainable and ***fit for purpose***

Programme design and delivery:

4.4 the curriculum must remain ***relevant to current practice***

4.8 the delivery of the programme ***must support and develop evidence-based practice***

While the HCPC requires practitioner psychologists to:

12. be able to assure the quality of their practice

12.1 be able to engage in ***evidence-based and evidence-informed practice,*** evaluate practice systematically and participate in audit procedures

12.2 be able to gather information, ***including qualitative and quantitative data, that helps to evaluate the responses of service users to their care or experience***

13. understand the key concepts of the knowledge base relevant to their profession

13.1 understand the ***structure and function of the human body,*** together with knowledge of ***health, well-being, disease, disorder and dysfunction relevant to their domain***

13.2 be aware of the ***principles and applications of scientific enquiry, including the evaluation of the effectiveness of interventions and the research process***

13.9 understand ***theories and evidence concerning psychological development and psychological difficulties across the lifespan*** and their assessment and remediation

13.10 understand ***more than one evidence-based model of formal psychological therapy***

13.12 understand ***psychological models related to a range of presentations including:***
– service users with presentations from acute to enduring and mild to severe;
– problems with biological or neuropsychological aspects; and
– problems with mainly psychosocial factors including problems of coping, adaptation and resilience to adverse circumstances and life events, including bereavement and other chronic physical and mental health conditions

14. be able to draw on appropriate knowledge and skills to inform practice

14.1 be able to apply psychology across a variety of different contexts using ***a range of evidence-based and theoretical models, frameworks and psychological paradigms***

Summary

The process of decolonisation that is currently underway across all courses, poses a serious threat to clinical psychology's scientific knowledge base. Despite the HCPC's requirement for clinical training courses to support and develop evidence-based practice, FOIs indicate widespread adoption of an anti-scientific world view. Existing psychological methods and theories considered too ***WEIRD*** are either being removed from the curriculum or adapted to meet the needs of CSJ and its political ends. Conformity to models that are poltical in nature and emanate solely from uncontested critical theories will likely result. There is a risk that trainees will graduate from these courses either lacking an understanding of the knowledge base relevant to their profession or dismissing it as oppressive. Some may be unable or unwilling to engage in evidence-based and evidence-informed practice. Ultimately, the undermining and dismissal of scientific knowledge will have serious consequences for those requiring help from mental health services.

Therapeutic practice

In this section, we turn our attention to CSJ's impact on therapeutic practice. We explore the effects of CSJ's divisive ***identity politics*** and its particular version of ***anti-racism*** on the ability of clinical psychologists to develop trusting therapeutic relationships with patients. We also consider whether CSJ, by its very nature, leads to unethical and discriminatory practice. Finally, we provide the relevant HCPC standards relating to these concerns and to duty of care.

The healing nature of therapy

According to Ellenberger (1970) [49]

> *"Efforts to heal people of a variety of ailments, via the nature of the relationship created between a 'healer' and a 'sufferer', have been part of human culture for hundreds of years"*

When someone seeks help from a clinical psychologist, it is usually because they are in distress and finding it hard to cope. It is important that the psychologist is respectful, warm and empathic, shows compassion for their concerns, is accepting and non-judgemental, develops genuine rapport and listens closely to the reasons why they are seeking help and what they hope to gain from therapy.

Therapy can be difficult and painful at times and if patients are to continue attending sessions and gain benefit from them, a strong and trusting therapeutic relationship must be established (Winston & Muran,1996) [50] . This can be achieved through empathy and the acknowledgement of common humanity: all human beings experience feelings such as fear and grief.

According to Reis & Brown (1999) [51] the most common reason given for leaving therapy is dissatisfaction with the therapeutic relationship. There are therapist behaviours that patients themselves have described as "intrusive" and as "having a negative impact on the relationship". These include:

> *"therapists **imposing their own values**, making irrelevant comments and **being critical**, rigid, bored, blaming, **moralistic**, or uncertain"*
>
> Ackerman & Hilsenroth (2001) [52]

CSJ Identity Politics

The first radical departure from traditional therapeutic practice comes from CSJ's devaluation of the individual in favour of group identity. People are categorised and labelled according to immutable characteristics. Those in ***majority*** groups are considered to hold *power*, to be *privileged* and ***oppressive*** and are held accountable for the ills of society: white people are labelled ***racist***, men ***sexist*** and heterosexual people ***homophobic.*** While those in ***minority*** groups are considered *oppressed* and *marginalised* by those in ***majority*** groups [53] .

This is completely contrary to the principles, aims and values of traditional therapeutic practice which focuses on the individual, avoids making generalisations or assumptions about people and does not judge, stereotype or label them. Clinical psychologists have traditionally been trained to be open-minded and to develop trusting and respectful relationships with their patients rather than adopt a divisive 'us-and-them' style of thinking.

In contrast, FOI responses show that CSJ Identity Politics leads clinical psychologists to do just that – to label, stereotype and judge people, based on their immutable characteristics – as ***privileged***, ***dominant*** and ***oppressive*** and to accuse them of ***marginalising minority*** groups. For example:

> **Manchester:**
> *An ability to draw on knowledge of historic and social processes by which **majority groups have marginalised minority groups***

Exeter:

…to challenge other areas of ***privilege and dominance*** *such as* ***heterosexism***

We note in their FOI response that Exeter declares "anti-heteronormativity" to be part of their "inclusive" learning process. This seems to suggest that their "inclusive" learning process deliberately excludes those who are considered "heteronormative".

Most courses employ CSJ concepts such as ***intersectionality, power*** and ***privilege***:

Manchester:

Trainees are required to have working knowledge of relevant theoretical constructs and practical applications within PPPI, e.g. … Power Threat Meaning (PTM) Framework*

**Privilege, power, position and intersectionality*

The Power Threat Meaning Framework (Johnstone & Boyle, 2018, p.125) [54] promotes the view that men ***dominate*** women and that being male in itself "confers many advantages, psychological, material and social" [55] . This means that a heterosexual male who is disadvantaged and on a low wage will be categorised as having ***power*** and ***privilege*** and labelled an ***oppressor*** simply because he belongs to a ***majority*** group due to his sex.

However, this simplistic approach overlooks the complexities and realities of people's lives [56] . It can also lead to discrimination in therapeutic practice [57] . UK statistics show that men can often be vulnerable, disadvantaged and at risk of mental health problems. Men account for 75% of all suicides in the UK, 75% of addictions and 30-40% of domestic abuse victims are male [58] . There is a strong case to be made for clinical psychologists to address these problems rather than making generalised and unhelpful assumptions [59] .

It is also unwise to make assumptions about those in ***minority*** groups. Individuals may not share the view that they are ***oppressed*** or ***marginalised*** and consider it patronising or distressing [60] . Problems with identity-based groupings may arise when individuals are of mixed heritage or considered by CSJ proponents to be ***white-adjacent*** [61] .Intersectionality can lead to disputes between ***minority*** groups as to who is considered the most oppressed and in need of support.

Regardless of the category in which patients are placed, making assumptions about individuals based on their group identity and labelling them 'good' or 'bad' can only interfere with the ability of clinical psychologists to develop trusting and mutually respectful therapeutic relationships with patients.

CSJ anti-racist training

Similar problems are likely to arise as a result of CSJ *anti-racist* training on *Whiteness* that has been introduced by many courses for trainees, staff and supervisors. For example:

Bangor:

Education of programme team staff, supervisors, experts by experience and trainees regarding the ***deconstruction of whiteness in clinical psychology*** *and the promotion of anti-racist and anti-discriminatory practice*

The University of East London has evaluated its entire curriculum based on ***Whiteness*** and now offers ***Whiteness*** training to other courses:

UEL:

We used the ***Whiteness framework*** *to evaluate the curriculum. These discussions were organised around the following questions:*

- ***What does Whiteness look like?***
- ***How can teaching be adapted to acknowledge Whiteness and discuss its implications?***
- ***How can teaching be structured to ensure discussion on Whiteness can happen and be integrated***

within whole group discussions?

- *To what extent do our assessments (questions, tasks, structure, content, marking etc.) embody Whiteness?*
- *What learning do you need to do for yourself to enable you to do the above better?*

In this specific case we have learned that the standard use of outcome measures to evaluate the effectiveness of psychological interventions is frowned upon because measuring outcomes is seen as perpetuating ***Whiteness***.

CSJ ***anti-racist*** training such as this has implications, not only for trainees and staff who are white, but also for patients. CSJ proponents argue that ***Whiteness*** does not refer specifically to white people but to societal structures. However, concepts such as *white fragility* and *white women's tears* are directed at individuals [62] . CSJ considers all white people inherently racist, although they are not allowed to express guilt for being white or to show their emotions [63] . As a result, white people often find themselves in a double bind.

Those who believe in colour-blindness face a similar plight. The reading list of the South Wales course includes a US 'Racism Scale' that asks respondents: ***"Where Do You Fall?"*** with a scale ranging from: ***"Terrorism: 'I would have killed a black person simply for being black' to: "Denial: 'I don't see color"".***

Hartz (2022) cites a troubling clinical example from the US that shows how patients who do not share this CSJ world view are guided towards ***correct thinking*** [64] . Others are encouraged to question and reject therapists who favour a colour-blind approach on the basis that they do not acknowledge the effects of *White supremacy* on mental health [65] .

Here in the UK, the BPS's Clinical Psychology Forum's special edition on racism in clinical psychology training [66] , recommends an article by US Clinical Psychologist Natasha Stovell titled "Whiteness on the Couch" [67] . Stovell states:

> *"The couch in my therapy office is occupied mostly by white people. We talk about everything. Except being white".*

The idea that patients need to talk about 'race' has led to the controversial practice of 'Broaching' [68] . This practice has been introduced into clinical training in Liverpool. At present it appears to be limited to the training of supervisors in their work with trainees on placement. However, in the US it is often used with patients [69] :

> **Liverpool:**
> *We have integrated anti-racist practice into foundation supervisor training as part of a half-day session on Equality and Human Rights in supervision: This includes a 'broaching' (Jones et al, 2019) role play in which supervisors are given skills-based training in opening-up conversations about diversity and identity in supervision and in how to maintain these conversations as a theme in supervision*

While some might welcome such discussion in therapy, others may not, particularly if they perceive that they are receiving a lecture in ***correct thinking*** or being accused of racism. In such cases it would be unethical and anti-therapeutic to 'broach' race. As we saw earlier, patients do not like therapists imposing their own values, being critical or moralistic.

How might a patient, who is feeling vulnerable and distressed, respond when they find that a psychologist, rather than listen and show them empathy and concern, follows their own political agenda and wants to talk about *White privilege*? The patient may respond with feelings of guilt, shame or anger, perhaps drop out of treatment and be reluctant to seek help elsewhere [70] .

It is therefore very important to consider the consequences of training clinical psychologists in CSJ principles and methods that could so easily lead to harm and to discriminatory and unethical practices. At the very least, the adoption of these principles may interfere with the development of trusting and respectful therapeutic relationships which are necessary to help people cope with their distress.

