PREFACE to this electronic version

The papers that follow were published in Clinical Psychology Forum 162, June 2006.

Unfortunately, the papers were published in a different order to that in which we expected they might most usefully be read. In this electronic version, we have taken the opportunity to re-order the papers as we originally intended.

Additionally, the special issue was titled “Critical and Community Psychology”. Whilst not fundamentally disagreeing with this description, if we had been consulted we would probably have decided to call it a special issue on “Social Materialist Psychology”, since in our view this description much more accurately characterises the position we begin to set out.

The Midlands Group - Introduction

Clinical Psychology Forum 162, 3-4

The first meetings of the group took place about three years ago in response to a feeling among its founding members that the workplace no longer offered opportunities to think honestly about theory and practice in psychology, whether academic or clinical/counselling.

This may not be everyone's experience of course, but in our case not only did there seem to be no *time* to get together with others to discuss and reflect upon what we are doing, and trying to do, in our work, but also the dominance of business practices in the management of both the NHS and the universities meant that when people did get together, it was to compete rather than co-operate. In these circumstances, discussion seemed to be limited either to issues to do with professional survival or to grandstanding and point-scoring in order to develop or maintain a grip on one's corner of the market.

It is perhaps obvious that a perspective such as ours is likely to be found in people who are critical of the status quo: people identifying with the psychological orthodoxy are probably happier with their lot and may feel no such need for a kinder and more accommodating intellectual environment. It is certainly the case that those of us who have persevered with the group (and indeed most of those who, for one reason or another, dropped out) shared at the outset a discomfort with the individualism of, in particular, orthodox clinical and counselling psychology, as well as with what seems to us a misplaced professional certainty about much of what we do.

What we wanted, then, was to find space and time outside the work context where we could discuss, debate, consider and share information in a constructive and mutually supportive atmosphere. Inevitably this meant meeting in the evening and, for some, travelling quite long distances (in practice, taking it in turns to shuttle between the East and the West Midlands). This is, of course, a lot to ask, and, over the period of a dozen or so meetings, the group has shrunk from about ten to the six currently involved in this Special Issue, with a few coming and going in between. The present membership of the group is one academic, one counselling and four clinical psychologists.

At first our meetings consisted of identifying common themes and concerns, and as part of this we invited outside speakers that one or other of us had contact with to come and lead a discussion centred round their work. Speakers included Tana Dineen, David Nightingale and John Shotter. Following this, we felt able to identify issues that were of common concern to those of us remaining, and began to get our views down on paper. A very useful procedure proved to be for someone to develop a topic of particular concern to him/her and circulate the result to the other members (by email), who would each comment in turn before we met to consider the final document. The idea of this was not to *critique* each other's view, but to find, clarify and develop common ground.

The fact that we have managed to produce the papers in this Special Issue signifies, if nothing else, that the broad aims of our meeting have been achieved: for us it has been a positive and rewarding experience. We feel it important to make the point that although the papers appear here as authored by specific people, they are all in fact very much joint productions, and thus represent a core or developing solidarity that we hope to be able to take further. Finally, we suggest that, although by no means essential, it might be most helpful if the papers are read in sequence.

John Cromby, Bob Diamond, Paul Kelly,
Paul Moloney, Penny Priest, DavidSmail

[636 words]

That was then, this is now

Penny Priest

Clinical Psychology Forum 162, 25-28

If you're hanging on to a rising balloon, you're presented with a difficult decision. Let go before it's too late? Or hang on and keep getting higher? Posing the question, how long can you keep a grip on the rope? (Robinson, 1989)

The emotions were once thought to reside in the heart, but scientists know now that they originate in the brain. (NIMH, 2001)

In *The Fountain at the Centre of the World*, Robert Newman (2003) introduces us to Evan Hatch, the Integrated Communications Manager, whose job it is to control public opinion. He works on the basis of 'a single, precise calculation. *It is easier and less costly to change the way people think about reality than to change reality*'. This is the corporate world of advertising, issues management and global power. But it could just as easily be the NHS and psychological therapy industry, trying to persuade people that the problem is not so much the reality of their lives, but rather what they think about that reality. Brewin (1988) summarises it: 'dysfunctional emotions such as anxiety and depression follow from people's perceptions and evaluations of the events in their lives rather than from the events themselves' (p.5). Reflecting a similar position, Chadwick, Birchwood & Trower (1996) quote the Greek philosopher Epictetus: 'Men are disturbed not by things but by the views which they take of them…'' (p.6).

The illusion of control inside the changing rooms

The marketing of the idea, that we can change the way we think to make ourselves feel better, seems to have been pretty successful, judging by the self-help books on the shelves: *The Power of Positive Thinking* (Peale, 1952); *You Can Heal Your Life* (Hay, 1984); *You Can't Afford the Luxury of a Negative Thought* (McWilliams, 1989), *Reinventing Your Life* (Young & Klosko, 1993) and so on. However, the extent to which people can control the way they think, or indeed feel and behave, is debatable. Drawing on computability theory from mathematics, Johnson-Laird (1988) explains how there is a dissociation between conscious and unconscious processes which

enable our minds to operate more effectively: 'On some occasions you can consciously control your behaviour; there are other occasions when, much as you would like to, you cannot control yourself. You may genuinely intend to give up smoking, for instance, but be unable to put your intention into practice…We are similarly often unable to control our feelings: we may suppress their expression, but the feeling itself will not go away' (p.357). Damasio (2000) draws similar conclusions from neurological studies: '…a spontaneous smile that comes from genuine delight or the spontaneous sobbing that is caused by grief are executed by brain structures located deep in the brain stem under the control of the cingulate region. We have no means of exerting direct voluntary control over the neural processes of these regions' (p.48). This illusion of control is also discussed by the neuroscientist, Michael Gazzaniga. He describes a brain device in the left hemisphere, an 'interpreter', which reconstructs our past experiences, 'weaving its story in order to convince itself and you that it is in full control' (1998, p.25). As John Cromby argues in this issue, language and thoughts might channel feeling states we already have, 'but the real primacy lies with feelings'. However, this is not to say that we are at the hands of our neurotransmitters, or that our feelings reside in the brain either, but rather that our feelings are part of our continuous individual interactions with our physical and social environments. Furthermore, even if we do have a feeling of being in control of our*selves*, the extent of control we have over our *environments* may be much less. In this respect, we are not only making ourselves up as we go along, as Cromby puts it, but also *being made up* as we go along.

Skinner, too, was famous for challenging the idea that we can choose what we think and how we behave. *'Beyond Freedom and Dignity'* was controversial in 1971. That was then. But with the rise of cognitive therapy and thought-makeovers, the idea that we don't have free-will is probably even more unwelcome now. Yet in reality, as has been debated in David Smail's online forum, *you can't choose to forget how to ride a bike.* Riding a bike is a skill, habit, or process laid down indelibly, through practice and mastery, such that it becomes transferred to areas of the brain (the cerebellum and basal ganglia) where it can then happen automatically, freeing up grey matter to deal with new things, in the brain's efficient way. Similarly we process emotional information (by way of the amygdala), so that we learn, for example, helplessness, as a result of repeated experiences of actually being helpless. Our helplessness is embodied, just as our ability to ride a bike. Alison begs to be told why

every time her life, uncharacteristically, seems to be going well, a feeling of dread creeps up on her and soon she is cloaked, enshrouded in desolation. Yet this same woman talks about how, at the age of four, her father used to hide in a cupboard in her bedroom, terrorizing her. At other times, she witnessed his alcohol-fuelled violence towards her mother. When her parents finally split up when she was seven, there followed a series of moves between refuges and relatives. At nine her new stepfather tried to rape her. The father of her first child, whom she bore at 15, ended up in prison for murder. Her next boyfriend poured a glass of bleach over her whilst she was in the bath. Another boyfriend locked her in a shed along with a pair of rats and a baby kitten. Through repeated experiences of awful things happening in her life, she has acquired an acute sense of dread that something awful is about to happen, because it so often has. This is not to say that our futures are programmed and our destinies inevitable. Luck, a partner, friendship, money and other environmental factors all help towards our future embodiment as well as our past. It is rather to emphasise the sometimes over-stated claims of change through therapy.

The gulf between fiction and reality

Perhaps we cling to the illusion of control because it's unbearable to think about the possibility that sometimes we are not much more powerful than the people we are trying to help. Bits of evidence get filtered in and out, seemingly to perpetuate the illusion. It is easy to get caught up in playing this game of changing people. Inevitably, those who come to us for help, often expect us to play this game too; Laura insists that something called CBT will give her the confidence to be seen in public, because she's seen it work on the TV. At the same time, she is adamant that she cannot change the way she thinks, at least not until she has changed the way she looks. Susan is certain she has invented an alternative reality in her head, to help her cope with her experience of sexual abuse. But it doesn't help. In fact she is increasingly disturbed by this, and her experience of intrusive voices is getting worse. She hopes someone can uninvent her voices.

Of course, a Gestalt therapist might use physical strategies to help someone experience an embodied change. A psychodynamic practitioner might hope that the therapeutic relationship would lead to a change in the person's other relationships. A Schema therapist might believe that the *doing* of experiments might lead to new ways of *being*. These approaches might bring about a shift in embodied feeling in a non-

cognitive sense, creating possibilities for a person to change the way they interact with the world. However, the emphasis is still primarily on changing the individual, rather than the environment. Once they step outside the therapy room, any therapeutic gains may be swamped by the hugeness of worldly forces around them.

Meanwhile, we might feel disingenuous pretending that our work is a scientific exercise, calling an intervention 'CBT', for example, as if this is some quantifiable thing and then calling the outcome successful or not successful on the basis of scores on a questionnaire. In actual fact, far from CBT being a standardized, distinct technique, Tarrier, Haddock, Barrowclough, & Wykes (2002) unpick a variety of techniques which go under this banner, and suggest that in practice, CBT may actually be indistinguishable from 'interpersonal psychotherapy'. Furthermore, they highlight the methodological problems in evaluating any therapy (which are further discussed by Maloney in this issue) and how non-specific factors, such as a therapist's theoretical orientation, can have a greater effect on therapeutic outcome than the specific therapeutic techniques themselves. In other words, can we really say that it is in fact possible to standardize a psychological therapy, or to standardize the way a person behaves in delivering a psychological therapy?

Becoming a member of the church of clinical psychology

Ironically, our inculcation into the scientist-practitioner model, which perpetuates the gulf between fiction and reality, and which is seen as trying to create objective, dispassionate scientists out of us all, possibly creates something quite the opposite, encouraging conformity, allegiance, conviction, faith, whatever the chosen model may be. The orthodoxy may simply be a way of maintaining the status quo, of maintaining power differentials and ultimately of warding off threats to the institution, whether that be the church of CBT, CAT, REBT, IPT, SFBT, EMDR, psychodynamic, systemic, narrative or community psychology. And what makes one religion better than any other?