HCPC Standards

HCPC Standards highlight the importance of treating patients as individuals, taking account of their needs and wishes, seeking informed consent, exercising duty of care and engaging in ethical, non-discriminatory practices that develop trust and mutual respect:

HCPC Standards for all registrants state that they must:

1. Promote and protect the interests of service users and carers

Treat service users and carers with respect

1.1 You must treat service users and carers ***as individuals,*** respecting their privacy and dignity

1.5 You ***must not discriminate against service users,*** carers or colleagues ***by allowing your personal views to affect your professional relationships or the care, treatment or other services that you provide***

2. Communicate appropriately and effectively

Communicate with service users and carers

2.2 You ***must listen to service users*** and carers ***and take account of their needs and wishes***

9. Be honest and trustworthy

Personal and professional behaviour

9.1 You must make sure that ***your conduct justifies the public's trust and confidence in you and your profession***

HCPC Standards for practitioner psychologists state that they must:

2. be able to practice within the legal and ethical boundaries of their profession:

2.1 understand the need to ***act in the best interests of service users at all times***

2.3 understand the need to ***respect and uphold the rights, dignity, values and autonomy of service users*** including their role in the assessment, treatment and intervention process and in maintaining health and wellbeing

2.4 recognise that ***relationships with service users should be based on mutual respect and trust and be able to maintain high standards of practice even in situations of personal incompatibility***

2.6 understand the importance of and be ***able to obtain informed consent***

2.7 be able to ***exercise a professional duty of care***

2.9 ***understand the power imbalance between practitioners and service users*** and how this can be managed appropriately

6. be able to practise in a non-discriminatory manner

9. be able to work appropriately with others

9.3 understand the need to engage service users and carers in planning and evaluating assessments, treatments and interventions ***to meet their needs and goals***

Summary

In this chapter we considered how CSJ ***identity politics*** and its version of ***anti-racist*** training is incompatible with traditional therapeutic practice. We have shown how courses, rather than view people as unique and complex individuals, are now categorising them according to their membership of ***majority*** or ***minority*** groups and labelling them as ***privileged*** or ***oppressed***. We have highlighted CSJ practices such as ***broaching*** race and the requirement for ***correct thinking***, both of which would be unethical were they used in therapeutic practice. Courses have claimed in FOI responses that they are upholding HCPC standards by acting in a non-discriminatory manner towards those who are disadvantaged. However, these standards must be applicable equally, across the board, to every individual, regardless of their immutable characteristics. We fear that the incursion of CSJ principles into clinical training may make that hard to achieve.

Clinical competence

In this final chapter we explore the many ways in which CSJ undermines clinical skills and competence. We discuss evidence from FOIs suggesting that courses are encouraging trainees to think and behave in ways that could compromise their ability to cope with the demands of their work. Finally, we return to HCPC standards which highlight the need to maintain fitness to practice, ensure the safety and well-being of patients and manage the psychological and emotional impact of clinical practice.

CSJ effects on behaviour and thinking

One would expect, when teaching trainees to become competent clinical psychologists, that training courses would adopt and model behaviours in accord with evidence from current psychological research. However, FOIs suggest this is not always the case. Instead, not only are trainees being encouraged to be judgemental and engage in 'us-and-them' ways of thinking, but courses are also implementing changes that lead trainees to behave in ways associated with the development and maintenance of anxiety [71] . Lukianoff & Haidt (2010) [72] point out that CSJ encourages ways of thinking which resemble a form of reverse CBT and that are likely to be detrimental to mental health.INSERT PLUCKROSE ENDNOTE

For example, avoidance is particularly evident in placement allocation procedures where ***minority*** trainees are offered the chance to select placements based on their identities and backgrounds, limiting exposure to colleagues and patients who are different to them:

> **Liverpool:**
> *We have adapted our placement preference form (where trainees express their hopes for their next placement) to ask about how trainees feel* ***their backgrounds and identities might impact on their placement preferences*** *when planning for their next placement*

In some cases, trainees are matched to supervisors and placements according to ethnicity or skin colour:

> **Surrey:**
> *Trainees who identify as being from a global majority* background are* ***offered the opportunity to be matched with a clinically qualified mentor who also identifies as being from a global majority background***
>
> **global majority is a 'decolonised' term used in preference to 'ethnic minorities'*

In others an assumption is made that trainees from ***minority*** backgrounds are at risk from certain groups of people:

> **Salomons:**
> *Placement allocation takes account of a trainee's racial background (…) (e.g.* ***we do not send a Black trainee to a White rural area for placement)***

Salomon's decision to 'protect' trainees in this way is counter to well-established evidence from research into anxiety disorders [73] . It is concerning that a course would choose to dismiss or ignore this evidence and encourage behaviour inconsistent with it. The most likely explanation is that the course is trying to prevent trainees from being subjected to racism. At the same time, they seem to be making troubling generalisations about local rural populations. They are not alone in these actions. FOI responses indicate that most courses are going to great lengths to protect ***minority*** trainees from racism and to provide them with safe spaces.

On the other hand, we have learned from trainees in both the UK and US of instances where those who are white have felt "dehumanised" or shamed following training modules on ***Whiteness***. Reportedly, these concerns have either been dismissed by course tutors or trainees have been told to mind their ***privilege*** and not give voice to their concerns [74] . We do not, of course, know whether this is a common experience for white trainees on clinical training courses but, bearing in mind the divisive nature of CSJ, we considered it worthy of mention as a possible cause for concern.

Returning to FOI responses, these indicate that courses have accepted the contested CSJ concept of '***microaggressions***' [75] without challenge and introduced systems to report these, despite strong evidence of the concept's scientific limitations [76] . Clinical psychologists should know that being constantly vigilant for perceived threat, in the form of ***microaggressions***, while ignoring intent and instead focusing on impact based on feelings, will likely foster grievance [77] , lead to confirmation bias [78] and result in problems relating to others:

> **Liverpool:**
> *We have adapted our Mid-Placement Review (MPR) agenda to ensure all trainees are routinely asked about* ***any experiences of micro-aggressions****, bullying or harassment on placement to encourage trainees to seek support with and address any concerns they wish to raise.*

> **Sheffield:**
> *A monthly Safe Space has been developed for trainees from racialised background as well as* ***a discrimination and racism reporting policy*** *with an accompanying flowchart outlining how to report and access support if people are a victim or witness to discrimination and/or racism"*

While no-one would want trainees to experience racism during their training or at any other time, it is important to consider whether separating ***minority*** trainees from their white peers, providing them with ***safe spaces***, 'protecting' them from white colleagues, patients and supervisors while, at the same time, ignoring important findings from research literature on anxiety and ***microaggressions***, is helpful for them, their practice, or for their patients in the long-term.

If trainees come to view themselves as victims, they will not learn how to manage the emotional and psychological impact of clinical work which is often demanding and unpredictable. By encouraging such avoidant and hypervigilant behaviour, courses may be failing to provide ***minority*** trainees with sufficient personal and professional skills to deal effectively with the real world of clinical practice.

We gathered evidence from Professor Christine Sefein [79] about the ways in which CSJ has affected clinical trainees in the US, where the incursion of this ideology is further advanced. Her troubling account of the consequences of CSJ teaching on student behaviour and thinking, such as being quick to blame and judge, can be seen in Appendix H. Professor Sefein also expressed concern about students' lack of resilience and ability to cope in challenging clinical settings. We are concerned that this may come to be the case in the UK.

Diminishing clinical skills

CSJ is also having a negative effect on clinical methods and skills. A concerning example of this was highlighted in the Cass Review Interim Report [80] which revealed the risks associated with adopting a ***gender affirming*** stance. This stance was advocated in BPS guidelines [81] , currently under review since the announced closure of the Tavistock Gender Identity Development Service (GIDS) clinic. However, the move towards ***affirming*** patients in their beliefs, rather than adopting an exploratory or questioning approach which, until recently, was normal practice in clinical psychology, presents challenges to the profession. It was not only present in the GIDS clinic but is being adopted more widely. For example:

> **Teesside:**
> *Following discussions in our EDI steering group we are launching the #Mynameis and pronouns initiative at Teesside DClinPsy*

The use of pronouns and self-ascribed terminology, which emanates from CSJ gender identity ideology, can lead to problems clinically. When the BPS suggested the term 'slut' be used if patients chose this as their 'preferred' term, it drew widespread criticism. One critic pointed out that it would be both untherapeutic and unprofessional to use such a derogatory term without exploring the reason why a patient described themselves in this way [82] .

The CSJ practice of ***affirming*** stems from the concept of ***lived experience***. FOIs show that courses are endorsing this concept:

> **Manchester:**
> *Have an awareness and understanding of **lived experience** of psychological distress in clinical psychologists (i.e. dual role of experts by training and experts by experience).*

> **Glasgow:**
> *Expansion of our teaching offers provided by people with expertise acquired through **lived experience***

Lived experience refers to perceived experiences of *oppression*. It is experience filtered through the lens of CSJ. Objectivity is viewed as a tool of ***oppression*** [83] and any suggestions made that there could be an alternative perspective are met with accusations of *epistemic violence*.

This has serious implications for clinical practice in which the ability to question a patient's subjective experience and reality-test their beliefs can be crucial to the recovery of their mental health. In contrast, CSJ requires that patients viewed as ***marginalised*** be ***affirmed*** in their beliefs even if those beliefs do not accord with reality. This is not the approach taken with any other mental health problem. A clinician would not ***affirm*** that a patient with body dysmorphic disorder is right to want a limb removed. The weakening of clinical skills and their replacement with ***affirming*** based on ***lived experience***, as demonstrated in the Cass Review [84] , raises questions about safeguarding and risk.

Devaluing expertise

FOI responses also show that trainees are being encouraged to adopt a '***non-expert***' position:

> **Glasgow:**
> *We will take a **critical** approach… (in order to) **loosen the profession's grip on the "expert" position***

> **Teesside:**
> *Our aim is to take **a non-expert position***

Responsibility for understanding clinical matters is, instead, passed to 'experts-by-experience' [85] who are seen as having greater 'expertise' and knowledge:

> **Liverpool:**
> *Many of our teaching sessions and trainees' research activities evidence co-production with **experts-by-experience.** Numerous examples of EbE involvement in teaching have been provided in the documents included, **evidencing the shifting power base of where knowledge and expertise lie***
>
> *We have high levels of EBE involvement in our teaching across the three years which **operationalises our pedagogical approach of aiming to re-privilege knowledge and experience from outside of the academy***

While it is considered best practice to work with patients and experts-by-experience collaboratively, clinical psychologists still require 'expert' knowledge and authority to practice effectively and safely. It would not be appropriate, or ethical, for a patient experiencing a psychotic episode or paranoid delusions to be made responsible for deciding their own best treatment. Patients seeking help expect to see someone who is 'expert' in their field. They would not expect, for example, to see a cardiologist whose professional grip on the 'expert' position had been 'loosened' and power shifted to their patients to advise them how to do their work.

Risks and safeguarding

Throughout this chapter we have highlighted how loss of expertise and clinical skill may lead to problems relating to risk and safeguarding. Clinical psychologists work with people who are often vulnerable, have complex needs and serious mental health difficulties that may include risk of self-harm or suicide. It is vital that clinicians are trained to be sufficiently 'expert' to manage such risks. It is also essential that the selection of candidates for clinical training is conducted with these risks in mind. However, this is not evident from

many FOI responses. Some courses propose amending their selection criteria to favour individuals who are affiliated to CSJ values:

> **IOP:**
> *We are piloting amendments to rating criteria that would* ***privilege EDI and/or antiracism awareness/experience.***

Others propose implementing positive action in order to select candidates based on the number of protected characteristics they possess:

> **Surrey:**
> *Positive Action Initiatives (are) Implemented at shortlisting and following interview. Candidates identifying as being from a global majority background will be prioritised. Other protected characteristics considered for positive action are sexuality, disability and gender.* ***Presence of more than one protected characteristics will have a cumulative impact.***

While the University of Liverpool proposes reducing their requirement to qualify for clinical training from a first degree to a 2:2 or 2:1.

The drive to be more inclusive cannot be allowed to surpass the requirement for clinical competence. The over-riding focus for selection panels should be on candidates' potential to develop clinical skills, scientific knowledge and the capacity to work effectively with patients. The more protected characteristics a candidate possesses, the more vulnerable they are likely to be. The interests of patients must be protected. Safeguards therefore need to be put in place to ensure that the needs of patients are considered first and foremost when selecting suitable candidates for training.

HCPC Standards

As we have seen from the examples above, the incursion of CSJ increases the risk that some trainees may fail to meet the standards of clinical competence required by the HCPC regulator.

HCPC standards for all registrants state that:

6. Manage risk

Identify and minimise risk

6.1 You must ***take all reasonable steps to reduce the risk of harm to service users***, carers and colleagues as far as possible.