As a trainee you are the novitiate in the church of clinical psychology, where you will be subservient, infantilised, moulded, ordained and maybe have your spirit broken. You have to do your rite of passage. We all have to do it. The work experience to get the assistant job. The assistant job, preferably combined with a masters degree. Another assistant job, ideally alongside a PhD. The first application. The second application. The last ditch attempt. The interviews. The personal suitability (are you some kind of weirdo?). The group therapy. The couch. The

homage to the models. The squeezing into boxes. The circles. The spirals. The translation from life and feeling to some numbers and a line on a graph. The minor mods. The major mods. The prospect of failure. All part of the initiation. And at the end, the further training. The CPD. The post-doctoral qualification. The research publications. The additional responsibilities. The specialization. It's all in Agenda for Change. Because you're worth it.

Some trainees can't play the game and some refuse. Some trainees are asked to leave the course, whilst others bend over backwards to fit what they feel is right into what they feel is wrong. The expert trainee realises that those in authority respond better if you treat them as all-knowing, even the social-constructionist practitioners, rather than squaring up to them. Ultimately the best advice and best judgements come from the expert person, whether a friend, supervisor, professor, or man in the pub, who just intuitively seems to know what is needed, how to answer prayers.

So what did we know then and what do we know now?

Before training, many of us were highly skilled in working with a wide variety of client groups across the whole lifespan, presenting with a full range of severity across outpatient, community, primary care, inpatient and residential settings. Many of us were conversant with various models of psychopathology, clinical psychometrics and neuropsychology, and confident about using distinct psychological therapies. Many of us were experienced in teaching and training and providing professional and clinical supervision. Many of us had planned, implemented and evaluated service developments, recruited staff and were able to boast clinical successes.

Since training, we now know more fancy names for what we were doing then. We know better than ever, but not necessarily as a result of our training, that usually it is our friends who are best able to help and support us, and more importantly point out where we are going wrong. We know that successes often seem arbitrary and that they may be just as elusive as they were before training.

Sometimes, especially since training, we may sit back after hours of chasing our tail, or somebody else's, and think, well, just about the only thing we might be able to do is change the way people think, because we're damned if we can do anything else. We may as well go for the thought-makeover. At least it might look a bit prettier for a while, and we won't be around to watch it all fall apart after we've left. Yet this has the effect that if, and often when, it all falls apart, we end up thinking

there is something wrong with us, rather than something wrong with our worlds, and our models of them. Then some of us probably end up going round like Boxer, the work-horse in Animal Farm, chanting, 'I must work harder'. Of course, thoughts are by no means all we engage with, yet somehow in the rush to become that expert scientist-practitioner and to sell the latest fancy therapy, we forget to smile at the things that have served us well, those ways of knowing and being with others that are unique to ourselves, and beyond words, and not for sale.

It is tempting to hold onto a behavioural notion of adding new skills to our repertoire, even if we can't delete the old ones. As people *wanting* psychological therapies, we might not be able to forget how to ride a bike, but we might be able to learn to use another form of transport. As people *providing* psychological therapies, we seem positively eager to seek out alternative forms of transport, sustainable or otherwise: a go-cart, a long board, or a piggy-back? A Ford Mustang (that was then)? Or a Nissan 350Z (this is now)? But beware if you're hitching a lift on that rising balloon. Why trust one therapy and not the other? That's politics, isn't it?*

*Paraphrased from the following passage in *Withnail and I* (Robinson, 1989):
DANNY: You have done something to your brain. You have made it high. If I lay ten mills of Diazepam on you, you will do something else to your brain. You will make it low. Why trust one drug and not the other? That's politics, isn't it?

References

Brewin, C. (1988) *Cognitive Foundations of Clinical Psychology.* Hove and London: Lawrence Erlbaum Associates.

Chadwick, P., Birchwood, M. & Trower, P. (1996) *Cognitive therapy for delusions, voices and paranoia.* Chichester: Wiley.

Damasio, A. (2000) *The Feeling of What Happens: Body, Emotion and the Making of Consciousness.* London: Vintage.

Gazzaniga, M. (1998) *The Mind's Past.* Berkeley and Los Angeles: University of California Press.

Hay, L. (1984) *You Can Heal Your Life.* Carlsbad, CA: Hay House.

Johnson-Laird, P. (1988) *The computer and the mind: an introduction to cognitive science.* London:

Fontana Paperbacks.

McWilliams, P. (1989) *You Can't Afford the Luxury of a Negative Thought.* New York: Wright-

Armstead Associates.

Newman, R. (2003) *The Fountain at the Centre of the World.* London: Verso.

Robinson, B. (1989) *Withnail and I and How to Get Ahead in Advertising*. London: Bloomsbury.

National Institute of Mental Health (2001) *Seeing Our Feelings: Imaging Emotion in the Brain.*

[Electronic version]. Retrieved Oct 25, 2005, from http://www.nimh.nih.gov/pulicat/feel.cfm

Peale, N.V. (1952). *The Power of Positive Thinking.* Englewood Cliffs, NJ: Prentice-Hall, Inc.

Skinner, B. F. (1971) *Beyond Freedom and Dignity.* New York: Knopf.

Tarrier, N., Haddock, G. Barrowclough, C. & Wykes, T. (2002) Are all psychological treatments for

psychosis equal? The need for CBT in the treatment of psychosis and not for psychodynamic

psychotherapy. *Psychology and Psychotherapy, 75 (4), 365-375.*

Young, J. & Klosko, J. (1993) *Reinventing Your Life: The Breakthrough Program to End Negative*

Behaviour… and Feel Great Again. New York: Dutton.

[2651 words]

Reflections on the Practice of Clinical Psychology

Bob Diamond

Clinical Psychology Forum 162, 5-8

Do you ever wonder why so little is written about the way so many of our psychological individual interventions achieve only modest, if any, positive outcomes? Why there is such a hiatus between text book accounts of therapy and actual practice? Why some psychotherapy services do not accept referrals on the basis of clients' circumstances, such as "too fragile" or, "insufficiently robust"? Why as a profession of psychological helpers we do not make more of the fact that there is a substantial body of evidence supporting both the non-specific factors in therapy (Frank, 1991, Stiles et al, 1986) and the effectiveness of lay counselling and support (Berman, 1985)?

Clinical psychology has many valuable things to say about the anguish and distress we all too often experience, not to mention a commitment to doing something about such states of despair. However, clinical psychology is also part of mental health services that on occasions, contribute more to people's distress than provide possible benefits. I was reminded of this recently by someone with a long history of using mental health services, who is gradually but distinctly getting on with his life, leaving behind shed loads of psychiatric cocktails of drugs, not to mention the almost palpable disbelief of staff that 'he'll be back before long'. How is it that on occasions, we may be doing more harm than good? It isn't always the case, nor mostly the case, but there are plenty of similar testaments to suggest that the iatrogenic effect of mental health services contribute to the on-going damage to people's lives (Johnstone, 2000; Rogers and Pilgrim 2003). As a profession, clinical psychology must ask itself how and in what ways it contributes to this process? This article invites clinical psychologists to look again at how our profession is developing. Clinical psychology has much to offer, and exactly what that is, is being considered here. I believe it is incumbent upon us to consider the questions posed above; not to do so, lays our profession open to the charge of "innocent fraud", (Galbraith, 2005, p3). Whilst he uses it to refer to economics, Galbraith's concept applies uncomfortably to psychology; he describes "innocent fraud" as a continuing divergence between

conventional approved belief and reality, adding, “What prevails in real life is not the reality but the current fashion and the pecuniary interest.”

Clinical psychology in and out of context

It doesn’t take long working as a clinical psychologist, to realise the text books on specific psychotherapeutic interventions are not all that they’re made out to be, including the *Zeitgeist*, cognitive behavioural therapy. This can throw psychologists into a spin that they’re not doing ‘it’ correctly. It is disconcerting how failure to observe strict adherence to specific therapeutic techniques of individual therapeutic work can arouse guilt in the practitioner, not to mention the desperation clients can feel as their distress proves more intransigent than therapy books suggest. There’s plenty of evidence showing positive outcomes to psychotherapy to be much more modest than our profession so far has acknowledged (Lomas, 1987; Epstein, 1996; Lambert, 2003; Moloney and Kelly, 2003).

Less individual and more social

If clinical psychology were less focused on the individual and more on the social, our theories would gain much in meaning and purpose (Boyle, 1990; Smail, 2005). To be human is to be social; that is, to exist in relation to other human beings, our humanity is constituted through physical, social, economic and political practices and forces. Yet when it comes to learning and understanding about what it is to be human, clinical psychology minimises the importance of these contexts virtually out of all recognition, preferring to focus on intra-personal states. Psychology pays scant attention to the social, economic and political environments that constantly shape our lives (Bostock,1998). The academic pursuit of psychology (Davison and Neale, 1982) prefers to consider human behaviour in isolation from its many contexts. So long as psychology persists with explanations of distress that are locked into intra-personal concepts that overlook the primacy of social contexts it fails to acknowledge many of the influences on distress. The inappropriate focus on the intra-personal neglects the possibility of developing support systems within a social context.

> Anne, Stuart, David, Beth and others have all struggled for many years with numerous intrusive voices rendering them socially isolated and unable to pursue the lives they would like to despite all previously receiving individual

psychological help. As a self-help group they have benefited much more from support, encouragement and practical help from one another. Their regular meetings offering collaborative peer support have enabled them to stay away from acute wards and get on with their lives in ways they have sought for years.

It is not only newly qualified psychologists, who feel confused, anxious, diffident and are left wondering what their profession requires of them. What is there in our post-qualification practice to help us cope with and assuage our anxieties over these uncertainties? It is often suggested that, time, experience and professional maturity will clarify such opacity. Why can't our profession set about its development with greater transparency? Once qualified, psychologists can feel professionally alienated within the services where they work. One of the reasons why so many psychologists feel anxious in their work is because clinical psychology is presented as an entity of packaged expertise to be grasped and peddled thereafter. Clinical psychology is reified as a commodity that purportedly leaves us with a sense of clinical competence, sometimes referred to as a set of skills. In reality it is much messier than this and clearly many of us, who either haven't grasped it, or never understood it, can feel ill-informed and poorly prepared for facing the realities of working life as a psychologist in the health service.

Less reductionist and more expansive

If the theories embraced by clinical psychology were less reductionist (Pilgrim, 1991) and more expansive, there would be greater inclusion of ideas. The assumptions that clinical psychology is synonymous with therapy, whatever is meant by this, has always seemed a little confusing. What is it about stepping over the threshold of qualification and being faced with the expectations particularly of our Healthcare colleagues that allows us to suppose that we, clinical psychologists, are equipped to provide a range of psychotherapeutic services? Perhaps this is why, I recall, a number of my training cohort turned to post-qualification psychotherapy courses. It's always struck me as a bit of an unspoken puzzle that training courses appear confused about whether they are there to produce applied clinical psychologists in health settings or to train psychotherapists/counsellors. It's this paper's contention that it is the former. Currently there appear to be assumptions that clinical psychologists are trained

inherently as psychotherapists by assimilating whatever is required through a process of professional osmosis.

The assumption that clinical psychology is synonymous with therapy again suggests that our profession is keen to emulate other professions that narrow their practice to applied sets of techniques, skills and treatments, thus achieving a "social closure" through professional dominance (Pilgrim, 1997, p119). Whilst the charge of reductionism is often aimed at a biologically driven psychiatry, our own profession is also guilty of reducing itself principally to a set of psychotherapeutic interventions. This especially applies within mental health services that all too often portray individuals as nothing more than a collection of faults and limitations.