7. Report concerns about safety

7.4 You must ***make sure that the safety and well-being of service users always comes before any professional or other loyalties***

9. Be honest and trustworthy

Personal and professional behaviour

9.1 You must make sure that your conduct justifies the public's trust and confidence in you and your profession

HCPC standards require practitioner psychologists to:

2. be able to practice within the legal and ethical boundaries of their profession

2.7 be able to exercise a ***professional duty of care***

3. be able to maintain fitness to practise

3.1 understand the need to ***maintain high standards of personal and professional conduct***

3.2 understand the ***importance of maintaining their own health***

3.3 understand both the need to ***keep skills and knowledge up to date*** and the importance of career-long learning

3.4 be able to ***manage the physical, psychological and emotional impact of their practice***

Summary

It is hard to conceive of clinical training programmes designed to make trainees think and behave in ways that are inconsistent with evidence from well-established psychological research. However, this appears to be the case since the incursion of CSJ. Courses are unquestioningly accepting contested CSJ concepts such as ***microaggressions*** and encouraging trainees to withdraw to ***safe spaces*** and avoid people they fear are a threat.

Without the benefit of coping skills and resilience, trainees may struggle in demanding clinical settings. Clinical skills and expertise are being weakened and replaced with an ***affirming*** stance that is dependent on lived experience filtered through a CSJ lens. At the same time, courses are changing their selection criteria to enable candidates with several protected characteristics or declared affiliation to CSJ principles to gain training places. These developments raise important questions about safeguarding and risk management that urgently need to be addressed.

5 Summary

This report, based on FOI responses from 21 clinical psychology training courses in the UK, demonstrates, without doubt, that CSJ is now widespread in the profession. This incursion has been achieved with funding from NHS Health Education England, encouragement from The British Psychological Society and through university EDI initiatives, with support from grassroots movements. The American Psychological Association has led the way in politicising clinical psychology and spreading CSJ's message to psychologists across the world.

FOIs show that trainees on UK courses are being schooled in ***social justice activism*** with the aim of changing "societal values, structures, policies and practices" (Goodman et al., 2004) [86] . Whereas the focus of clinical psychology has previously been the individual, trainees are now encouraged to engage in ***identity politics***, categorising people by ***majority*** or ***minority*** groups and labelling them ***privileged*** or ***oppressed***.

Those in ***majority*** groups face the prospect of receiving moral re-education in ***correct thinking***, while those in ***minority*** groups face the stark choice of viewing themselves as ***oppressed*** victims, required to take up political activism to save themselves, or being accused of ***internalised racism*** or ***homophobia*** if they disagree.

Meanwhile, the concept of colour-blindness which, until very recently, was considered both desirable and benign, has now, without any debate or discussion, been re-labelled ***racist***. Health Education England has imposed on courses a CSJ ***anti-racist*** agenda, supported by The British Psychological Society. It is based on the divisive, unevidenced and disruptive CSJ values of critical theorist Ibram X. Kendi [87] , who calls for discrimination against white people. This form of ***anti-racism*** which has itself been criticised for being racist, will likely lead to further division and discriminatory practices within the profession that pose a risk to vulnerable patients seeking help for their mental health difficulties.

Political methods such as ***Liberation Psychology*** are being introduced into training courses, without any evidence of their clinical validity or utility, while standard ways of measuring the effectiveness of interventions are being rejected because they perpetuate ***Whiteness*** or are considered too ***WEIRD***. The very notion of objectivity is rejected in favour of ***lived experience*** – a concept that science has traditionally rejected as being anecdotal – and which is applied exclusively to those that CSJ proponents perceive to be ***oppressed***. Patients are to be ***affirmed*** in their beliefs, regardless of whether this is harmful to their mental or physical health.

Exclusion in the name of inclusion is evident in the division of trainees into those from ***minority*** backgrounds who are protected from white patients and colleagues, given ***safe spaces*** and encouraged to be vigilant for racism and ***microaggressions*** while white trainees are silenced and told to mind their ***privilege***. Vulnerable men and boys are viewed as being ***dominant*** and having ***toxic masculinity*** despite statistics showing they are at the highest risk of suicide in the UK.

A further risk to patients comes from ***decolonisation*** of curricula as well-established, evidence-based psychological methods and treatments are undermined at the bidding of Health Education England. EDI officers, unidentified external consultants and, in one case, representatives from Black Lives Matter, are being brought in to advise on curricula and decolonisation processes, although in most cases there is little evidence that they have any clinical knowledge or experience. Meanwhile, the very idea of clinical skills, expertise and competence is being devalued and candidates for training selected on the basis of how many ***protected characteristics*** they possess.

This report has highlighted CSJ's divisive, authoritarian beliefs and contested and damaging values: the way it encourages blame and judgement; its calls for re-education or silencing of people who do not conform to its views; its rejection of diversity of thought and societal 'norms'. It is remarkable that courses are now designed in ways that actively and unquestioningly support CSJ values: encouraging trainees to engage in thinking styles that research shows are detrimental to mental health; advocating behaviours such as avoidance, that

may compromise their fitness to practice. This does not bode well for students in training or for the patients they treat. Politics is coming directly into conflict with duty of care.

Nowhere is this more evident than the Tavistock Gender Identity Development Service (GIDS) which, following the Cass Review Interim Report [88] , has been declared "not safe" for children and is to close. This is a welcome first step towards removing CSJ ideology from the NHS. However, as this report demonstrates, far more needs to be done and urgent action must be taken to prevent further harm being caused to patients in the name of Critical Social Justice.

It should be of great concern to the HCPC regulator that clinical psychology training courses no longer provide training that fully meets its standards. The adoption of discriminatory and unethical practices is certainly not in the best interests of patients. Clinical psychology's scientific knowledge base and evidence-based practice are being eroded. The undermining of clinical competence and expertise has implications for the management of risk and safeguarding. Courses are in thrall to CSJ ideology and the disparity between what they are teaching and the Government regulator's standards is, in itself, a scandal.

Conclusion

The profession of clinical psychology – one that is scientist-practitioner led, focuses on the unique individual and adopts a non-judgemental approach, is now at serious risk from an extremist ideology. It is of particular concern that this is happening in the wake of the Covid-19 pandemic which has led to a 25% increase in anxiety and depression worldwide [89] , resulting in an even greater need for experienced and well-trained clinical psychologists.

We therefore call on the Health & Care Professions Council regulator and the Secretary of State for Health to take urgent action to halt the incursion of this political ideology into clinical psychology training courses before the profession is damaged beyond repair.

We also call for an urgent review of Health Education England's Action Plan which has introduced this ideology into clinical training and which serves to perpetuate its divisive and discriminatory values and beliefs These measures are essential to prevent future harm to vulnerable patients on a scale potentially far greater than that already exposed in the case of the Tavistock Clinic. It is time for clinical psychologists to be reminded of their duty to "First Do No Harm".

6 Endnotes

1 Cass Review Interim Report: https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf

2 HCPC standards for practitioner psychologists:

https://www.hcpc-uk.org/standards/standards-of-proficiency/practitioner-psychologists/

HCPC standards for all registrants: https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/

HCPC standards for education and training:
https://www.hcpc-uk.org/standards/standards-relevant-to-education-and-training/

3 https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide

4 Clinical psychologists are trained to work with individuals, families and groups of different ages experiencing psychological distress or behavioural problems which disrupt their everyday functioning and wellbeing. Psychological difficulties include a range of issues such as anxiety, depression, eating disorders, addictions, learning disabilities and family or relationship issues. Drawing on scientific knowledge to bring about positive change, clinical psychologists work in partnership with patients to design and implement inteventions to overcome their condition or improve their quality of life.
https://www.healthcareers.nhs.uk/explore-roles/psychological-therapies/roles/clinical-psychologist

5 Clinical psychology training comprises a three-year full-time doctorate programme of academic study, research and work on placement. Its practitioners and clinical courses are regulated by the Healthcare Professions Council (HCPC). The professional body for clinical psychologists is the British Psychological Society (BPS): its role is to represent psychology and psychologists in the UK. The BPS also provides accreditation for clinical training courses

6 Pluckrose, H. (2021. February 17). What do we mean by Critical Social Justice? Counterweight. Retrieved 30 September 2022 from: https://counterweightsupport.com/2021/02/17/what-do-we-mean-by-critical-social-justice/

7 James Esses: https://www.crowdjustice.com/case/expelled-university-free-speech/

8 Miller, K. (2020, August 27). The now 'cancelled' letter to the British Psychological Society. Retrieved 20 September 2022 from https://drkirsty.medium.com/the-now-cancelled-letter-to-the-british-psychological-society-3b4582334bc7

9 Rolojo-Howell, D. (2020, February 24, last updated 2022, September 16). Diversity, Oppression, and Decolonisation – Are There Too Many Social Justice Articles on 'The Psychologist'? Psychreg. Retrieved 20 September 2022 from https://www.psychreg.org/diversity-oppression-decolonisation-social-justice-articles

10 Moss, D. (2021). On having whiteness. *JAPA, 69(2)*, 355-371. https://doi.org/10.1177/00030651211008507

11 Morrison, R. J. (2022, January 18). Professor leaves UVM five months after refusing public demand of resignation. *The Vermont Cynic*. r Retrieved 3 October 2022 from: https://vtcynic.com/news/professor-leaves-uvm-nine-months-after-refusing-public-demand-of-resignation/

12 https://criticaltherapyantidote.org

13 Professor Christine Sefein, Foundation Against Intolerance & Racism:
https://fairforall.substack.com/p/fair-news-an-alarming-trend-in-psychotherapy

14 Pincourt, C., & Lindsay, J. (2021) Counter Wokecraft: A Field Manual for Combatting the Woke in the University and Beyond. New Discourses

15 BPS politicisation:
https://www.bps.org.uk/member-networks/division-clinical-psychology/equality-diversity-inclusion-anti-racism

16 Concerns raised about BPS:
https://www.change.org/p/charity-commission-stop-the-politicisation-of-psychology

17 Kendi, I.X. (2019). *How To Be An Antiracist*. London: Penguin Random House.
https://www.waterstones.com/book/how-to-be-an-antiracist/ibram-x-kendi/9781847925992

18 Please see these links:
https://www.nes.scot.nhs.uk and https://heiw.nhs.wales. .

19 Psychologists for social change: http://www.psychchange.org

20 BPS Minorities in Clinical Psychology Subcommittee: https://www.bps.org.uk/member-networks/division-clinical-psychology/equality-diversity-inclusion-anti-racism; https://medium.com/@minorities.cp/a-letter-to-clinical-psychology-by-the-minorities-in-clinical-psychology-subcommittee-983cf332abb7

21 Ahsan, S. (2022, September 6). I'm a psychologist – and I believe we've been told devastating lies about mental health. *The Guardian*. Retrieved 11 September 2022 from https://www.theguardian.com/commentisfree/2022/sep/06/psychologist-devastating-lies-mental-health-problems-politics?CMP=fb_cif

22 Ong, L. (2021). White Clinical Psychologists, Race and Racism. A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Professional Doctorate in Clinical Psychology. 1-158 https://repository.uel.ac.uk/download/81321c7362754c8a684680388fcb92c0a6f3b2a1e2cc5e5b2533caa091bf4ad5/1896253/2021_ClinPsychD_Ong.pdf

23 Clinical Psychology Forum Special Issue: Racism during training in clinical psychology, Edited by Nick Wood & Nimisha Patel, 323, 20-24. https://shop.bps.org.uk/clinical-psychology-forum-no-323-november-2019

24 Goad, M. (2022, September 2). The American Psychological Association has fully committed itself – and its field – to identity politics. *Color-Coded Mental Health*. Retrieved 11 September 2022 from https://www.city-journal.org/american-psychological-association-politicizes-itself

25 Shamsi, T. (2022, Aug 15). How ideological capture is hurting clinical psychology. *Foundation Against Intolerance & Racism*. Retrieved 11 September 2022 from https://fairforall.substack.com/p/clinical-psychology-ideological-capture?utm_source=substack&utm_medium=email&utm_content=share

26 https://www.apa.org/about/apa/equity-diversity-inclusion/framework

27 https://www.apa.org/about/apa/addressing-racism/racial-equity-action-plan.pdf

28 Thomas, V. (5 February 2022). 'Woke' Therapy Weakens the Client, *Critical Therapy Antidote*. Retrieved 9 September 2022 from https://criticaltherapyantidote.org/2022/02/05/woke-therapy-weakens-the-client

29 This quote is discussed further in the Decolonisation chapter

30 Goodman, L.A., Liang, B., Helms, J.E., Latta, R.E., Sparks, E., Weintraub, S.R. (2004). Training Counseling Psychologists as Social Justice Agents: Feminist and Multicultural Principles in Action. *The Counseling Psychologist, 32 (6),* 793-836. https://journals.sagepub.com/doi/10.1177/0011000004268802

31 Consciousness raising: https://www.bl.uk/sisterhood/articles/consciousness-raising

32 Goodman et al.'s approach is endorsed by a fellow of the American Psychological Society and is currently being taught in US clinical training courses: Falender, C.A. & Shafranske, E.P., (2021) *Clinical Supervision A Competency-Based Approach*, (2nd ed.). Washington, DC: American Psychological Association. https://www.apa.org/pubs/books/clinical-supervision-second-edition
See Chapter 4: "Building Multiculturalism and Diversity Competence in Clinical Supervision

33 BPS practice guidelines, 3rd edition, 2017. Downloadable PDF, p9: https://www.bps.org.uk/guideline/bps-practice-guidelines-2017-0

34 Audre Lorde, a black feminist, drawing on the metaphor of slavery, made the case that dominant systems will never be dismantled or disrupted using the 'tools' of those same systems so alternative methods need to be used to achieve this aim and overcome oppression. Lorde, Audre. "The Master's Tools Will Never Dismantle the Master's House." 1984. *Sister Outsider: Essays and Speeches*. Ed. Berkeley, CA: Crossing Press. 110- 114. 2007. https://collectiveliberation.org/wp-content/uploads/2013/01/Lorde_The_Masters_Tools.pdf

35 Wood, N., & Patel, N. (2017). On addressing 'Whiteness' during clinical psychology training. *South African Journal of Psychology, 47 (3)*, 280-291. https://doi.org/10.1177/0081246317722099

36 Hellowell, M., & Schwerdtle, P.N. (2022), Powerful ideas? Decolonisation and the future of global health. BMJ Global Health, 7, -4. https://gh.bmj.com/content/bmjgh/7/1/e006924.full.pdf

37 Táíwò, O. (2022). *Against Decolonisation: Taking African Agency Seriously*. London: Hurst & Company. https://www.hurstpublishers.com/book/against-decolonisation/

38 National Institute for Health and Care Excellence: https://www.nice.org.uk/guidance/qs53/chapter/quality-statement-2-psychological-interventions

39 Guilaine Kinouani, founder of the British Psychological Society's Minorities Group wrote an article (currently unavailable) accusing CBT of "*epistemic violence*" and describing it as "*The Master's Tools*". https://racereflections.co.uk/about-the-author/

40 Riegner, G., Posey, G., Oliva, V., Youngkyoo, J., Mobley, W., Zeidan, F. Disentangling self from pain: mindfulness meditation-induced pain relief is driven by thalamic-default mode network decoupling. *Pain, 10.1097*. https://journals.lww.com/pain/abstract/9900/disentangling_self_from_pain__mindfulness.127.aspx

41 Prajapati, R., Kadir, S., & King, S. (2019). Dealing with racism within clinical psychology training: Reflections of three BAME trainee clinical psychologists. *Clinical Psychology Forum Special Issue: Racism during training in clinical psychology, Edited by Nick Wood & Nimisha Patel, 323,* 20-24. https://shop.bps.org.uk/clinical-psychology-forum-no-323-november-2019

42 Burnham, J. (1993) Systemic Supervision: the evolution of reflexivity in the context of the supervisory relationships. Human Systems. *The Journal of Systemic Consultation and Management, 4* (3-4): 349-381. https://www.basw.co.uk/media/news/2020/jul/social-graces-practical-tool-address-inequality

43 Birdsey, N., & Kustner, C. (2020). Reviewing the Social GRACES: What Do They Add and Limit in Systemic Thinking and Practice, *American Journal of Family Therapy, 49 (2),* 429-442. https://www.tandfonline.com/doi/abs/10.1080/01926187.2020.1830731

44 Comas-Diaz, L., & Rivera, E.T. (Eds.) (2020). *Liberation Psychology: Theory, Method, Practice and Social Justice.* Washington DC: American Psychological Association. https://www.apa.org/pubs/books/liberation-psychology

45 Keenan, H., & Lil Miss Hot Mess. (2021). Drag pedagogy: The playful practice of queer imagination in early childhood. *Curriculum Inquiry, 50 (5),* 440-461 https://www.tandfonline.com/doi/full/10.1080/03626784.2020.1864621

46 Rawls, J., (2021, December 13). Defending Pedophilia is the Logical Conclusion of Queer Theory. *The Federalist.* Retrieved 10 September 2022 from: https://thefederalist.com/2021/12/13/defending-pedophilia-is-the-logical-conclusion-of-queer-theory/

47 https://www.physio-pedia.com/Biopsychosocial_Model

48 The WAIS is the Wechsler Adult Intelligence Scale, widely used to assess cognitive ability in adults. "Passing out on the WAIS" was previously a requirement for trainees so that they could demonstrate their competence in administering the scale prior to graduating as a qualified clinician. It appears that this is no longer considered appropriate, despite its wide usage in clinical psychology settings.

49 Cited (p2) in: Gilbert, P., & Leahy, R. L., (2007). Introduction and overview: Basic issues in the therapeutic relationship. In Gilbert, P., & Leahy, R.L., (Eds.) *The Therapeutic Relationship in the Cognitive Behavioral Psychotherapies.* (pp.2-23). New York, NY: Routledge/Taylor & Francis Group. E-book https://psycnet.apa.org/record/2007-01083-000

50 Cited (p32) in: Hardy, G., Cahill, J., & Barkham, M. (2007). Active ingredients of the therapeutic relationship that promote client change. In Gilbert, P;, & Leahy, R.L., (Eds.) *The Therapeutic Relationship in the Cognitive Behavioral Psychotherapies.* (pp.24-42). New York, NY: Routledge/Taylor & Francis Group. E-book https://psycnet.apa.org/record/2007-01083-000

51 ibid. (p31)

52 ibid. (p33)

53 Pluckrose, H., & Lindsay, J. (2020) *Cynical Theories: How Activist Scholarship Made Everything about Race, Gender and Identity and Why This Harms Everybody.* Durham, North Carolina: Pitchstone. https://www.waterstones.com/book/cynical-theories/helen-pluckrose/james-lindsay/9781800750326

54 Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* Leicester: British Psychological Society. https://www.bps.org.uk/member-networks/division-clinical-psychology/power- threat-meaning-framework
The PTM Framework has been widely criticised. It was described by Professor Paul Salkovskis as: "a hybrid social-constructionist, anti-psychiatry, anti-science and political agenda" that is "more manifesto than scholarly document", casting doubt on the scientific basis for its claims: https://www.nationalelfservice.net/mental-health/power-threat-meaning-framework-innovative-and-important-ptmframework/

55 Seager, M. (2018, September). The Power Threat Meaning Framework (PTMF) takes a dim view of the male gender. *Centre for Male Psychology.* Retrieved 10 September 2022 from: https://www.centreformalepsychology.com/male-psychology-magazine-listings/the-power-threat-meaning-framework-ptmf-takes-a-dim-view-of-the-male-gender

56 Pilgrim, D. (2022). *Identity Politics: Where Did It All Go Wrong?* Oxfordshire: Phoenix Publishing House Ltd. https://firingthemind.com/product/9781800131002/

57 Hartz, A. (2022, June). Leftist Extremism Is Turning Therapists And Counselors Against Their Own Clients. *The Federalist.* Retrieved 10 September 2022 from: https://thefederalist.com/2022/06/02/leftist-extremism-is-turning-therapists-and-counselors-against-their-own-clients/

58 Source: Seager, M. The Centre for Male Psychology: https://www.centreformalepsychology.com/about-the-centre-for-male-psycholog

59 Seager, M., & Barry, J. (2019, May 09). Toxic acts, not toxic masculinity. The Psychologist. Retrieved 10 September 2022 from: https://www.bps.org.uk/psychologist/toxic-acts-not-toxic-masculinity#:~:text=Sadly%2C%20only%20toxic%20acts%20tend,good%20science%20and%20empathic%20humanity

60 Bhat, Chadrashekar. (2022, August 04). *Diversity officer held guilty of discrimination for assuming her colleague was 'oppressed' because of her race.* Retrieved 10 September 2022 from: https://www.easterneye.biz/diversity-officer-held-guilty-of-discrimination-for-assuming-her-colleague-was-oppressed-because-of-her-race/

61 Gerstmann, Evan. (2019, October 01). *Why The Asian American Students Lost Their Case Against Harvard (But Should Have Won).* Retrieved 10 September 2022 from: https://www.forbes.com/sites/evangerstmann/2019/10/01/why-the-asian-american-students-lost-their-case-against-harvard-but-should-have-won/?sh=2b0f589d63c1

62 Diangelo, R., (2019). *White Fragility: Why It's So Hard for White People to Talk About Racism*. London: Allen Lane. https://www.waterstones.com/book/white-fragility/robin-diangelo/9780141990569

63 ibid.

64 Hartz, A. (2022, June). Leftist Extremism Is Turning Therapists And Counselors Against Their Own Clients. The Federalist. Retrieved 10 September 2022 from: https://thefederalist.com/2022/06/02/leftist-extremism-is-turning-therapists-and-counselors-against-their-own-clients/

65 In their module on "Race, Heritage and Religion", Teesside Doctorate in Counselling Psychology included this video of clinical psychologist Thema Bryant titled: Moving From Cultural Competence to Antiracism: https://www.youtube.com/watch?v=_wJ_pvbC3SI

66 Clinical Psychology Forum Special Issue: Racism during training in clinical psychology, Edited by Nick Wood & Nimisha Patel, 323, 20-24. https://shop.bps.org.uk/clinical-psychology-forum-no-323-november-2019

67 Stovell, N. (2019, August). *Whiteness on the Couch*. Retrieved 10 September 2022 from: https://longreads.com/2019/08/12/whiteness-on-the-couch/

68 Day-Vines, N.L., Cluxton-Keller, F., Agorsor, C., Gubara, S. (2021). Strategies for Broaching the Subjects of Race, Ethnicity and Culture. *Journal of Counseling & Development, 99 (3),* 348-357. https://onlinelibrary.wiley.com/doi/10.1002/jcad.12380

69 Elliott, L., (2021, December 6). *The Future of Counseling is Racist*. Retrieved 10 September 2022 from: https://criticaltherapyantidote.org/2021/12/06/the-future-of-counseling-is-racist/

70 Cooley, E., Brown-Iannuzzi, J.L., Lei, R.F., & Cipolli, W. III. (2019) Complex intersections of race and class: Among social liberals, learning about White privilege reduces sympathy, increases blame and decreases external attributions for White people struggling with poverty. *Journal of Experimental Psychology: General, 148(*12*),* 2218-2228. https://psycnet.apa.org/doiLanding?doi=10.1037%2Fxge0000605

71 Krypotos, A-M., Effting, M., Kindt, M., & Beckers, T. (2015). Avoidance learning: a review of theoretical models and recent developments. *Frontiers in Behavioral Neuroscience, (9)*, 189-189. https://doi.org/10.3389/fnbeh.2015.00189

72 Lukianoff, G., & Haidt, J. (2019). *The Coddling of The American Mind: How Good Intentions and Bad Ideas Are Setting Up a Generation for Failure*. New York: Penguin Books. https://www.thecoddling.com

73 Clark, D.M. (1999). Anxiety disorders: why they persist and how to treat them. *Behaviour Research Therapy, 37*, 5-27. 10.1016/s0005-7967(99)00048-0

74 Elliott, L., (2021, December 6). The Future of Counseling is Racist. Retrieved 10 September 2022 from: https://criticaltherapyantidote.org/2021/12/06/the-future-of-counseling-is-racist/

75 Sue, D., Capodilupo, C.M., Torino, G.C., & Bucceri, J.M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62* (4), 271-286. https://psycnet.apa.org/doiLanding?doi=10.1037%2F0003-066X.62.4.271