> Susan, described by mental health services as "personality disordered" along with a catalogue of other disabling, pathologizing symptoms, explained how she felt entangled in mental health services, unable to free herself. Her strengths were in teaching abilities and her priorities were to establish a meaningful life outside of mental health services. Initially linking with a social support group and focusing on her previous interests and abilities, she has joined an evening class, is making friends and regularly teaches numerous mental health professions.

It appears that the profession of clinical psychology approaches its development as though psychologists are receptacles of knowledge, to be shaped and produced through some professional manufacturing process. Post-qualification training emphasises the acquisition of tools or skills. There is a danger that our profession may become more interested in how we fashion ourselves as healthcare experts, rather than as healthcare professionals who retain a psychological perspective that contributes to health services. The allure of promoting ourselves as experts is understandable but we should ensure that our work is based in reality and not premised on prevailing popular, even fashionable concepts. Psychological axioms that pander to contemporary demands are more akin to a form of psychological trickery than a search for the real causes and influences of distress.

Less inward and more outward

If clinical psychology were less inwardly preoccupied and more outwardly orientated, it would be more accessible. The current national pay scales initiative, Agenda for Change (Amicus, 2003) and the ensuing knowledge/skills framework based on

accomplishing competencies will further entrench the 'expert' role. For instance, over the past 20 years our profession has become obsessed with cognitive behavioural therapy, of which we say more in other papers. The process of acquiring specialist techniques is in part in the belief that at some later point, we then share such knowledge with others. There is a danger however, that the potentially flimsy nature of such knowledge, i.e., the excessive emphasis on intra-personal cognitive states, inescapably traps psychologists, who in turn are likely to resort to claims of professional wizardry as a way forward. Our consumer driven society has recently witnessed a massive demand for psychological therapies. Psychology is more popular now than ever before, has almost become a fetish (see the latest lifestyle magazine entitled '*Psychologies*'). It appears there will never be an end to the constant stream of brand-name therapies that appear on our professional doorstep. In the past few months I came across several newcomers such as emotional freedom therapy, acceptance and commitment therapies. It has become Clinical Psychology's business to deliver therapies on demand. Psychology has become a commodity, a convenience at the beck and call of market needs and demands. Any profession that builds upon the shaky foundations of consumerist demand places its integrity at risk and the popularity it enjoys will be ephemeral. Granted, it is not only psychology where this applies, Bauman (2005) eloquently describes contemporary life as "liquid life" a way of living that comprises a stream of illusary images, a constant drip feed that all things in life are possible, yet once grasped, immediately dissolve into another desired state and image to be pursued. Particular emotional states of health and well-being are promoted and considered desirable. Our embodied selves are increasingly regulated and controlled through what Bauman describes as "agencies" such as, specific psychotherapies. He adds there is a "a realm of hypocrisy stretching between popular beliefs and the realities of consumers lives…Each single promise must be deceitful, or at least exaggerated" (p81) for liquid life to be maintained.

The profession of psychology must ensure that it can address any future potential charge of deceit by maintaining an open door of accountability and transparency to its practice. Our professional endeavours and personal-professional interests are increasingly and inextricably entwined in such ways that it is essential to exercise great caution when distinguishing between both the merits of particular psychological interventions and also the origins of the distress we strive to

understand. Our profession must be clear about when and what it is that people experiencing significant distress find helpful.

> Daniel had seen several therapists for individual work yet remained incarcerated in the bowels of mental health services. It wasn't until he met a girlfriend, later to be his wife, someone who showed a genuine interest and belief in him that changes came about in his well-being. He questioned the psychiatric wisdom that he would always need psychiatric drugs, that he was too fragile to pursue a career. Practical help setting up home, work, support contacts was crucial. Three years later, Daniel has a flat, is employed and hasn't felt the need for psychiatric drugs for a couple of years.

Psychology has much to offer in understanding and sharing explanations of distress. Our role as inquirers remains as important as ever. What can then be done about the despair we experience is another matter and is more closely linked to the opportunities and resources we may or may not have access to (Hagan and Smail, 1997). Whilst specific psychological approaches may continue to offer some help to some people, some of the time, such claims should be more modestly made. Clinical psychology is at risk of putting all its eggs in the basket of therapeutic techniques, tools and skills whilst neglecting the wider social, political and cultural contexts. As a profession, we are at risk of compounding the fact that on some occasions some people will be more damaged than helped by mental health services.

References

Amicus the Union (2003) *Agenda for Change: A commentary, pay modernisation in the NHS.*

Amicus London.

Bauman, Z. (2005) *Liquid Life* Cambridge Polity press

Berman, J.S. & Norton, N.C. (1985) Does professional training make a therapist more effective?

Psychological Bulletin, 98, No 2 401-407

Bostock, J. (1998) Developing coherence in community and clinical psychology: The integration of idealism and pragmatism. *Journal of Community & applied Social Psychology*, Vol 8. 1-9

Boyle, M. (1990) *Schizophrenia: A Scientific delusion?* London Routledge

Davison, G. C. & Neale, J. M. (1982) *Abnormal Psychology.* New York John Wiley

Epstein, W. (1995) *The Illusion of Psychotherapy* New York Transaction Publishers

Frank, J. (1991) *Persuasion and healing: a comparative study of Psychotherapy (3rd edition)*

New York John Hopkins University Press

Galbraith, J.K. (2005) *The economics of Innocent Fraud.* London Penguin

Hagan, T. & Smail, D. (1997) Power-mapping -1 Background and basic methodology. *Journal of*

Community & Applied Social Psychology, 7, 257-267

Johnstone, L. (2000) *2nd edition Users and Abusers of Psychiatry: A critical look at traditional*

psychiatric practice. London Routledge

Lambert, M.J. (2003) 5th edition of *Bergin & Garfield's Handbook of Psychotherapy & Behaviour*

Change, New York John Wiley

Lomas, P. (1987) *The Limits of Interpretation: What's wrong with Psychoanalysis?* London

Penguin

Moloney, P. & Kelly, P. (2003) Beck never lived in Birmingham: Why Cognitive Behaviour

Therapy (CBT) may be a less useful treatment for psychological distress than is often

supposed *The Journal of Critical Psychology, Counselling and Psychotherapy.* **3,** 216- 228

Pilgrim, D. (1991) Psychotherapy and social blinkers. *The Psychologist: Bulletin of the British*

Psychological Society, 2, 52-55

Pilgrim, D. (1997) *Psychotherapy and society* London Sage

Rogers, A. & Pilgrim, D. (2003) *Mental Health and Inequality* Basingstoke *Palgrave*

macmillan

Smail, D. (2005) *Power Interest and Psychology: Elements of a social materialist understanding of distress* Ross-0n-Wye PCCS Books

Stiles, W.B. Shapiro,D.A. Elliott, R. (1986) "Are all psychotherapies equivalent?" *American Psychologist*, 41, No. 2 165-180

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[2477 words]

Fundamental Questions for Psychology

John Cromby

Clinical Psychology Forum 162, 9-12

Why do we need a new way of thinking about work with distressed individuals? What is wrong with the many different styles of therapy and intervention already in use?

Like any discipline, psychology has its problems. With regard to clinical work, many of these problems flow from the fundamentally dualistic character of psychology, the way in which it typically conceptualises important aspects of our being as so distinct and different that interactions and relationships between them appear problematic. The dualisms we are most concerned with here are that between mind and body, and that between individual and society.

Mind-Body Dualism

The relationship between mind and body continues to be a troubling issue for both philosophy and psychology. At least since Descartes, philosophers have explicitly addressed this relationship and have formulated numerous ways of understanding it (see for example Graham, 1993; Heil, 2004). By contrast, aside from the occasional mention in third-year undergraduate modules, in psychology the problems of this relationship are largely ignored. On the one hand psychology maintains a predominantly empirical focus, which means that underlying *conceptual* questions have less prominence. And on the other, the continuing relevance of mind-body dualism for psychology is concealed by the ways in which the discipline is fragmented and compartmentalised. For example, we have neuropsychology and biological psychology – and we also have the psychologies of cognition and attitudes. One set of subdisciplines addresses the brain (body), the other addresses thoughts (mind): but the subdisciplines remain almost entirely distinct from each other. Not only are they taught at university in separate modules, their advocates pursue disparate research agendas, attending conferences and publishing papers almost exclusively within the confines of their own specialism. In a sense, then, psychology has handled the problem of mind-body dualism primarily by enshrining it deep within the structure of the discipline. Consequently, whilst it is true to say that psychology,

as a whole, does address both body and mind, the nature of the actual *relationship between them* is nevertheless rarely considered.

Individual-Society Dualism

The issue of how individuals and their society are related appears not only deeply problematic but also highly contentious, since it lies at the heart of many political philosophies and social policies; consequently, this dualism is problematic for other disciplines too. It is much discussed in sociology, for example, where it is referred to as agency-structure dualism – the question being whether individual agency or social structure are the most important determinants of societal reproduction and transformation (e.g. Archer, 2000). With regard to psychology, there are parallels between this issue and the problem of mind-body dualism. One parallel concerns how both dualisms are submerged by the disciplinary organization of academic knowledge and research. However, whereas the mind-body problem is primarily dissolved into subdisciplines of psychology, the problem of individual-society dualism is primarily dissolved into the distinctions between actual disciplines. So we have history, anthropology, sociology, economics, politics and cultural studies, which all study society and culture – and then we have psychology, the "science of the individual". Again, this disciplinary specialization means that the precise character of the *relationship between* individuals and their society simply tends to be ignored, as researchers pursue separate agendas within which this issue apparently plays only a minor role. As a consequence, individuals and their society typically appear as such totally distinct, separate entities that it then seems difficult to understand how they could possibly be related (Burkitt, 1991).

Psychology's character

Speaking very generally, then, psychology is fragmented internally, within the actual discipline, by mind-body dualism; and at the same time it is circumscribed externally, at it's boundaries with other disciplines, by the divide between individual and society. Note, however, that this claim describes general tendencies rather than absolute demarcations. For example, psychology is also structured *externally* by mind-body dualism, especially with the recent rise of cognitive neuroscience (Gazzaniga, 2000). It is also to some extent structured *internally* by individual-society dualism, as the

perennially crisis ridden character of social psychology demonstrates (Parker, 1989). Moreover, it is not that bodies and the social world never become relevant within psychology, since clearly they do. The problem is that, as a consequence of the structuring influence of these two dualisms, they tend only to appear in particular ways. Because they are already conceived of as separate from and different to the primary stuff of psychology, which is usually taken to be cognition, bodies and the social world tend to enter psychology only as relatively static, uniform, fragmentary or contextual influences. Instead of being conceptualized from the outset as fundamentally necessary, integral, dynamic, constitutive elements of subjective experience, bodies and the social world tend to get included in theories and research designs as mere variables, relatively inert, neatly demarcated and primarily contextual factors, whose character and nature is definable, measurable, and clearly distinguishable from the disembodied, individual cognitions that form the primary focus of interest (Stam, 1998; Tolman, 1994).