76 Lilienfeld, S.O. (2017). Microaggressions: Strong Claims, Inadequate Evidence. *Perspectives on Psychological Science, 12* (1m 138-169. https://journals.sagepub.com/doi/10.1177/1745691616659391

77 Referring to microaggressions, Lukianoff & Haidt (2019, p.46) ibid. observe that: *"If someone wanted to create an environment of perpetual anger and intergroup conflict, this would be an effective way to do it. Teaching students to use the least generous interpretations possible is likely to engender precisely the feelings of marginalization and oppression that almost everyone wants to eliminate"*

78 Noor, I., (2020, June 10). How Confirmation Bias Works. *Simply Psychology*. Retrieved 11 September 2020 from https://www.simplypsychology.org/confirmation-bias.html

79 Sefein, C. (2021, December 3). American Clinical Psychology Professor Resigns Due to 'Alarming Trend in Psychotherapy'. *Critical Therapy Antidote*. Retrieved 11 September 2022 from https://criticaltherapyantidote.org/2021/12/03/american-clinical-psychology-professor-resigns-due-to-alarming-trend-in-psychotherapy/

80 Cass Review Interim Report: https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf

81 https://www.bps.org.uk/guideline/guidelines-psychologists-working-gender-sexuality-and-relationship-diversity

82 https://twitter.com/TaniaAMarshall/status/1479158099483107328?s=20

83 Ferguson, S. (2016, March 27). 4 Reasons Demanding 'Objectivity' in Social Justice Debates Can be oppressive. *Everyday Feminism*. Retrieved 20 September 2022 from https://everydayfeminism.com/2016/03/objectivity-can-be-oppressive/

84 Cass Review Interim Report: https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf

85 BPS Practice Guidelines state:

3.1 Working with Experts by Experience

In relevant services it is best practice for psychologists to work collaboratively with clients and Experts by Experience in developing and delivering all aspects of psychological services. In mental health, the Government is committed to shared decision-making and the principle 'no decision about me without me'. This applies from work with an individual client through to changes in government policy relevant to the services provided by psychologists. Psychologists should develop services, policies and guidelines in collaboration with the people who use their services.

In professional practice it is important and helpful to work collaboratively with clients and, where relevant, others in order to ensure that the application of psychological research and theory is understood by and adapted appropriately to the client group and context, which may differ from the populations on which the research was based.

86 Goodman, L.A., Liang, B., Helms, J.E., Latta, R.E., Sparks, E., Weintraub, S.R. (2004). Training Counseling Psychologists as Social Justice Agents: Feminist and Multicultural Principles in Action. The Counseling Psychologist, 32 (6), 793-836. https://journals.sagepub.com/doi/10.1177/0011000004268802

87 Kendi, I.X. (2019). *How To Be An Antiracist*. London: Penguin Random House. https://www.waterstones.com/book/how-to-be-an-antiracist/ibram-x-kendi/9781847925992

88 Cass Review Interim Report: https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf

89 https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide

7 Appendices

A Letter to Health & Care Professions Council

B Clinical Psychology Training Courses in the UK

C Health & Care Professions Council relevant standards

D Critical Social Justice terminology and crossover words

E NHS Health Education England Action Plan

F Information for Guest Lecturers (Coventry & Warwick)

G Cycle of Professional Practice

H Critical Social Justice: influences on clinical psychology trainees

I Appendices' endnotes

Appendix A

Letter to Health & Care Professions Council 31 January 2022:

Emma Leary
Head of Policy, Standards & Strategic Relationships
Health & Care Professions Council
184–186 Kennington Park Road
London
SE11 4BU

31 January 2022

Dear Ms Leary

I am writing to you as a concerned member of the public and a past practitioner psychologist registrant of the HCPC. I worked as a Clinical Psychologist in the NHS and private practice for many years and am now retired but continue to maintain an interest in the profession.

In recent years, fears have been growing about the incursion of Critical Social Justice ideology into clinical psychology and other therapeutic professions. The aims and assertions of this ideology appear to be at odds with many of the HCPC's Standards of conduct, performance and ethics for practitioner psychologists and this is the reason I have contacted you.

What is Critical Social Justice?

Critical Social Justice (CSJ) is a theoretical approach arising from a combination of Marxist thought and postmodern concepts of knowledge, power and discourses. It aims to address prejudice and discrimination on the basis of race, sex, sexuality, gender identity, disability and body size. The way it proposes achieving this goal is by changing society through social justice activism. CSJ rejects objective scientific enquiry and research methods, viewing these as embedded in oppressive societal power systems such as 'white supremacy' and 'patriarchy'.

CSJ proponents categorise people according to their 'identity group' and treat them as either 'oppressor' or 'oppressed'. Notions of objectivity, neutrality and the unique individual are viewed as 'problematic' as are evidence-based psychological treatments because they emanate from 'white western science'. Scientific endeavour is labelled 'WEIRD' – **W**estern **E**ducated **I**ndustrialised **R**ich and **D**emocratic. Such ideas have gained traction in recent years due to the popularity of books such as "White Fragility" by Robin Di Angelo and "How to be an Anti-Racist" by Ibram X. Kendi. These authors advocate Critical Race Theory which stems from Critical Theory and the CSJ movement.

CSJ is already widespread in the US and embedded in the American Psychological Association. In Canada the accrediting boards for graduate clinical psychology training programs are now planning to refuse to accredit university clinical programmes unless they have a 'social justice' orientation. The British Psychological Society has also adopted a CSJ agenda and this is reflected in its journal *The Psychologist*. Their commitment accelerated following the death of George Floyd and the Black Lives Matter protests in 2020. The BPS now follows the 'anti-racist' agenda advocated by Ibram X Kendi and CSJ initiatives are being embedded in clinical training courses in the UK.

Why does this matter?

I hope to demonstrate why this should be of concern to the HCPC by illustrating some of the ways in which CSJ is, in my view, incompatible with many of the regulatory standards and ethics to which clinical psychologists and other practitioner psychologists, are meant to abide.

I will start with a draft document recently produced by the University of Lancaster, regarding 'decolonisation' of their curricula. This document is indicative of changes happening across UK clinical training courses. It contains a summary from a Clinical Tutor on the DClinPsy course, quotes from which are inserted below. The first two quotes raise questions regarding the following HCPC standards which state that registrant practitioner psychologists must:

1. be able to practice safely and effectively ***within their scope of practice***
2. be able to practice within the legal and ***ethical boundaries*** of their profession

2.2 ***understand what is required of them*** by the Health and Care Professions Council

Example 1

Reflective summary of DClinPsy work (redacted) University of Lancaster

Quote 1: "We are widening the scope from the individual and the 'scientist-practitioner' model as the primary focus to explicitly include social and political contexts in training. We are encouraging trainees to use their position as future leaders to lobby for social change and take an activist stance".

Quote 2: "The social justice agenda of our programme is a key attraction for many trainees".

The role of the Clinical Psychologist is described by NHS England as one in which "you will draw on your scientific knowledge to bring about positive change". It goes on: "you'll work in partnership with service users to design and implement interventions to overcome their condition or improve their quality of life".

This is a description of the ***scientist practitioner model*** advocated by the HCPC and, until recently, the BPS.

How is the adoption of a politicised agenda that advocates clinical psychologists becoming ***social justice activists*** compatible with that model?

What skills and experience are required to become a ***social justice activist***? Are such clinical psychologist/activists practising safely and within their scope of practice?

Is it ethical to work in such an explicitly political way with service-users?

Do those running the DClinPsy course and the trainees attracted to its social justice agenda fully understand what is required of them by the HCPC?

Val Thomas, a psychotherapist and author who runs an organisation called "Critical Therapy Antidote" to support practitioner psychologists and other therapists who are concerned about the incursion of CSJ into their institutions, expresses these concerns clearly in an article in Areo:

"From Psychotherapist to Psychoactivist: How Therapy is Becoming Derailed":

"New generations of practitioners are being trained to accept not only a different way of achieving social justice, but also that achieving social justice is the **job of therapy** (my emphasis). These ideas have been entering professional therapy education by way of the compulsory diversity modules—an important training component designed to prepare students for working with diverse client groups."

"The goal is the creation of therapist-activists, who will diagnose presenting problems through a collective lens and use the client-therapist encounter to inculcate an ideology that fosters grievance and victimhood: the only solution offered to presenting problems will be a never-ending political activism. This disastrous trajectory will surely be speeded up as younger generations, who have been imbibing this ideology in their school and college educations, arrive in the training centres."

In addition to questions about safe, ethical and effective practice, further questions arise from the University of Lancaster document, relating to the following standards which state that registrants must:

12.1 be able to engage in ***evidence-based*** and ***evidence-informed*** practice

13. understand the key concepts of ***the knowledge base*** relevant to their profession

14.39 be able to implement therapeutic interventions based on a range of ***evidence-based*** models of formal psychological therapy, including the use of ***cognitive behavioural therapy***.

Example 2

Reflective summary of DClinPsy work (redacted – Clinical Psychology) University of Lancaster

Quote 3: "In clinical psychology, we have taken the stance that decolonising is not solely about the curriculum but about our systems and processes. We know that the 'interventions' that make up our clinical practice are "ahistorical, depoliticised and contextually distant" (Pillay, 2017) and we need to critically appraise them. We understand that "psychological imperialism" undermines and subjugates the knowledge that is generated from indigenous communities and that the psychological theories our discipline is based on were developed by Western theorists and on research with WEIRD participants – **W**estern **E**ducated **I**ndustrialised **R**ich and **D**emocratic – with models used in clinical psychology based on individualistic, not collectivistic, cultures."

The aim of 'decolonisation' is to reduce or remove material emanating from Western white and male authors and researchers, replacing it with material from non-white and non-western sources. A recent article in the BMJ raises concerns about the potential harm of 'decolonisation' in undermining confidence in scientific knowledge. 'Decolonisation' may have serious implications for evidence-based treatments such as Cognitive Behaviour Therapy (CBT) – a proven effective psychological treatment that has benefited many people and is recommended by NICE. Many CSJ advocates are critical of CBT. It has been described it as "epistemic violence" and "his master's tools" and suggestions made that it be "dismantled". Others try to incorporate CBT into "anti-oppressive" practices to "raise critical consciousness".

As to the HCPC standards above, while clinical psychologists may understand the key concepts of the knowledge base relevant to their profession, some of them are questioning the nature of the science that underpins that knowledge base. They are also questioning the ***"systems and processes"*** that constitute current clinical practice, including the focus on the individual. If evidence-based treatments such as CBT are considered too "Western, individualistic and potentially harmful to non-white clients, clinical psychologists may, in future, be reluctant to implement therapeutic interventions based on such treatments. What would replace them, however, is not at all clear, although the BPS's Division of Clinical Psychology recommends the "Power Threat Meaning Framework", described by Professor Paul Salkovskis as: "a hybrid social-constructionist, anti-psychiatry, anti-science and political agenda" that is "more manifesto than scholarly document".

What could this mean for service-users?

Please consider the following Standards when reading the final section:

2.1 understand the need to act in the ***best interests of service users*** at all times

2.3 understand the need to ***respect and uphold the rights, dignity, values and autonomy of service users*** including their role in the assessment, treatment and intervention process and in maintaining health and wellbeing

2.6 understand the importance of and be able to ***obtain informed consent***

2.9 understand the ***power imbalance*** between practitioners and service users and how this can be managed appropriately

6. be able to practise in a ***non-discriminatory manner***

A paper by Grzanka et al., provides some insight into what therapeutic work might look like in the future. Although it emanates from the US, many of the ideas contained in the paper are already being adopted enthusiastically in the UK.

Example 3

Patrick R. Grzanka, Kirsten A. Gonzales & Lisa B. Spanierman, "White Supremacy and Counseling Psychology: A Critical-Conceptual Framework", The Counseling Psychologist

The authors call for psychologists to: "harness the tools of psychology to actively challenge White supremacy in their work as therapists, educators, scientists, advocates and activists."

They ask: "What might the field gain if social justice were at the center of all our work, including our work with White people?".

They then suggest: "three steps for sharpening counseling psychologists' approaches to social justice: rejecting racial progress narratives, engaging in social justice-oriented practice with White clients and centering White supremacy as a key problem for the field of counseling psychology and allied helping professions."

This is not the only research paper encouraging such an anti-therapeutic approach. The prospect of service-users seeking help for mental health problems and being confronted by a psychologist who, rather than treat those specific problems, instead categorises them as an "oppressor" and decides to "cure" them of racism, or any other "ism" is a troubling one that could be viewed as discriminatory.

It also raises questions about the purpose of therapeutic treatment and the potential impact on service-users of psychologists' imposing their political beliefs and values on them. American psychologist Jonathan Haidt and his co-author Greg Lukianoff have pointed out that many of the ways of thinking encouraged by advocates of CSJ, such as "emotional reasoning" and "all or nothing thinking" are associated with depression and anxiety and resemble a form of 'reverse Cognitive Behaviour Therapy'. I have similarly expressed concerns about the potential for harm to those engaging in these ways of thinking.

Implications for HCPC Standards and ethics

I hope you will agree that the factors I have outlined above raise serious questions about the compatibility of CSJ with the HCPC's standards and ethics for practitioner psychologists.

Firstly, the politicisation of clinical psychology and the training of psychologists to become social justice activists is beyond the scope of clinical practice, incompatible with the scientist-practitioner model and a potential risk to service-users.

Secondly, the rejection of objective scientific enquiry poses a serious threat to the provision of efficacious and evidence-based psychological treatments.

Lastly, the widespread adoption of CSJ has the potential for causing harm to the profession, to the NHS and other mental healthcare services.

Questions for HCPC

In view of these concerns, I would be most grateful if you could consider the following questions:

1. What is the HCPC's position regarding the introduction of Critical Social Justice activism into Clinical Psychology and its training programmes?
2. What is the HCPC's view regarding the compatibility of Critical Social Justice activism with its current Standards?
3. What concerns would the HCPC have about a registrant practitioner's fitness to practice were they to adopt Critical Social Justice approaches in their work with service-users?
4. What measures will the HCPC take to reduce the risk of harm to the public arising from the incursion of Critical Social Justice into Clinical Psychology and other similar professions it regulates?

Thank you for taking the time to read this long and complex letter. I would very much appreciate your response. Please do not hesitate to contact me if you have any questions or require clarification.

I look forward to hearing from you.

With many thanks,

Yours sincerely

Carole Sherwood, DClinPsy

cc John Barwick, Chief Executive HCPC

Appendix B

Clinical Psychology Training Courses in the UK

21/30 positive responses; 6 declined; 3 no response.

COURSE	*ABBREVIATION*	*RECEIVED*	*DECLINED*	*NO RESPONSE*
BANGOR UNIVERSITY, NORTH WALES	Bangor	✓		
UNIVERSITY OF BATH			✓	
UNIVERSITY OF BIRMINGHAM			✓	
COVENTRY & WARWICK	C&W	✓		
UNIVERSITY OF EAST ANGLIA			✓	
UNIVERSITY OF EAST LONDON	UEL	✓		
UNIVERSITY OF EDINBURGH	Edinburgh	✓		
UNIVERSITY OF ESSEX	Essex	✓		
UNIVERSITY OF EXETER	Exeter	✓		
UNIVERSITY OF GLASGOW	Glasgow	✓		
UNIVERSITY OF HERTFORDSHIRE	Hertfordshire	✓		
INSTITUTE OF PSYCHIATRY, KINGS COLLEGE LONDON	IOP	✓		
UNIVERSITY OF LANCASTER	Lancaster	✓		
UNIVERSITY OF LEEDS	Leeds	✓		
UNIVERSITY OF LEICESTER	Leicester	✓		
UNIVERSITY OF LIVERPOOL	Liverpool	✓		
UNIVERSITY OF MANCHESTER	Manchester	✓		
NEWCASTLE UNIVERSITY	Newcastle	✓		
NORTH THAMES (UNIVERSITY COLLEGE, LONDON)	UCL	✓		
OXFORD				✓
UNIVERSITY OF PLYMOUTH			✓	
ROYAL HOLLOWAY				✓
SALOMONS, CANTERBURY CHRIST CHURCH UNIVERSITY	Salomons	✓		
UNIVERSITY OF SHEFFIELD	Sheffield	✓		
UNIVERSITY OF SOUTHAMPTON			✓	
SOUTH WALES, CARDIFF UNIVERSITY	South Wales	✓		
STAFFORDSHIRE UNIVERSITY				✓
UNIVERSITY OF SURREY	Surrey	✓		
TEESSIDE UNIVERSITY	Teesside	✓		
TRENT (LINCOLN & NOTTINGHAM)			✓	

Appendix C

Health & Care Professions Council relevant standards

The Health & Care Professions Council (HCPC) is an evidence-based organisation that regulates health professionals in the UK. Its standards are aligned with the scientific principles that underpin clinical psychology. It is important to bear this in mind when reading the report as, when we provide evidence that training is diverging from its scientific, evidence-based principles, this suggests that courses may be diverging from the standards expected of them by the HCPC.

Courses providing training for clinical psychologists are required to meet HCPC standards. Psychologists using the HCPC's 'protected title' [1] of 'clinical psychologist', are required to meet the regulator's standards (a) for all registrants and (b) for practitioner psychologists. Clinical psychology students graduating from training courses must register with the HCPC if they gain employment in the NHS and so must be trained in ways designed to meet the regulator's requirements.

To help the reader understand our concerns we have provided a list of HCPC standards relating to (a) training courses, (b) all registrants and (c) practitioner psychologists that we consider relevant to our findings. A full list of standards can be found on the HCPC website [2] . At the end of each chapter, we refer to specific standards that we consider pertinent. We recommend that readers familiarize themselves with the relevant standards listed below.

Health & Care Professions Council – Standards relevant to this report

(a) Education and training courses:

3.1 The programme must be sustainable and ***fit for purpose***

4.4 The curriculum must remain ***relevant to current practice***

4.5 Integration of ***theory and practice*** must be appropriate to the effective delivery of the learning outcomes

4.7 The delivery of the programme must support and develop ***autonomous and reflective thinking***

4.8 The delivery of the programme must support and develop ***evidence-based practice***

(b) All registrants:

1. Promote and protect the interests of service users and carers

1.1 You must treat service users and carers ***as individuals, respecting their privacy and dignity***

1.5 ***You must not discriminate against service users, carers or colleagues by allowing your personal views to affect your professional relationships or the care, treatment or other services that you provide***

2.1 You must be polite and considerate

2.2 You must listen to service users and carers ***and take account of their needs and wishes***

3.1 You must ***keep within your scope of practice*** by only practising in the areas you have appropriate knowledge, skills and experience for

3.3 You must keep your ***knowledge and skills*** up to date and ***relevant to your scope of practice*** through continuing professional development.

3.4 You must keep up to date with and ***follow the law, our guidance and other requirements relevant to your practice***

6.3 You must make changes to how you practise, or stop practising, if your physical ***or mental health may affect your performance or judgement,*** or put others at risk for any other reason

7.4 You must make sure that the ***safety and well-being of service users always comes before any professional or other loyalties***

9.1 You must make sure that your conduct justifies the public's trust and confidence in you and your profession

9.4 You must declare issues that might create conflicts of interest and make sure that they do not influence your judgement

(c) Registrant practitioner psychologists (clinical psychologists)

1. be able to practice safely and effectively ***within their scope of practice***

2. be able to practice ***within the legal and ethical boundaries*** of their profession

2.1 understand the need to act in the best interests of service users at all times

2.2 ***understand what is required of them by the Health and Care Professions Council***

2.3 understand the need to ***respect and uphold the rights, dignity, values and autonomy of service users*** including their role in the assessment, treatment and intervention process and in maintaining health and wellbeing

2.4 recognise that relationships with service users should be based on ***mutual respect and trust*** and be able to maintain high standards of practice even in situations of personal incompatibility

2.6 understand the importance of and be able to ***obtain informed consent***

2.7 be able to exercise a ***professional duty of care***

3. be able to ***maintain fitness to practise***

3.1 understand the need to maintain ***high standards of personal and professional conduct***

3.2 understand the importance of ***maintaining their own health***

3.3 understand both the need to ***keep skills and knowledge up to date*** and the importance of career-long learning

3.4 be able to ***manage the physical, psychological and emotional impact of their practice***

6. be able to ***practise in a non-discriminatory manner***

9.3 understand the need to engage service users and carers in planning and evaluating assessments, treatments and interventions to meet their needs and goals

12.3 be aware of the role of audit and review in quality management, including quality control, quality assurance and ***the use of appropriate outcome measures***

12.1 be able to ***engage in evidence-based and evidence-informed practice,*** evaluate practice systematically and participate in audit procedures

12.2 be able to gather information, ***including qualitative and quantitative data***, that helps to evaluate the responses of service users to their care or experience

12.6 be able to ***evaluate intervention plans using recognised outcome measures*** and revise the plans as necessary in conjunction with the service user

13. understand the key concepts of ***the knowledge base relevant to their profession***

13.2 be aware of the ***principles and applications of scientific enquiry***, including the evaluation of the effectiveness of interventions and the research process

13.9 ***understand theories and evidence concerning psychological development and psychological difficulties across the lifespan and their assessment and remediation***

14.1 be able to apply psychology across a variety of different contexts using ***a range of evidence-based and theoretical models, frameworks and psychological paradigms***

Appendix D

Critical Social Justice (CSJ) terminology and crossover words*

*Crossover terms are indicated by an asterisk **

Anti-racism does not simply mean 'against racism'. CSJ claims all white people are inherently racist and that the question is not 'did racism take place' but 'how did racism manifest in this situation' [3] . To be anti-racist requires action: looking for racism everywhere and all the time in every person and every situation, even when it is not apparent. CSJ insists that white people cannot experience racism because they possess greater power than minorities. Discrimination in the name of equity is considered necessary [4] .

***Critical** in the accepted sense means teaching students to think critically, not accepting anything at face value but using logic and seeking evidence that supports or refutes an argument. **Critical** in CSJ usage refers to **Critical** education which is rooted in neo-Marxist literature on **Critical Theory**. Students are taught ways of identifying how power shapes our understanding of the world so that they can take action to address social injustices. See also **Social Justice/Critical Social Justice** below.

Critical Consciousness is the ability to recognise perceived oppressive social forces said to be shaping society and to take action against them

Cultural appropriation means taking elements of another's culture for one's own use or profit without understanding, acknowledgment, or respect for its value in the source culture.

Decolonising is active resistance against perceived colonial power. Theorists claim that Western institutions maintain a power hierarchy in institutions that is still predominantly white, heterosexual, male and Western. Decolonising seeks to remove material emanating from white and Western sources and replace it with materials from non-white and non-Western sources.

***Diversity** in the accepted sense means variety. **Diversity** in CSJ means giving privilege to the marginalised while marginalising the privileged in order to redress the imbalances CSJ sees in society. Diversity in this sense is only interested in physical characteristics and cultural differences which are evaluated according to CSJ conceptions of privilege and marginalisation. CSJ does not welcome diversity of thought.

Epistemic violence means, in effect, silencing the voices of marginalised groups. The use of the term 'violence' in relation to forms of Western knowledge, is an example of harm inflation (Haslam et al., 2020) [5] which is a characteristic of CSJ.

***Equity** in the accepted sense means something that is equitable or free from bias or favouritism. **Equity** in CSJ is differentiated from 'equality'. Where equality means that persons A and B are treated equally, equity means adjusting shares in order to make persons A and B equal. Its aim is to redistribute shares, not necessarily along lines of economic disparity but in order to adjust for and correct current and historical injustices, both as exist in reality and as have been identified by various critical theories.

Heteronormative denoting or relating to the view that heterosexuality is the normal or preferred sexual orientation (derives from Queer Theory).