Some readers may object to this thumbnail sketch, feeling that this is both unfair and inaccurate. What about the biopsychosocial model? What about psychoanalysis, and social constructionism? Well, psychoanalysis and constructionism are both somewhat marginal in psychology, and so might exemplify precisely the kind of fragmentation we have described. Moreover, as alternatives they are not without their own problems: both are further fragmented into subdisciplinary schools of thought (Mitchell & Black, 1995; Nightingale & Cromby, 1999), and both are themselves somewhat dualistic in ways that resemble the psychological mainstream.

For example, most psychoanalytic approaches reduce the body to metaphorical entities or processes, and maintain a relatively close focus on the *internal* dynamics of the person – in conjunction, perhaps, with the interpersonal dynamics of close relationships. However, interactions between individuals are *always* simultaneously societal as well as interpersonal: they occur in material contexts structured by social divisions such as class and gender; they are mediated by discursive and practical skills acquired through enculturation; and they are ordered by the norms and expectations of particular subcultures. Much psychoanalytic work fails to sufficiently address these fundamentally societal aspects of our relationships (Billig, 1999), and so might also obscure the societal origins of much distress. And whilst recent advances in neuropsychoanalysis do partly redress the disembodiment of other psychodynamic

schools (Solms & Turnbull, 2002), for the moment at least this remains just one more subdiscipline. Unless these advances are taken up and thoroughly integrated within psychodynamic thought, more broadly considered, mind-body dualism will simply be reinstated at a different level. Similarly, most variants of social constructionism fail to theorise or study actual, embodied individuals, instead focusing more-or-less exclusively on the discourses and positions that construct their identities and subject positions. Here, the social is not ignored, but instead treated as though its linguistic aspect exhaustively embraces everything else. Somewhat paradoxically, social constructionism reflects the reductionism of mainstream psychology but simply inverts it into a kind of mirror image, substituting reduction to discourse for reduction to the individual (Cromby, 2004).

By contrast, the biopsychosocial model *is* firmly within the mainstream of psychology - but as the Monty Python team might have said, "It's only a model!" As such, it tends to be used in relatively undisciplined ways; it does not develop in coherent lines of progression; and in practice it tends to act primarily as a discursive warrant for linking together a chain of variables from different realms, often with some kind of foundational precedence given to the biological. Indeed, within the biopsychosocial model, just as elsewhere in psychology, the actual *relationships between* biology, individuals and society are rarely conceptualized. Instead, they are left to emerge piecemeal from the accumulation of empirical studies whose evidence is *already* shaped by unexamined preconceptions concerning the nature of these relationships - preconceptions which are consequently reproduced (typically covertly) within the evidence. The biopsychosocial model, in short, explains nothing because it does not set out to do so: it is a model, rather than a theory, and being limited to this status means that its preconceptions are rarely examined, and more rarely still refined and developed.

Moreover, although other tendencies in psychology or related areas might seem to challenge these dualisms, on closer examination they have similar problems (for example, cognitive neuroscience struggles with conceptual issues analogous to those described here – see Bennett & Hacker, 2003). In any case, the continual reappearance of new attempts to cross the divides between individual and society or mind and body is itself yet more evidence of how deeply rooted these problems are. Broadly speaking, then, we think it fair to conclude that psychology is predominantly structured and shaped by dualisms in the way that we have described here.

So what?

These issues might seem far removed from the day to day business of intervening in the lives of distressed people, but a moment's consideration should show that they are highly relevant. The history of clinical treatments and interventions falls into two broad strands, one focused primarily on the body and the other on the mind. Psychotherapeutic models of distress typically locate causality in the mind, whilst biological or psychiatric models locate it within the brain-body system. Both, however, tend to locate it within the individual, even though the influence of the social (as *context*, rather than *constituent)* might be acknowledged. With the exception of approaches within systemic, family therapy or community psychology, treatments and interventions tend to be similarly individualistic: and of these, only community psychology has the conceptual reach to address the structuring effects of social inequality.

As a consequence, a relatively bizarre kind of psychology has become the mainstream. It is a psychology that prioritises conscious rational thought – cognition - over all other influences upon human activity: as though what people do (especially, perhaps, people in the extremes of distress) typically follows the contours of formal rationality. This psychology endows cognition with a weight of responsibility and a power of transformation that the evidence largely belies. It treats individuals as separate and distinct from the social fabric and power relations within which they are actually *bodily embedded,* and which in large part constitutes their moment-by-moment experience. It positions individuals as insightful, aware and controlling even though many of the influences upon them are far beyond their everyday comprehension. It is a disembodied psychology of individual cognitions.

References

Archer, M. (2000). *Being Human: the problem of agency*. Cambridge: Cambridge University Press.

Bennett, M. R., & Hacker, P. M. S. (2003). *Philosophical Foundations of Neuroscience*. Oxford: Blackwells.

Billig, M. (1999). *Freudian Repression: conversation creating the unconscious*. Cambridge: Cambridge University Press.

Burkitt, I. (1991). *Social Selves*. London: Sage Publications.

Cromby, J. (2004). Between constructionism and neuroscience: the societal co-constitution of embodied subjectivity. *Theory and Psychology*, *14*(6), 797-821.

Gazzaniga, M. S. (2000). *The Mind's Past*. Berkeley: University of California Press.

Graham, G. (1993). *Philosophy of Mind: an introduction*. Oxford: Blackwells.

Heil, J. (2004). *Philosophy of Mind: a guide and anthology*. Oxford: Oxford University Press.

Mitchell, S. A., & Black, M. J. (1995). *Freud and Beyond: a history of modern psychoanalytic thought*. New York: Basic Books.

Nightingale, D. J., & Cromby, J. (1999). *Social Constructionist Psychology: a critical analysis of theory and practice*. Buckingham: Open University Press.

Parker, I. (1989). *The Crisis in Modern Social Psychology and How to End It*. London: Routledge.

Solms, M., & Turnbull, O. (2002). *The brain and the inner world: an introduction to the neuroscience of subjective experience*. New York: Other Press.

Stam, H. (Ed.). (1998). *The Body and Psychology*. London: Sage Publications.

Tolman, C. (1994). *Psychology, Soc iety, Subjectivity: an introduction to German Critical Psychology*. London: Routledge

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[1935 Words]

The Trouble with Psychotherapy

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The term "psychotherapy" refers to a broad family of talking treatments for personal distress which are of proven effectiveness, where some approaches are helpful for certain kinds of personal difficulty, and where accredited professional training will confer particular expertise and skill (see McLeod, 1994). The assumptions contained within this statement are unlikely to meet with dissent from the average person in the street (see Furedi, 2003), and in one form or another constitute the taken for granted world of the psychotherapy professionals themselves. For example, they are endorsed in the training programmes of clinical and counselling psychology (BPS, 2002; 2004), in central government recommendations for the use of psychological therapies in the NHS (DoH, 2001); and most recently - in calls by Richard Layard - one of the UK government's key economic consultants - for psychological therapy to be made "available to all", as the main answer to the personal and social malaise which seems to be afflicting us at record levels (see Roth and Stirling, 2006).

In contrast to this warmly consensual picture, the enduring reality is that the psychotherapy outcome literature offers precious little support for any of the above notions. This is an observation that surely has some importance for any profession that concerns itself with the understanding and alleviation of personal distress, and yet it is one that seems to have been consistently ignored. In this paper we attempt to critically review some of the key psychotherapy outcome literature and to ask why it has been so hard for psychologists to acknowledge the poor evidence on therapy outcome.

Does therapy work?

It is widely recognised that there are numerous and complex difficulties in assessing the effects of psychological therapies, and that one of the best ways of doing this is by means of the randomized placebo control trial (or RPCT). A large number of investigations into this question have been conducted over the last half-century or

more, and although the results of these studies have often been extremely variable, so called meta-analyses - in which the findings of large numbers of studies have been aggregated and then analysed together – seem to suggest that most forms of psychological therapy are at least mildly helpful. Effect sizes upward of half a standard deviation or more are routinely touted. That is to say, undergoing psychological therapy is claimed to reliably lead to significant improvement in the mental health of up to a quarter or above of all recipients (Smith et al, 1980). This compares favourably with other psychiatric treatments that may themselves have a very large placebo component, such as anti-depressant medication (Breggin and Cohen, 1999).

Not surprisingly perhaps, these claims seem to be authorized by the core psychotherapy professions (see Fonagy and Roth, 1996). Yet there are a number of serious methodological problems associated with attempts to assess the effectiveness of counselling or psychotherapy in this way. So much so, that at least some academics and practitioners admit that it is hard to decide whether these studies as a whole do or do not support the notion that psychotherapy or counselling is generally helpful (McLeod, 1994).

To begin with, the field has long suffered from a bias toward the selective reporting *and* publication of those studies that show only the desired positive results (Boyle, 2002; Epstein, 1996). Many psychotherapy RPCT trials have included inadequate control groups for comparison purposes, often consisting of individuals who remain on a waiting list or who receive a less credible form of pseudo-therapy, delivered with visibly limited commitment by the researchers (Holmes, 2002; Mair, 1992). Conversely, there has been a trend toward excessive reliance upon selected research populations, such as university students or individuals with less severe problems than are typically found in clinical settings. A large proportion of studies have also suffered from systematic participant attrition or retention effects that make the results hard to interpret (Dineen, 1999; Eisner, 2000). Statistically significant differences in outcome between participant groups have often concealed large numbers of people for whom psychotherapy has been ineffective. While assessments of outcome have used mainly abstract numerical measurements and pre-set diagnostic inventories that leave little room for subjective experience, and which may therefore have limited personal or even clinical meaning (Kline, 1988, and see Tolman, 1994)

Aside from these far from minor difficulties, this literature may suffer from an even more pervasive problem. This is the tendency to rely almost exclusively upon the reports of participants - including the client, the clinician and workers from the agencies and institutions that support the therapeutic work - in the absence of any fully independent check upon the treated person's progress in the world outside of the consulting room (Eisner, 2000; Epstein, 1996). This is a serious issue in psychotherapy research, because of the range of powerful social and interpersonal influences are likely to be in play, in what is in many ways a unique situation in our culture: part confessional, part ritual of healing and social affirmation, and much else besides (Frank and Frank, 1991). On this basis, it may be worth discussing the question of bias in client reports in more detail.

To start at the most basic level, both client and clinician will from the outset usually desire the same broad result: – an improvement in the formers' mental health, whether this is defined as happiness, adjustment, or relative freedom from distress. The patient's cooperation toward this aim will be engaged through the practitioner's efforts to establish a therapeutic relationship, which implicitly entrains the client into the given therapeutic model. For instance, many humanist therapists seek to build a relationship with their client that is intense and deep enough to exceed most ordinary professional-lay person encounters (Gendlin, 1981; Mearns, 1994). Other practitioners may emphasise the complexities of the psychodynamic transference relationship (e.g. Casement, 1995); or the alleged scientific and technical authority for what they do - as in cognitive behavioural therapy (e.g. Hawton, et al, 1989).

As a result the client will likely have invested a great deal of trust and hope in the person of the practitioner. All the more so, perhaps, for having disclosed worries and fears hitherto shared with few others. Both parties may also share potent, culturally sanctioned beliefs, which equate any failure to benefit from therapy with the client's wilful rescinding of the inner strength or discipline needed to overcome adversity (Cushman, 1995). For the latter, these factors may combine to render any admission of failure in the therapeutic process a sign of personal inadequacy and a source of anxiety about earning the tacit disapproval of their therapist. It therefore seems reasonable to think that such admissions of disappointment might be avoided or denied by many clients: even - or perhaps especially - to themselves (Epstein, 2006; Kline, 1988). And indeed at least some clinicians fell that they have observed this process in action (Kelly, 2000).

The key question, of course, is *to what extent* the claims for psychotherapy effectiveness might be distorted by this shaping of client self report. As William Epstein points out, the scale of this problem becomes apparent when estimates of psychotherapy effect size are compared with estimates of so called "demand characteristics". These are the expectations that researchers can unconsciously convey to participants in laboratory based psychological experiments. In the absence of thorough controls such demand factors can typically account for between 0.70 and 1.0 standard deviation of the reported effect sizes. This is for situations that are relatively impersonal and short term in comparison to most psychotherapeutic interventions, and in which the participants might therefore be expected to have a much lower stake in the final outcome (see Rosenthal and Rubin, 1978). Nevertheless, Epstein notes that these estimates of researcher influences at least equal (and often surpass) the average gains reported for psychotherapy, even for the better-controlled studies.

> This is obviously a basic issue for the psychotherapy field, where therapist expectations of client improvement are inbuilt for virtually every approach. Yet rather than getting to grips with these findings, the whole area seems instead to have continued to rely upon the reports of clients (and other closely involved parties) in the absence of any form of truly external corroboration. The result being that researcher expectancy cues are inseparable from virtually all of the RPCT research to date, and may confound it. In the end, the clear possibility remains that most of the claimed benefits of psychotherapy might reside in placebo effects (Epstein, 2006; 1996).

This last prospect is strongly underscored by four further lines of evidence. These are, first, that, aside from (decidedly) modest indications for the greater efficacy of behavioural approaches in relation to phobias, the comparative research literature seems to offer little support for the idea that any one treatment is more effective than another (Assay and Lambert, 1999). This observation seems hard to reconcile with the confident assertions of therapeutic potency and specificity that are often trumpeted by adherents of the mainstream therapies (Hansen, et al, 2003). Yet within the field…"*there is tremendous resistance to accepting this finding as a legitimate one*" (Bergin and Garfield, 1994, p822).

Second, the available evidence suggests that, rather than specific techniques, a range of so called "non-specific" factors may account for most of the beneficial effects of psychological treatments. Among these features, the client's wider life circumstances and the quality of the therapeutic relationship seem to be the most important by far (Bohart, 2000; Bergin and Garfield, 1994; Mahrer, 1998).

Third, comparisons of qualified practitioners with amateurs who have received no specific training in therapeutic models or methods suggest that there are few real differences between them in effectiveness, however this is measured. This is a surprisingly robust (though, again, seldom acknowledged) finding, which is supported by 39 separate research studies conducted over a period of more than a decade (Dawes, 1994; Stivers, 1999).

Fourth, a reliable trend within the psychotherapy outcome literature is that the closer the study comes to real life clinical settings, then the less significant the outcomes tend to be (Epstein, 1996). For instance, the recent American multi-centre research trial known as the "Fort Bragg demonstration project" involved the analysis of the treatment of 42, 000 clients (who were largely children) over a span of five years. Yet the results were disappointing in that there was no evidence that psychological therapy led to improvement in the lives of these recipients, many of whom were struggling with significant social adversities. As the clinical psychologist Tana Dineen observes: "*these results should raise serious doubts about some current clinical beliefs about the effectiveness of psychological services…there is scant evidence of its effectiveness in real life settings*" (Dineen, 1999, p128)

What then can we conclude about the effectiveness of psychotherapy?
Overall, the findings examined in this paper highlight the overwhelming import of "non-specific effects" in psychological treatment the one hand, and of the frequently flawed nature of RPCT methodology, on the other. None of which seems to be very encouraging for the official view of psychological therapy as a well-validated body of effective clinical treatments. Instead of rebuttal, the tendency inside the main therapeutic professions seems to have been to ignore or downplay these considerations (see Howard, 2005), and it therefore seems worth asking why this is so. Personal conviction is doubtless one of the reasons. Within the confines of the consulting room both therapists and their clients will often observe that the latter seem to undergo a significant relief from their distress. As already indicated, this is one instance where *immediate* personal experience can be compelling but also highly deceptive, especially when backed up by prevalent cultural myths.

Another element in this situation may be the reliance of the field upon large-scale meta-analytic studies, a trend that is reinforced by the accumulating NICE guidelines on psychotherapeutic practice in the NHS. Although officially presented as

both definitive and authoritative (see for example, NICE, 2003) such methods are notoriously prone to generating misleading or inconclusive data, as the previous discussion has shown. The meta-analytic approach simply fails to capture the way in which knowledge is developed and validated within the wider scientific community. When pursued in good faith, scientific knowledge emerges from a craft-like process that entails the careful exploration and sifting of ideas against the limits of personal experience and reasoned reflection, and not from managerial directives or the behest of professional interest groups, operating under the guise of impersonal authority (Charlton, 2000; and see Polanyi, 1955).

The significance of all this becomes clearer when set against the evidence that - contrary to the claims of Layard – the nature of our current social arrangements may underpin much of the distress that brings people to the consulting room (see, for example Perelman, 2005; Vail et al, 1999; Wilkinson, 1996). In this situation, the interests of the therapeutic professions are likely to dovetail only too well with those of a political order that is intent upon convincing its citizens that their private troubles have little connection with events in the public realm. And in this respect, the myth of individual psychological therapy as cure fits the bill admirably.

References

Assay, T.P; & Lambert, M. J. (1999) The empirical case for common factors in therapy: Quantitative findings. In, M.A. Hubble, B.L. Duncan, & S.D. Miller (Eds.) *The Heart and Soul of Change: What Works in Therapy*. pp33-56. Washington DC: American Psychological Association.

Bergin, A. and S. Garfield (1994). *Handbook of Psychotherapy and Behaviour Change*. New York, John Wiley.

Bohart, A.C. (2000) The Client is the Most Important Common Factor: Clients' Self-Healing Capacities and Psychotherapy. *Journal of Psychotherapy Integration*, 10 (2), pp. 127 - 149.

Boyle, M. (2002). *Schizophrenia: a Scientific Delusion?* (Second Edition) London, Routledge.

Breggin, P. and D. Cohen (1999). *Your Drug May Be Your Problem:How And To Stop Taking*

Psychiatric Medications. Reading:massachusettts, Perseus Books.

British Psychological Society (2002) Criteria for the Accreditation of Postgraduate Training

Programmes in Clinical Psychology. Division of Clinical Psychology. Leicester: British

Psychological Society

British Psychological Society (2004). Board of Examiners in Counselling Psychology: Regulations and

Syllabus for the Qualification in Counselling Psychology. Leicester.

Casement, P. (1995). *Further Learning from the Patient: the Analytic Space and Process.* London, Tavistock.

Charlton, B. G. (2000). The new management of scientific knowledge: a change in direciton with profound implications. *NICE, GHI and the NHS reforms: enabling excellence or imposing control?* M. Hampton and B. Hurwitz. London, Aesculapius Medical Press**:** 13 - 32.

Cushman, P. (1995). *Constructing the Self, Constructing America.* Cambridge, Ma., Perseus Publishing.

Dawes, R. (1994). *House of Cards: Psychology and Psychotherapy Built on Myth.* New York, Macmillan.

Department of Health. *Treatment Choice in Psychological Therapies and Counselling*. London.

HMSO. 2001

Dineen, T. (1999). *Manufacturing Victims: what the psychology industry is doing to people.* London, Constable.

Eisner, D. (2000). *The Death of Psychotherapy: from Freud to Alien Abductions.* New York, Preager.

Epstein, W. (2006) The Civil Divine: Psychotherapy as Religion. University of Nevada Press.

Epstein, W. (1996). *The Illusion of Psychotherapy.* New York, Transaction.

Frank, J. D. and J. B. Frank (1991). *Persuasion and Healing: A Comparative Study of Psychotherapy*. Baltimore, Johns Hopkins University Press.

Fonagy, T. and Roth, A. (1996) *What works for whom? A critical review of psychotherapy research.*
New York, Guilford Press.

Furedi, F. (2003). *Therapy Culture: Cultivating Vulnerability in an Uncertain Age.* London, Routledge.

Gendlin, E. (1981). *Focusing*. New York, Bantam.

Hansen, S., A. McHoul, et al. (2003). *Beyond Help: A consumer's guide to psychology.* Ross-on-Wye, PCCS Books.

Hawton, K; Salkovskis, P; Kirk, J. and Clarke, D. (1989) *Cognitive Behaviour Therapy for Psychiatric Problems: A Practical Guide*. Oxford University Press.

Holmes, J. (2002). "All You Need Is Cognitive Behaviour Therapy?" *British Medical Journal* 324: 288-291.

Howard, A. (2005). *Identity and Counselling*. London, Palgrave.

Kelly, A. E. (2000). "A self-presentational view of psychotherapy." *Psychological Bulletin* 126(4): 475 - 494.

Kline, P. (1988). *Psychology Exposed: or The Emperor's New Clothes*. London, Routledge.

Mahrer, A. (1998). "Embarrassing Problems for the field of Psychotherapy,." *BPS Psychotherapy Section Newsletter* **23**(3): 3 – 25.

Mair, K. (1992). The Myth of Therapist Expertise. *Psychotherapy and it's Discontents.* W. Dryden and C. Feltham. Buckinghamshire, Open University.

Mcleod, J. (1994). *Doing Counselling Research*. London, Sage.

Mearns, D. (1994). *Developing Person Centred Counselling.* London, Sage.

National Institute for Clinical Excellence (2003). Depression: the management of depression in primary
and secondary care. Second consultation draft. December.

Perleman, R. (2005). *Manufacturing Discontent: The Trap of Individualism in Corporate Society*. London and Ann Arbour, Michigan, Pluto Press.

Polanyi, M. (1955). *Personal Knowledge: Towards a Post-Critical Philosophy.* London, Routledge.

Roth, T. and Stirling, P. (2006) Expanding the availability of psychological therapy. Retrieved 12th
February 2006 (http://www.bps.org.uk/dcp/news/layard.cfm)

Smith, M. L. and Glass, G.V and Miller, T. I. (1980) The Benefits of Psychotherapy. Baltimore M.D.: Johns Hopkins University.

Stivers, R. (1999). *Technology as Magic: the triumph of the irrational.* New York, Continuum.

Rosenthal, R. and Rubin, D. B. (1978) Interpersonal Expectancy Effects: The first 345 studies. Behavioural and Brain Sciences 3, pp. 377 - 415.

Tolman, C. (1994). *Psychology, Society, and Subjectivity: An Introduction to German Crtical Psychology*. London, Routledge.

Vail, J. (1999). *Insecure Times: Living with Insecurity in contemporary society.* London, Routledge.