Identity is central to the thought and activism of CSJ as it is through identity politics that Social Justice is to be achieved. In CSJ identity refers to social or political identity. One's social group is defined by intersecting and socially constructed group categories defined by immutable characteristics, including race, sex, gender, sexuality, dis/ability, body size, age, class, national origin and religion.

***Inclusion** in the accepted sense means including or accommodating everyone. **Inclusion** in CSJ means including those who have historically been excluded because of their race, gender, sexuality or ability. In practice, it often leads to the exclusion of those from groups considered privileged.

Intersectionality is a framework created by Kimberlé Crenshaw (1989) [6] designed to show the interactive effects of various forms of discrimination and disempowerment, noting that overlapping vulnerabilities create specific and compound problems.

Lived experience is the primary way in which knowledge is obtained in CSJ. It is not the same as subjective or first-hand experience but refers to life experiences in allegedly systemic power dynamics of dominance and oppression that shape society structurally. Lived experience refers to the interpretation that CSJ gives to anecdotal accounts of experience. Only lived experiences of oppression count. People in dominant groups cannot call their own experiences lived experience.

Master's House/Master's tools are terms used by black feminist Audre Lorde [7] , who made the point that the 'tools' of the dominant system would not dismantle the dominant system itself. The statement draws on the metaphor of slavery and insists that means and methods outside of the dominant system will be required to disrupt and dismantle that system and the oppression it causes.

Marginalising in CSJ means to exclude certain people from the benefits of society. CSJ assumes that society is socially constructed in a way that allows members of dominant groups to exclude and oppress members of marginalised groups and their ways of knowing.

Microaggressions are described by CSJ theorists as the everyday verbal and nonverbal slights or insults, intentional or not, which communicate hostile, derogatory, or negative messages to marginalised groups and individuals.

Oppression is a central concept in CSJ. According to CSJ theorists it affects all minority groups, including racial minorities, women, gender and sexual minorities, the disabled, overweight, those from countries or cultures outside of 'the West' and indigenous people. This is regardless of whether or not individuals are, or consider themselves to be, oppressed.

Power is considered by CSJ to be at the root of all interactions between individuals and groups in society. The main purpose is for the powerful to impose their ideas and interests on everyone.

Privilege refers to societal privilege that benefits dominant groups over minorities, particularly if they are otherwise under the same social, political, or economic circumstances. Privilege is considered by CSJ theorists to be unearned and unquestioned. Dominant groups are unaware of it but are motivated to maintain it by questioning CSJ principles.

Problematising is CSJ's method of questioning the common usage of language and suggesting that specific language perpetuates systems of power.

Racism (in contrast to individual racial prejudice) In CSJ racism involves a dominant group carrying out systematic discrimination through the institutional policies and practices of society. A common formulation is Racism=Prejudice+Power.

Systemic racism refers to systems and structures that have procedures or processes that disadvantage people of colour and advantage white people.

***Social justice** in the accepted sense means moving steadily and incrementally towards creating a fair society which is just for everyone and which there is fairness, respect and equal opportunities for all.

Critical Social Justice is a theoretical approach, rooted in Marxist and Postmodernist theories, that addresses issues of prejudice and discrimination on the grounds of characteristics like race, sex, sexuality, gender identity, dis/ability and body size. CSJ holds that knowledge is not objective but culturally constructed to maintain oppressive power systems. CSJ theorists and activists apply their 'critical' methods to analyse systems, language and interactions in society to 'uncover' these power systems and make them visible in order to right historical wrongs and ensure the oppressed are prioritised in society. They believe that in this way society can be revolutionised and social justice achieved, provided everyone accepts the moral imperative

to pay attention to and accept their interpretations. This is often referred to as 'doing the work' or simply 'educating yourself'. Any scepticism of these interpretations is assumed to be an attempt to preserve one's own privilege if one is of a group perceived to be privileged or, if one is not a member of a privileged group, it is seen as evidence of one having internalised the oppressive power system. [8]

Toxic Masculinity is a term sometimes used to describe men's behaviour that is socially dominant, misogynistic, violent or homophobic [9] .

Ways of knowing refers to epistemologies (theories of what knowledge is, how it's produced and transmitted). Ways of knowing that are of interest to CSJ are those considered to have been unjustly excluded or marginalised by white Western science, such as superstition and storytelling. CSJ theorists claim that Western knowledge has been unfairly privileged and imposed on other cultures as a result of colonialism. See also 'Master's House/Master's Tools.'

W.E.I.R.D. means **W**estern **E**ducated **I**ndustrialised **R**ich and **D**emocratic and refers to Western science.

Whiteness refers to the specific dimensions of racism that elevate white people and white dominant culture over people of colour. Whiteness is understood in CSJ as a socially constructed system of power that is self-interested and maintains white dominance and the oppression of people of colour.

White (Asian, Jewish, etc.) complicity/ adjacency is the idea that dominant classes are unknowingly advancing dominance and power over marginalised people. **Adjacency** implies a more active, conscious role in supporting the dominant power structure.

White fragility is a term invented by Diangelo (2019) [10] to describe the defensive reactions of white people when they are accused of racism and when they feel implicated in white supremacy. **Brown fragility** describes the same phenomenon among non-black ethnic minorities.

White privilege refers to the set of structural advantages that dominant groups have but which are denied to oppressed groups. CSJ theorists claim that all white people have dominance by virtue of their skin colour and the societal and institutional processes that have rendered their beliefs and values 'normal' and universal.

White supremacy refers to the idea that advantages for white people are woven throughout institutions and social practices, making people of colour vulnerable to exploitation, domination and violence. More traditionally, it is the belief that white people are superior to those of all other races and should therefore dominate society.

White women's tears are considered a political act that brings attention to white women's emotional needs and distracts from their racism. In CSJ emotions are viewed as political because they are shaped by biases, beliefs and cultural frameworks. White women's tears are considered a manifestation of white fragility and viewed as problematic in CSJ due to historical instances where black men have been harmed due to white women's distress.

Sources

The glossary has been compiled and adapted from the following sources with thanks:

Jewish Institute for Liberal Values, *Glossary of Social Justice Terminology: A Guide for the Perplexed:* https://jilv.org/glossary/

Lindsay, J. New Discourses: https://newdiscourses.com

Pincourt, C., & Lindsay, J. (2021) *Counter Wokecraft: A Field Manual for Combatting the Woke in the University and Beyond*. New Discourses.

Appendix E

NHS Health Education England Action Plan

NHS
Health Education England

Action Plan to Improve Equity of Access and Inclusion for Black, Asian and Minority Ethnic Entrants to Clinical Psychology Training

This action plan forms part of Health Education England's plans for delivering:

- The Five Year Forward View for Mental Health's commitment to improve Black, Asian and Minority Ethnic people's experiences of mental health care[1]
- The NHS Long Term Plan's commitment to respect, equality and diversity across the NHS workforce[2]

The delivery of the plan will be overseen by the Health Education England Mental Health Workforce Delivery Board, advised by the Equality and Diversity Subgroup of this Board.

The action plan is intended to increase fairness and equity of access to, and inclusion in, clinical psychology training for Black, Asian and Minority Ethnic candidates[3], to be implemented collaboratively by universities, placement providers, the British Psychological Society as the course accrediting body, and Health Education England. These are equitable actions designed to achieve greater equality of outcomes. It is recognised that implementing these actions and delivering sustainable change will require proper resourcing by all stakeholders. Courses are expected to implement these actions and will be accountable to HEE commissioners on delivering these. Detail of local implementation will require consultation and widespread engagement with local stakeholders. These actions should sit alongside a broader programme that ensures fair access to training across the protected characteristics and recognises the impact of socioeconomic status as an intersectional disadvantage.

[1] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[2] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
[3] Whilst this action plan uses the phrasing of "Black, Asian and Minority Ethnic" as opposed to alternatives such as People of Colour or Black and Brown people, it is acknowledged that this phrasing choice has many shortcomings, including treating people of many different races and ethnicities as a homogenous group. It is expected that those implementing the action plan will also be cognizant of these shortcomings.

Each University provider of clinical psychology training will negotiate a set of locally defined targets and will report quarterly to their regional HEE commissioners demonstrating progress with each action and to provide data in relation to the Equality Act (2010) protected characteristics (including but not limited to applicants, recruitment, enrolment, progression and graduation), this will be stipulated within the contractual obligations and as a key performance indicator. This information will be then be collated to provide a national report, with specific follow up for providers who are not adequately progressing. Future commissioning of programmes will define specific action to be taken, and again will form part of the contractual obligations of providers.

Goal: Sustained, effective action on inclusion and anti-racism before, during and after training. This action will lead to an increase in Black, Asian and Minority Ethnic recruitment to clinical psychology training so that the ethnic diversity within trainee cohorts increasingly reflects the ethnic diversity of the population.

ACTIONS:

1. Leadership Commitment

Leadership at all levels within the training organisations and their partners will evidence continuous commitment to delivering this plan, demonstrating transparency about existing problems and the necessary steps to rectify these problems. Leaders will recognise their positions of power in organisations, paying particular attention to a race, culture and ethnicity perspective, which will inform specific, concrete steps to address racial and ethnic disparities in leadership recruitment and representation.

2. Anti-racist Education for Course Staff and Supervisors

An ability to discuss racism and ethnic discrimination, at both an individual and systemic level, and engage in anti-racism will be treated as a meta-competency for all course staff and supervisors. Courses will be able to evidence development of this meta-competency through an effective programme that is mandatory for all course staff and supervisors. This programme will ensure awareness of race, ethnicity, racism and ethnic discrimination and robustly challenge and remove racism and ethnic discrimination within course and supervision delivery. Unconscious bias training is not seen as fit for this purpose. Training and development will be ongoing and supervisors and course providers will be supported to reflect on race, ethnicity and difference and how this can be engaged with constructively.

3. Curriculum Review

A thorough review of all University Clinical Psychology Curricula, across all aspects of training, to decolonise the curriculum and ensure racism, ethnic discrimination and other forms of discrimination are addressed and content changed as necessary. This review will involve a wide and inclusive range of experts, including Experts by Experience.

4. Support for Black, Asian and Minority Ethnic Trainees

A robust and varied support programme should be available to every Black, Asian and Minority Ethnic trainee and evidence presented that this programme is effective and valued by Black, Asian and Minority Ethnic trainees. This support will be co-produced and a variety of choices will be offered, including informal peer support alongside more formalised course support, in order to create a diversity of spaces where Black, Asian and Minority Ethnic trainees can share their experiences. There will also be a variety of formal and informal routes for raising complaints of racism and ethnic discrimination that are embedded in course policy and procedures.

5. Introduction of Contextual and Anti-Racist Recruitment Processes

Courses should demonstrate that they have taken effective action to:

a. Address race and ethnic discrimination in recruitment, with an awareness of how other protected characteristics and socio-economic status may intersect with race and ethnicity and how this may affect recruitment.
b. Introduce appropriately sophisticated and evidence-based systems of contextual recruitment that ensure selection criteria are applied in light of objective contextual factors that may have impacted on attainment of qualifications or experience that discriminate for course entry. These processes will be designed to reduce the impact of systemic obstacles to attainment that correlate with race and ethnicity.
c. Evaluate current selection criteria to ensure they do not replicate racial and ethnic disparities at other stages in an applicant's training journey.

6. Reporting of Student Recruitment and Retention Data by Ethnicity

Each course willroutinely and transparently report and publish age, gender and ethnicity data for recruitment and retention each year, including differential success rates by race and ethnicity. This data will then be used by courses to identify areas for equitable improvement.

7. Positive Action Initiatives

Courses will demonstrate positive action, informed by local data about barriers to entry, under the below sections of the Equality Act (2010). Section 149 of the Equality Act also outlines the Public Sector Equality Duty (PSED).

a. Section 149: Courses will update their Equality Objectives to reflect the required changes in this Action Plan.
b. Section 158: Engage in positive action through outreach activities including open days, career talks and mentoring schemes, with a particular emphasis on reaching those at earlier stages of their career journey.

c. Section 159: Undertake direct action at the points of shortlisting and interview on the basis of key protected characteristics, where there is evidence of under-representation in relation to that protected characteristic *and* two candidates are of equal merit.