Wilkinson, R. (1996). *Unhealthy Societies: The Afflictions of Inequality*. London, Routledge.

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[2878 words]

Lost for words: why the "alternative post-modern" therapies might not be as alternative as they seem.

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Philosophy's like medicine: lots of drugs, few remedies, and hardly any complete cures (Chamfort; in Parmee, 2003, p. 42).

In recent years, psychological theorising and the turn towards discourse have increasingly been reflected in the field of psychotherapy, in particular in relation to the theories and practices of family/systemic interventions, solution focused therapies, and more recently in the growing popularity of narrative approaches to psychological therapy (e.g. Fish, 1996; Payne, 2000). In this paper we critically evaluate these developments within therapeutic psychology, with a particular focus on 'narrative therapy'.

Narrative therapy emerged in the early 1990's from its parent discipline of family therapy predominantly through the work of Michael White in Australia and David Epston in New Zealand (White and Epston, 1990). Its theoretical base draws upon social constructionism (Burr, 1995; Gergen, 1999), emphasising how experiences are mediated through language, organised into discourses and narratives or 'stories'. Psychological distress emerges when these narratives become oppressive, painful, chaotic or incoherent and do not reflect the person's lived experiences. Narrative therapy assists the client to separate their identities from these painful narratives (or problem stories) by recognising the latter as a solution of sorts to a difficult set of circumstances and then redefining the self as resourceful and strong (White and Epston, 1993).

Dominant models of psychotherapy have been criticised for neglecting the role of power in psychological distress (Pilgrim, 1997;Smail, 1993). Despite overwhelming evidence that social inequalities such as poverty fundamentally create and maintain psychological and physical ill health (Wilkinson, 2005), most mainstream psychological therapies continue to promote internalised and de-contextualised theories and practices, and in doing so contribute to 'victim blaming'

(Moloney and Kelly, 2003). In contrast, narrative therapy highlights the importance of ideological power in human distress, emphasising how dominant discourses within society in relation to race, gender, and "mental illness" may impact negatively on the well being of clients. An attempt is therefore made to assist individuals to challenge these discourses and to thereby link psychological distress to social issues. This is an approach which is clearly distinct from the more conventional psychotherapeutic and psychiatric focus on the '*individual as the locus of problems*' (Hare-Mustin and Marecek, 1997, p113).

Nevertheless, it has become clear that the social constructionist philosophy underpinning narrative therapy may have serious philosophical and practical limitations which cause problems for narrative therapy itself. Like most variants of constructionism, narrative therapies rest upon varieties of relativism, in which there is no sense in which the world could be said to exist independently of our constructions of it (Gergen, 1999). The merits and shortcomings of this stance have been extensively discussed in the "realism-relativism" debate, which has clearly demonstrated that the extreme relativist stance is internally inconsistent, sabotages any possibility for the integration of constructionism with other forms of knowledge, and is in any case dependent upon rhetorical devices for its apparent plausibility (Bhaskar, 1989; Erwin, 1997).

This debate has many implications for the narrative therapies, and in what follows we consider some of the perhaps less frequently discussed limitations and dangers arising from this relativist position. We suggest that there are two related kinds of problem. The first, flowing from the organic, embodied nature of human beings; and the second, from the social relationships in which virtually all of human experience is embedded.

When words are not enough: the question of embodiment

One of the key assumptions of the narrative therapies is that "*in the end we become the autobiographical narratives which we tell about our lives*" (Bruner, 2004, p15). In this sense, the narrative therapist teaches the client to be a philosopher, who must accept that changing the language (or story) around their problem will actually change the problem itself.

Yet there are many circumstances in which this privileging of language may be misconceived. Developmental psychology, for instance, shows that our embodied

and practical knowledge develops in direct interplay with nature and material culture, so that much of our basic sense of our selves and of our relation to the world remains tacit, and can only be hinted at via metaphors or indicated through our actions (Archer, 2000; Clarke, 1996). In daily life, there are numerous situations in which our utterances fail us and cannot live up to our feelings. It may be true that words make the poem, but it is also true that the poet may struggle to set her creation to words. As the philosopher Suzanne Langer observed "*…the forms of human feeling are much more congruent with musical forms than with the forms of language, music can reveal the nature of feelings with a detail and truth that language cannot approach"* (Langer, 1951, p199).

> In the clinical setting, these issues are brought into particularly sharp focus since suffering of all kinds has a felt corporeal dimension that may render it beyond the reach of mere utterance. A key aspect of suffering almost certainly resides in its arbitrary, unjust or even meaningless nature: particularly where bodily affliction and pain are involved. Some writers have therefore argued that such experiences can only be fully acknowledged through acts of care and practical comfort, rather than through the verbalization (or perhaps intellectualization) of a psychotherapist (Radley, 2004). The experience of providing psychotherapy likewise throws into question the whole idea that self-created narratives are what necessarily propel people into action. Clients are often unable to articulate the reasons for their distress or the conduct that may be associated with it. Instead, the person's likely motives may have to be inferred from a painstaking examination of their history and of the wider context in which they live (van Deurzen, 1998; Smail, 1978).

More generally, there seem to be regular patterns within human experience that belie the idea of social and mental life as the endlessly changeable objects of language. In modern industrial societies, for example, embodied human capacities and external material and social constraints can come together to yield predictable negative health effects. Particularly, evidence suggests that widespread social inequalities constitute as powerful a determinant of mental and physical wellbeing as the presence of key environmental polluters, such as asbestos (e.g. Wilkinson, 2005).

Indeed, persistent social and material adversity may negatively and pervasively shape the individuals' sense of self worth and expectations of others; and, most insidiously of all, leading to perhaps irreversible changes in neuro-endocrine and immune functioning that significantly harm health and longevity. In this way, cumulative experiences of insecurity and loss can work themselves into our body and mind in a process that is much closer to the gradual deposition of sediment than to the spinning of conversations. Far from being the mutable products of discourse, it seems that many individuals find that they can never quite escape the fearful or self-

deprecating moulds into which they have been cast by a lifetime of ill treatment (Bourdieu 1985; Lyng and Franks, 2002; Wilkinson, 2005).

The social and material context of personal distress

Perhaps one of the main hallmarks of the narrative approach is the self-consciously "politically radical" stance that many practitioners adopt in their work. This may indeed be an advance upon much of the current theory and practice of psychological therapy, which has typically sought to adjust individuals to an iniquitous social world that is preordained (Cushman, 1995; Smail, 1993). In contrast, narrative practitioners assume that as the psychologically damaging effects of our society can be resisted and overcome through equipping the client with new stories in which to frame their problems and to reshape their mode of being (White and Epston, 1990).

Although these aims are worthy, there are serious obstacles to achieving them in practice, since the focus on discourse has at best downplayed or at worst denied the importance of embodiment, materiality and structural power in the origins of many peoples' problems (Nightingale and Cromby, 1999). This observation is supported by the psychotherapy outcome literature, which has long indicated the client's social and financial status as crucial to the success of talking treatment. Conversely, the most socially and economically disadvantaged clients may be the least likely to find any long-term improvement in their distress as a result of undergoing individual psychological therapy – whatever the approach that is used (Epstein, 1996).

> One of the reasons why this situation may be hard for many therapists (and perhaps clients) to grasp is that, in the UK at least, the whole topic of social class has receded from popular and political consciousness in recent years, replaced by a form of unreflective identity politics, which asserts our supposed ability to be self creating and upwardly mobile as a matter of personal choice (Bauman, 2004: Furedi, 2004).

Despite these trends, the mental health and epidemiological literature continues to tell a very different story. The outlines of social and economic class divisions may be less visible than was the case for previous generations. Nevertheless, the former are still very much with us and in combination with factors like ethnicity and gender, continue to be among the key factors determining the life course and indeed the experience of mental health and illness, as already indicated. Indeed, the available evidence suggests that occupancy of the lower steps of the social pyramid can only be partially offset by the use of anti-discriminatory practices and discourses

on the part of institutions and individuals concerned - assuming, of course, that they are even aware of the need for them. In other words, occupancy of a low social class position can be aversive not just because of the negative stories that individuals (and others) tell about themselves, but because of their having less access to material wealth and to the valued objects, relationships and resources that it brings (Pilgrim, 1997; Sayer, 2005).

For the most disempowered people, durable positive change is more likely to arise from a shift in the kinds of social and material environments to which they have access. While the consulting room is one such environment, it can be no more than wishful thinking to believe that it represents anything other than a relatively small and-short lived influence in the scheme of the client's overall life. Adherents of the traditional psychological therapies have themselves sought to turn this wishful thinking into a credible story, in which psychological insight is said to lead to personal change. False though it may be, this dictum of mainstream psychotherapy - that "*it's all in the mind*" - has enormous social and cultural resonance in the present time. Sadly, practitioners of the narrative therapies may be doing little more than replacing this received notion with a new and equally mystifying claim – that…."*it's all in the language…"*. Ultimately, it is not words but walls of stone that make the prison.

Conclusion: putting words back in their place

What is missing from narrative therapeutics, then, is the acknowledgement that relationships of power - whether found at social or bodily sites - amount to a reality that is shot through with discourse but which can never be reducible to it. As such, this reality is no more likely to yield to the application of narrative techniques than those of any other individualized talking cure. Worryingly, this conflation of words with embodied, material relations of power may be all the harder to detect because of the way in which the narrative therapies encourage practitioners to engage with issues of identity and oppression. Critics have long argued that professional training has the covert aim of teaching practitioners to develop an unconscious blind spot to the politically conservative aims of their work (Baritz, 1960; Schmidt, 2000). Perhaps then, in adopting this kind of superficial radicalism, narrative therapists are…."*unintentionally revealing their awareness of the system's power over them, [in] the lengths to which they go to avoid appearing to themselves and to others as the*

servants of the system that they are" (Schmidt, 2000, p67).

References

Archer, M. (2000) *Being Human: The Problem of Agency*. Cambridge University Press.

Baritz, L. (1960) *The Servants of Power: A history of the use of social science in American industry.* Middletown, Connecticut. Wesleyan University Press.

Bauman, Z. (2004) *Work, Consumerism and the new poor* (Second edition). Maidenhead, Berkshire, Open University.

Bhaskar, R. (1989). *Reclaiming Reality*. London, Verso.

Bourdieu, P. (1985). *Distinction: a Social Critique of the Judgement of Taste*. London, Routeledge.

Bruner, J. (2004). *Making Stories: Law, Literature, Life*. Harvard, Harvard University Press.

Burr, V. (1995). *An Introduction to Social Constructionism*. London: Routledge.

Clarke, A. (1996) *Being There: Putting Brain, Body and World back together again.* Cambridge University Press.

Cushman, P. (1995) *Constructing the Self, Constructing America.* Cambridge, Ma. Perseus Publishing.

Epstein, W. (1996) *The Illusion of Psychotherapy.* New Jersey: Transaction.

Erwin, E. (1997) *Philosophy and Psychotherapy*. London. Sage.

Fish, V. (1993). Poststructuralism in family therapy: Interrogating the conversational mode. *Journal of Marital and Family Therapy*, 19, 3, 221-232.

Furedi, F. (2004). *Where Have all the Intellectuals Gone?: Confronting 21st Century Philistinism*. London, Continuum.

Gergen, K. (1999). *An Invitation to Social Construction.* London: Sage.

Hare-Mustin, R.T. & Marecek, J. (1997). Abnormal and Clinical Psychology: The Politics of Madness. In Fox, D. & Prilleltensky, I. *Critical Psychology: An Introduction.* London: Sage.

Langer, S. (1951) *Philosophy in a New Key*. New York. New American Library

Lyng, S. and D. D. Franks (2002) *Sociology and the Real World*. Maryland, Rowan and Littlefield.

Moloney, P., & Kelly, P. (2003). Beck never lived in Birmingham: Why cognitive behaviour therapy (CBT) may be a less useful treatment for psychological distress than is often supposed. *Journal of Critical Psychology, Counselling and Psychotherapy*, **3**, 214-229.

Nightingale, D. and J. Cromby (1999) (Editors) *Social Constructionist Psychology: A Critical Analysis of theory and Practice*. Buckinghamshire, Open University.

O'hara, M. (2006). Vital Statistics. *The Guardian*. Society Section. February 8th 2006.

Parmee, D., Ed. (2003). Chamfort: *Reflections on Life, Love and Society*. London, Short Books.

Payne, M. (2000). *Narrative Therapy*. London, Sage.

Pilgrim, D. (1997). *Psychotherapy and Society.* London, Sage.

Radley, A. (2004). Suffering. In, M. Murray. (Editor) *Critical Health Psychology.* London, Palgrave.

Sayer, A. (2005). *The Moral Significance of Class*. Cambridge, Cambridge University Press.

Schmidt, J. (2000). *Disciplined Minds: A Critcal Look at Salaried Professionals and the Soul-Battering System that Shapes their Lives*. New York, Rownan and Littlefield.

Smail, D. (1978). *Psychotherapy: A Personal Approach.* London, Dent.

Smail, D. (1993). *The Origins of Unhappiness: A new understanding of personal distress*. London, Harper Collins.

Van Deurzen, e. (1998). *Passion and Paradox in Psychotherapy*. London, Johnathon Wiley.

White, M. & Epston, D. (1990) *Narrative Means to Therapeutic Ends.* New York. Norton.

Wilkinson, R. (1996). *Unhealthy Societies: The Afflictions of Inequality*. London, Routledge.

Wilkinson, R. (2005). *The Impact of Inequality: How to make sick societies healthier.* London, Routledge.

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[2481 words]

Reconstructing the Person

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So far in this special issue, we've suggested in various ways that cognition and it's alternatives, narrative and discourse, are not primary in human experience. But what is?

Feeling Bodies

The moment by moment flow of our experience consists, before it consists of anything else, of a flow of embodied sensations or *feelings*. In neural terms, this is the fundamental fabric of consciousness: deprive the brain of all physical feedback from the body, and consciousness also disappears (Damasio, 1999). The body-brain system that enables consciousness provides it, whilst we are awake, with a constant flow of feelings from our viscera, muscles, joints, and skin. These get fluidly interwoven with other feelings, generated on the one hand as part of our emotional responses to stimuli, and on the other as elements of our memories for previous events.

So feelings are not just emotions. They include emotions, but they also include a far wider class of experiences. Being hungry, thirsty or tired are feelings but not emotions, as are being gripped by sexual desire or pain. And there are other half-recognised, inarticulate feelings, that arise fleetingly in social interaction and which lead us afterwards to say things like "well, it just *felt* wrong". And although they are embodied experiences, feelings are nevertheless thoroughly socialised: evidence for this comes from neuroscience (Damasio, 1994); anthropology (Shweder, 2004); sociology and social theory (Bourdieu, 1977; Charlesworth, 1999; Elias, 1978) ; and psychology (Benson, 2001; Ginsburg & Harrington, 1996; Ratner, 2000; Shotter, 1993).

Feelings, then, are the core stuff of our psychological being. Because their source is twofold, their character and meaning bears two kinds of influence. On the one hand they are biological, generated from information gathered by the body-brain system to support the process of homeodynamics. And on the other they are enculturated, or socialised: they are the extra-verbal, non-pictorial, bodily component of elements of prior learning and of memory. Moreover, these two sources, the

biological and the social, remain neither separate nor distinct. They interact sensitively and profoundly through the early years of infancy, when important brain systems and structures are still maturing and hormonal-physiological equilibriums are being established, and continue to do so throughout life (see Gerhardt, 2004).

So to be a person is first and foremost to be a feeling body. The feelings that constitute subjectivity give us a constant, "automatic" sense of our bodies: we don't have to *decide* whether the chair we sit in is comfortable, we just *know*. They bias us toward goals, depending on material influences such as bodily state (hunger biases us towards eating), elements of previous history (a situation that felt bad previously is one we might more readily avoid in the future), and broad patterns of socialisation (people tend to do the things that "feel right" for them, based upon acquired subcultural norms). Feelings also direct our attention, making some objects appear more pertinent and others recede into the background.

Because social and material feelings primordially constitute experience, their influence is continuous. Even when we imagine that we are simply being 'rational', the very *form* of our rationality will, in all probability, be one that feels appropriate to the current situation (and if not, we will be uncomfortably aware of this). Feelings are not cognitive, in the usual sense of that word: they are not simply information about body and self that enters some kind of decision making model. Rather, feelings are the pre-cognitive, unreflective ground upon which information processing, 'rational' choosing and decision making occur. It is not that feelings cannot be taken as information: we can, for example, recognise that we feel tired and make deliberate efforts to compensate. But whether we recognise their influence or not, feelings are *always* present: shaping our goals, biasing our evaluations, and guiding our attention.

Feelings, language and inner speech

Many will be surprised by this analysis since it is often assumed that language, in the form of *inner speech*, is the primary element of subjective experience. Vygotsky (1962) is often credited with being the first to theorise this, showing how the contents of inner speech are acquired in social interaction. Things said to us during these interactions are first rehearsed aloud (outer or "egocentric" speech, as Piaget called it) before later being spoken wordlessly as inner speech. The claim that socialised, embodied feelings constitute the core of subjectivity is not a denial of the experience

of inner speech. The point is that inner speech typically comes *afterwards*, and is not the primary force shaping our activity.

Evidence for the secondary role of inner speech is suggested by work with split-brain patients (Gazzaniga et al., 1996); by studies of people with anasognosia (where impairment consequent upon brain injuries is not recognised or even denied) (Damasio, 1999), and by other, rarer neurological conditions. Drawing on this and other evidence (including extensive experimental findings), renegade cognitive psychologists like Zajonc have also argued for versions of affective primacy, as have most psychodynamic theorists. A similar conclusion may be suggested by empirical studies of discourse which show that what people say is situated and occasioned in orientation to their current social situation, rather than being the simple expression of an "inner" decision-making process (Edwards & Potter, 1992). Such evidence suggests that there is a kind of primacy to feelings, and that inner speech functions to make sense of them, relate them to things that are going on: to *fix* them, if you will, such that we can represent them to ourselves and *know*, in a thoroughly human sense, what our feelings mean. Through inner speech we make sense of our feelings, and because what we tend to remember of situations is the sense we made of them inner speech can appear primary. But the appearance is illusory: as Vygotsky himself theorised, inner speech functions to *complete* feelings, which always come first. This does not mean that inner speech has no influence, since clearly it does. We can, indeed, consciously choose to do one thing rather than another: not to have that extra cream cake, for example. But when inner speech guides our actions in these ways it does so by calling out further, alternate states of feeling. Indeed, the everyday phrase we use to reference such moments – "talk ourselves into…" – already suggests the secondary role that language typically has.

So things that happen evoke feelings, which we name with inner speech. This inner speech can call out more feelings, which in turn may incite further commentary or reflection. There is a constant iteration between socialised feelings and socially-derived inner speech, a dialectical relationship, a ceaseless flux of fluid movement from one to the other. But because language is representational in ways that feelings are not, our introspection and memories tend to emphasise the *words* that became relevant to our state of being rather than the nameless feelings that preceded them. Words (our own, or other people's) can call out states of feeling, and they can to some extent *guide* or *channel* feelings we already have so that we act upon them, or relate to

them, in one way rather than another - and again, when it fulfils this role we easily imagine that language *made us do* what we did. In these ways language and inner speech are hugely significant in our experience of being a person, so significant that they can appear primary in our experience. But the real primacy lies with feelings.

Making it up as we go along?

At least since Spinoza, thinkers have recognised that feelings resist conscious efforts to change them. Since one of their key functions is to imbue subjectivity with a character appropriate to the material and social conditions we occupy, this may not be surprising. Feelings are how our primordial being-in-the-world is disclosed: both as habitual embodied intentional stances (which psychologists usually refer to using such constructs as "beliefs"), and also momentarily, in the here-and-now, in our immediate, pre-cognitive responses to things that happen, the events that occur and the situations we encounter.

However, this is not to say that socialised feelings simply and unproblematically locate us in our worlds, since our fully human sense of our selves only emerges from their dialectical interaction with language (relationally, and as inner speech). But the fundamentally non-verbal character of feelings problematises their direct translation into words; moreover, the actual sources of our feelings are sometimes mysterious to us. So although feelings influence the trajectory of inner speech they do not wholly determine it. For example, if we fail to notice or recognise what prompted a particular feeling, our interpretation of it may be incorrect. Moreover, we often have good reason to disavow our feelings: to keep us going to a job we dislike, to avoid hurt to someone we care for, to protect ourselves against understandings too difficult or painful to contemplate. In these ways inner speech imbues our experience with a realm of ideality that can be both protective and harmful. In some situations, too, feelings may be mixed, vacillating or confused, further problematising their interpretation. Scheff (2003) proposes that the mixture of fear and shame is especially toxic, for example, and possibly productive not only of erroneous interpretations but also of aggressive or even violent behaviour.

As a result, the view from the fleeting point of "rational" reflection that is "I" is always somewhat limited. Introspection is in any case not a natural ability, but rather a mode of culturally plausible commentary on the reasons for our own behaviour that, like other metacognitive abilities, we develop through interaction with

others (King-Spooner, 1990). Compounding this, there are often too many influences making up our present for us to be cognisant of them all without getting hopelessly lost in reflection. Moreover, much of what we feel is driven by immediate situational, environmental or social structural factors, or subtended by neural mechanisms that operate outside of conscious awareness. The sources of other feelings are chronologically distant, or otherwise hard to identify – for example because it is in our immediate interest to ignore them, or because they are the outcome of social forces that remain mysterious to most of us (Smail, 2005).

Consequently, we are in important ways making it up as we go along. We are, in fact, making our *selves* up as we go along, spinning out narrative constructions to fix our experiences, to render them coherent, sensible, morally acceptable, and rationally accountable to ourselves and others, according to prevailing subcultural norms. Nevertheless, our selves are not just socially constructed in discourse. They are socially *co-constituted* - in language and discourse, to be sure, but also, and much more fundamentally, in the embodied, material, socially situated flow of our being in the world. In this way, we are *being made up* by the experiences our narratives strive to fix, and this making up is more important and powerful than the retrospective ordering that mere narrative provides.