8. Establishing Racially and Ethnically Representative Selection Processes

Courses should demonstrate action and progress towards establishing racially and ethnically representative selection processes against a target timeframe of no more than one year. The goal will be to align each recruitment process to represent the England population, or the local population if more diverse. This should be embedded as part of a wider commitment to employing more racially and ethnically diverse staff across all levels and sectors of the institution.

9. Improving Equity of Access to Experience

Courses will collaborate with employers to develop, recognise and support schemes that enable more aspiring psychologists to gain relevant experience in paid work, and undertake and evaluate other action to remove cumulative advantage gained by those able to access certain work and experience. As part of this, courses will value a wide range of both professional and personal experience during the application process.

Appendix F

Information for guest lecturers (Coventry & Warwick)

Doctorate in Clinical Psychology 2021-22: Teaching Information for Guest Lecturers

Diversity and Inclusion:

As you may be aware about the discussions that are happening within the training community and profession more broadly, there is a great deal of work around decolonising the curriculum. Some of the work will be happening outside of the programme at national and regional level with professional bodies and key stakeholders in clinical psychology training. We are part of that work and it will, in turn, inform the development of the curriculum. At the same time, we have been developing our own approach to the teaching with regard to power, privilege, diversity and inclusion and thought it might be helpful to share where we're up to. Whilst much of this work starts in the modules relating to Professional Practice in Clinical Psychology, we emphasise that the learning for all of us that occurs in formal teaching and training should be taken out onto placement/clinical work and into other teaching sessions, much as it would with, for example teaching on ethics or leadership. We're including this here and now as part of our work, as a programme, on making our teaching and learning more inclusive and hope that this is the start of an ongoing conversation, reflection and meaningful action.

The starting point for us is cultural humility (Tervalon and Murray-Garcia, 1998). Other models explored in initial training sessions are Social GRACES (Burnham, 1993) and Intersectionality (Crenshaw, 1989).

General Principles

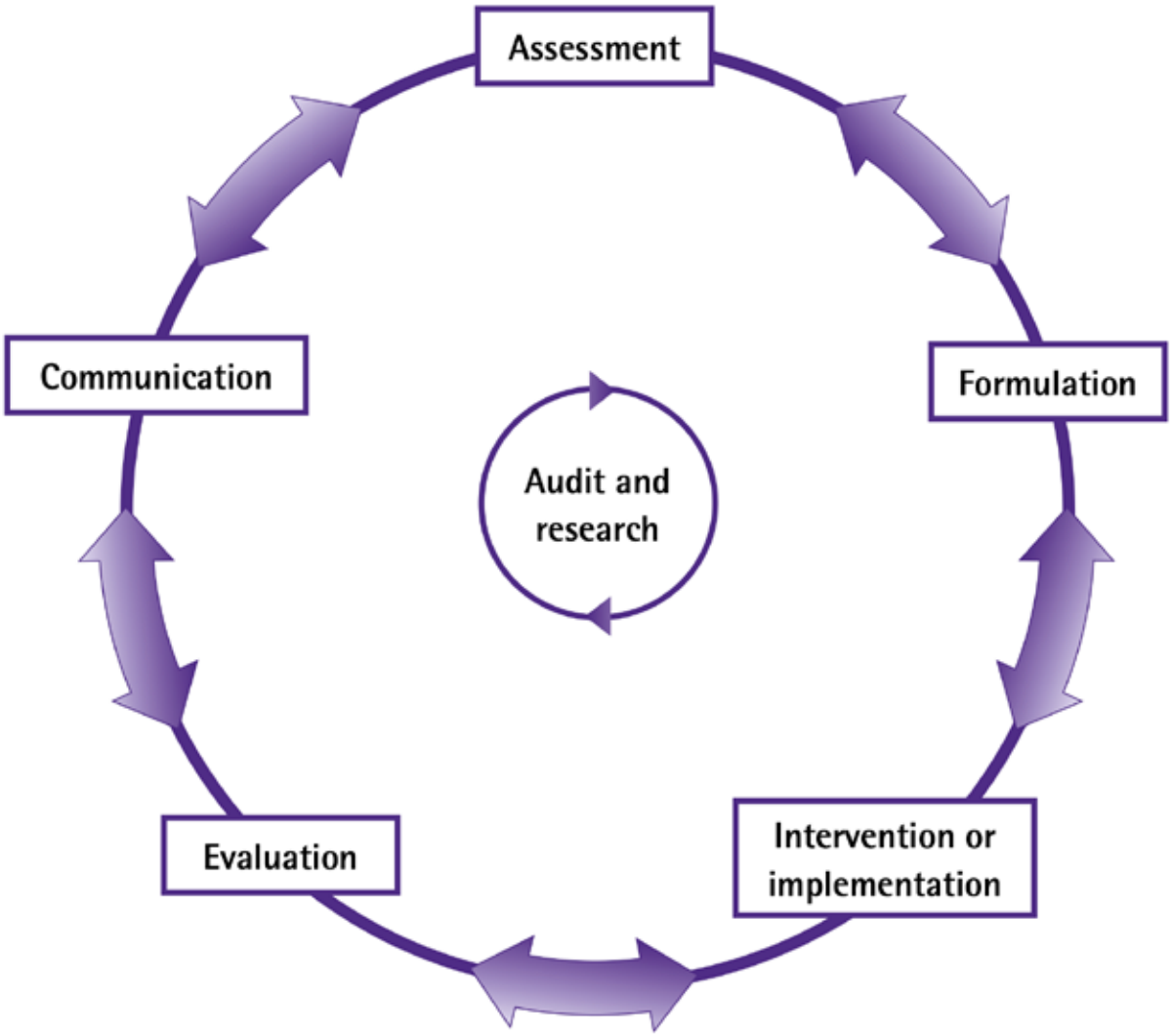
We recognise that:

- Any paradigm/model/theory/framework/piece of work has its strengths and limitations.
- We cannot know everything.
- We all come from diverse settings and backgrounds and with our own wealth of experience. Bringing and sharing our knowledge (and lack of) benefits everyone – trainees, lecturers and clients.
- We learn by practice, receiving and listening to feedback, reading, reflecting and doing things differently next time (whilst retaining the stuff that works!)
- We acknowledge and note the importance of vulnerability in learning and change and encourage both trainees and lecturers alike to make space for this: we are all 'work-in-progress'.

Therefore, guest lecturers and facilitators, please include what you can within your teaching, speaking from your own experience of working with difference (taking an intersectional approach to the understanding of difference), as well as consider where the gaps are, in anticipation that ideas can be shared in the teaching. Trainees, are asked to please bring prior learning and experience, as well as that from placement and the Professional Practice modules teaching (D51PY and D58PY) into the 'classroom'. Ask questions, consider how what you are learning applies to where you are on placement and where there are gaps and think together with your peers and lecturers about how to develop services/practice in these areas.

Appendix G

Cycle of Professional Practice



Appendix H

Critical Social Justice: influences on clinical psychology trainees

We wanted to gather more information about the effect of CSJ on trainees and so interviewed Professor Christine Sefein, who resigned from her post at Antioch University in the US due to the incursion of CSJ into the university's clinical psychology training course. Below are examples of troubling behaviour that she witnessed while training clinical psychology students:

- Students who were 'captured' by CSJ engaged in 'blaming' behaviour and tended to "crush one group of people and elevate another".
- In a screening of a video showing a 70-year-old white man talking about how he believed someone's death was his fault, the class reaction was unsympathetic, evoking comments such as "white old man with money" and "Narcissistic".
- When a video, featuring a white person talking about a new treatment for addiction, was shown to them: "students focused on the speaker's skin colour instead of the essential content."
- A student "justified turning in assignments late because they were 'traumatised' by a debate in class and needed a week in bed to recover."
- Students "quit working as counsellors due to perceived microaggressions from clients or co-workers". An example was cited of a student resigning after a patient made an appreciative comment about Asian cookery.
- Many white students confided in Professor Sefein, saying "I am not understood" and that they felt "shamed"
- One white male student told her "As a privileged white man, I have no business speaking up in class". He asked her "Am I Bad?" He and his partner fostered children but, for him, "Being white erases everything I've done"

These examples show that trainees are being shamed and feeling guilty for their skin colour. There are also instances of blaming and judgemental behaviour, vindictive protectiveness [11] and thinking styles [12] such as selective attention and catastrophising. 'Harm inflation' and 'concept creep' [13] are also evident in the report of a student feeling '***traumatised***' by a debate in class. Trainees who think and behave in such ways may lack the clinical competence necessary to practice responsibly and effectively.

Indeed, Professor Sefein, commenting on her students' lack of resilience and inability to cope with course content and in clinical settings, wondered what would happen when they were faced with a patient who had serious mental health or addiction problems who "calls you every name in the book to your face". Would they simply refuse to see those patients?

I Appendices Endnotes

1 HCPC 'protected titles': https://www.hcpc-uk.org/about-us/who-we-regulate/the-professions/

2 HCPC standards: https://www.hcpc-uk.org/standards/

3 Diangelo, R., (2019). White Fragility: Why It's So Hard for White People to Talk About Racism. London: Allen Lane. https://www.waterstones.com/book/white-fragility/robin-diangelo/9780141990569

4 Kendi, I.X. (2019). How To Be An Antiracist. London: Penguin Random House https://www.waterstones.com/book/how-to-be-an-antiracist/ibram-x-kendi/9781847925992

5 Haslam, N., Dakin B.C., Fabiano, F., McGrath, M.J., Ree, J., Vylomova, E., Weaving, M., & Wheeler, M.A. (2020). Harm Inflation: Making sense of concept creep. European Review of Social Psychology, 31 (1), 254-286. https://www.tandfonline.com/doi/abs/10.1080/10463283.2020.179608

6 Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. University of Chicago Legal Forum https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8/?utm_source=chicagounbound.uchicago.edu%2Fuclf%2Fvol1989%2Fiss1%2F8&utm_medium=PDF&utm_campaign=PDFCoverPages

7 Lorde, Audre. "The Master's Tools Will Never Dismantle the Master's House." 1984. Sister Outsider: Essays and Speeches. Ed. Berkeley, CA: Crossing Press. 110- 114. 2007. https://collectiveliberation.org/wp-content/uploads/2013/01/Lorde_The_Masters_Tools.pdf

8 Pluckrose, H. (2021. February 17). What do we mean by Critical Social Justice? *Counterweight*. Retrieved 30 September 2022 from: https://counterweightsupport.com/2021/02/17/what-do-we-mean-by-critical-social-justice/

9 Barry, J., Walker, R., Liddon, L., & Seager, M. (2020). Reactions to contemporary narratives about masculinity: A pilot study. *Psychreg Journal of Psychology*. https://www.pjp.psychreg.org/wp-content/uploads/2020/06/8-21.barry_.pdf

10 Diangelo, R., (2019). White Fragility: Why It's So Hard for White People to Talk About Racism. London: Allen Lane. https://www.waterstones.com/book/white-fragility/robin-diangelo/9780141990569

11 'Vindictive protectiveness' is a term used by Lukianoff & Haidt, (2019) to describe students who 'call out' or shame others for things they consider offensive or insensitive to protect someone they perceive has been harmed. Lukianoff & Haidt note that such behaviour leads to self-censorship and makes it hard to have open discussions or debate points of disagreement.

12 Thinking styles are cognitive biases associated with depression and anxiety: https://www.unh.edu/pacs/unhelpful-thinking-styles

13 'Harm inflation' and 'concept creep' are terms used by psychologist Nick Haslam, to describe the growth, in recent years, of harm-related concepts such as 'trauma' and increased sensitivity to harm. He highlights their potential to contribute to social and political polarisation.

Haslam, N., Dakin B.C., Fabiano, F., McGrath, M.J., Ree, J., Vylomova, E., Weaving, M., & Wheeler, M.A. (2020). Harm Inflation: Making sense of concept creep. *European Review of Social Psychology, **31 (1)***, 254-286. https://www.tandfonline.com/doi/abs/10.1080/10463283.2020.179608

DESIGN: WWW.HOWARD-SHERWOOD.CO.UK