Inevitably, then, selfhood is a somewhat fragile achievement. Those whose early parenting was insufficient to protect them from the hardships they encountered already know this, to the very core of their being. Where parenting is more adequate, however, and where the acquired internal dynamic (of feeling and inner speech) continues to resonate in broad consonance with the social and material conditions that shaped it, the self may garner the illusion of solidity and permanence. But when power causes social and material conditions to change, and particularly when those changes are sudden, large and uncontrolled, this apparent stability may be revealed for the sensitive interdependence it actually is. In such ways, states of distress are produced.

References

Benson, C. (2001). *The Cultural Psychology of Self: place, morality and art in human worlds*. London: Routledge.

Bourdieu, P. (1977). *Outline of a Theory of Practice*. Cambridge: Cambridge University Press.

Charlesworth, S. (1999). *A Phenomenology of working class experience*. Cambridge: Cambridge University Press.

Damasio, A. R. (1994). *Descartes Error: emotion, reason and the human brain*. London: Picador.

Damasio, A. R. (1999). *The Feeling of What Happens: body, emotion and the making of consciousness*. London: William Heinemann.

Edwards, D., & Potter, J. (1992). *Discursive Psychology*. London: Sage Publications.

Elias, N. (1978). *The History of Manners: the civilising process volume 1*. Oxford: Basil Blackwell.

Gazzaniga, M. S., Eliassen, J., Nisenson, L., Wessinger, M., Fendrich, R., & Baynes, K. (1996). Collaboration between the hemispheres of a callosotomy patient: emerging right-hemisphere speech and the left hemisphere interpreter. *Brain and Cognition, 119*, 1255-1262.

Gerhardt, S. (2004). *Why Love Matters: how affection shapes a baby's brain*. Hove: Brunner-Routledge.

Ginsburg, G. P., & Harrington, M. E. (1996). Bodily states and context in situated lines of action. In R. Harre & W. G. Parrott (Eds.), *The Emotions: social, cultural and biological dimensions* (pp. 229-258). London: Sage Publications.

King-Spooner, S. (1990). The Fictional Nature of Introspection. *BPS Psychotherapy Section Newsletter, 8*, 19-29.

Ratner, C. (2000). A cultural-psychological analysis of emotions. *Culture and Psychology, 6*, 5-39.

Scheff, T. (2003). Male emotions/relations and violence: a case study. *Human Relations, 56*(6), 727-749.

Shotter, J. (1993). *Cultural Politics of Everyday Life*. Buckingham: Open University Press.

Shweder, R. A. (2004). Deconstructing the emotions for the sake of comparative research. In A. Manstead, N. Frijda & A. Fischer (Eds.), *Feelings and Emotions: the Amsterdam Symposium*. Cambridge: Cambridge University Press.

Smail, D. J. (2005). *Power, Interest and Psychology: elements of a social materialist understanding of distress*. Ross-On-Wye: PCCS Books.

Vygotsky, L. S. (1962). *Thought and Language* (E. Hanfmann & G. Vakar, Trans.). Cambridge, Mass.: M.I.T. Press.

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[2244 words]

Implications for Practice

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Clinical Psychology Forum 162, 17-20

In the 1970s British clinical psychology took a calculated turn to make our role as scientists secondary to our role as practitioners. There can be little doubt that this led quickly to substantial gains both financially and in terms of our professional independence from psychiatry. It also, however, locked us into a set of assumptions about the nature of our practice that reflected our interests far more than it did a valid scientific appraisal of our subject matter—i.e., psychological distress. It is mainly with these assumptions that we are concerned in the Special Issue. For in following—however unwittingly—our interest in justifying our role as practitioners of psychological therapies, clinical and counselling psychologists have been led to overlook, if not actively ignore, the difficulties and contradictions such a role leads to.

It is important to add, however, that our critique does not apply equally to the whole range of clinical psychological activities. What concerns us in particular is what is probably seen, and taught, as the core role of clinical, as well as counselling, psychology, i.e., face-to-face interaction with distressed individuals (and to a lesser extent groups), which has led in particular to our adherence to cognitive behaviourism as our orientation-of-choice. There are of course many psychologists who do not work focally within this kind of setting, particularly those working with children and families, older people and people with learning and other disabilities. For these latter groups the importance of both environment and embodiment are harder to underplay and so they are less likely to find themselves entangled in the practical and theoretical problems we have sought to highlight.

In summary, the essence of our critique is as follows:-

- Clinical theorizing focuses too much on what (supposedly) goes on inside clients' heads. This means, specifically, that crucial factors of embodiment as well as social structure and context are left out of the accounts we give of clients' difficulties.
- 'Postmodernist' approaches such as discourse analysis, narrative therapy, etc., do not escape the difficulties arising out of this disembodiment and dissociation of clients.

- Rational, conscious thought plays a much smaller role in the generation of conduct than is conceived in humanistic, dynamic and cognitivist approaches.
- Introspection is not the key to agency, and will-power not the engine of change.
- Subjective experience and, most importantly, distress, depend at least as much on encultured, embodied feelings as they do on the private rehearsal of language.
- Evidence for the effectiveness of psychological therapies is far weaker than can be considered acceptable.
- Largely to avoid these difficulties and complications, clinical psychology has tended to opt for dogma rather than truth and, correspondingly, replace learning with initiation.
- There tends thus to be a mismatch between training and experience, taught theory and actual practice, leading to the uncritical acquisition of 'skills' that bear little relation to anything in the real world.

It is probably no longer realistic to think that, even if any of us wanted to, we could return to a purely scientific role in which we would be afforded the luxury of research and reflection unsullied by the ideological priorities of our paymasters and the expectations of clients. At the present time, indeed, the pressures and inducements are on clinical psychologists to become more, not less involved in intervening in the lives of their clients—witness the recent debate concerning our prospective role as 'clinical supervisors' (e.g. Diamond et al., 2005; Pilgrim, 2005). If, therefore, our critique is to take constructive account of our professional interest, we need to suggest ways in which we might repair the integrity of the practice of clinical psychology without rendering it simply untenable.

Recognizing our limits

Over-investment in professionalized, technique-based practice cuts both clients and practitioners out of a reality structured both biologically and socially, and so tends to foster a belief in psychological magic. This means that we tend to panic and to fear loss of credibility when such social and biological constraints re-appear as obstacles to the effectiveness of our procedures. If we can't solve the problems presented to us, what use are we and what right have we to continue to practice? However,

acknowledgement that we are not magicians should in the longer term prove more to our advantage than our downfall, and certainly it is our experience that clients tend to find a realistic assessment of their options—i.e. one that takes account of the limits imposed on their freedom of action both by the social environment and their nature as physical beings—more reassuring than threatening. A clinical account of what people can and cannot achieve is likely to be more productive if based on an assessment of the powers and resources available to them than one which focuses more or less exclusively on the contents of their heads (Hagan and Smail 1997; Smail 2005). This means, of course, that there will be many occasions when provision of significant help is beyond our own possibilities; we need to recognize that there is no shame in that, as well, perhaps, as spend more time establishing exactly what *are* the limits of our competence.

Outsight rather than insight

Psychological therapies have assumed the importance of *insight* for so long and so uncritically that we have tended to overlook the distinct possibility that *outsight* may be at least as valuable when it comes to someone gaining an understanding of their predicament. And *understanding*, after all, is perhaps one of the principal benefits that psychological help has to offer. In this respect outsight, or demystification, while it may lead to a more realistic view than 'therapy' of what someone can or cannot do to alleviate their situation, also relieves them of much of the burden of guilt and inadequacy that therapeutic approaches so often impose, if only tacitly. 'Therapy' thus becomes a matter of considering whether there are things that the client can do, or that can be done in his/her immediate environment, that might make a difference. If, as may too often be the case, there is very little that can be done, at least the client does not have to bear the responsibility for circumstances beyond his/her (and possibly anybody's) control.

Including society

The development of outsight is more or less synonymous with taking account, both theoretically and practically, of the role of social factors in the generation of distress. Traditional individual therapies have done this only at the most proximal level—that of clients' families—and then only insofar as family relations figured in the accounts clients gave. When it comes to more distal—and potentially much more potent—social influences, it is perfectly possible that both client and therapist have no knowledge of what they are, and furthermore, within the limited context of the consulting room, no way of reliably exploring and addressing them The development of community psychology has of course followed on the recognition by clinical psychologists that not only is useful understanding dependent on taking a much wider view than was customary of clients' difficulties, but also that effective intervention will necessitate involving people and structures well beyond the family (Bostock and Diamond, 2005). In our view this is a very important development for clinical psychology, but as yet the conceptual tools available to us from conventional training, deriving as they have from individualistic and introspectionist viewpoints, are hardly up to the job (see Smail, 2005, for an elaboration of these issues).

Depsychologization

This inelegant term is meant to suggest that psychology does not have to depend for its *raison d'être* on a conceptual vocabulary that places the reasons for what we do inside individual heads (e.g. as 'complexes', impulses', 'beliefs' 'cognitions', etc.). It is not meant to suggest that psychology itself, as an enterprise or a practice, is necessarily invalid, but that it may well become so if it tears the person out of a social context as well as a state of embodiment—if, that is to say, it persists in treating people as *dissociated* as well as *disembodied.* What gives clinical psychology its legitimacy as a discipline is not an adherence to psychologizing concepts and language, but its fundamental concern with personal *subjectivity*, i.e. with how people experience themselves and their world, how they feel and, in particular, suffer. While these factors can obviously be thought of as in a sense as *interior*, an understanding and explanation of how they are produced points us, for the most part, *outside* the person.

The concept of 'empowerment' provides a good example of how a perfectly valid notion can, and indeed in therapeutic discourse frequently has, become psychologized. The availability or otherwise of power to individuals, groups and institutions within the social structure is absolutely crucial to their functioning and to our understanding of how influence and change come about. But this is *real* power: means of influence and persuasion that are actually available to people in extremely varied amounts. Too often, however, psychological therapies conceive of 'empowerment' as a psychological acquisition, i.e. something people *feel* or *believe* they have: a 'sense of' power that need bear no relation to any material social phenomenon. Similar difficulties exist with notions such as 'self-esteem', 'inadequacy', etc., that may be posited as purely psychological characteristics rather than actual, embodied states that have been acquired within a real social context.

Politics

Taking account of such issues as these leads almost inevitably to the realization that a great deal of the psychological and emotional distress to which we are vulnerable has its origins in the way society is organized and in whose interest social power is distributed. How to organize society is, however, not the professional concern of clinical psychologists, but of politicians and the citizens they represent. It may well be difficult for some of those whose work immerses them in the everyday misery our society gives rise to not to develop a political critique of that society and indeed to

become politically active within it. At the same time, however, it is important to bear in mind the kind of reservations expressed by Ivan Illich about 'disabling professions' (Illich 1977) in his book of that title—now seemingly conveniently forgotten by those to whom it is most relevant. The kind of dangers Illich underlined can readily be discerned in our own field—see, for example, Prilleltensky and Nelson's *Doing Psychology Critically* (2002), which is an egregious example of how professional interest can (all unawares, to be sure) expropriate the citizen's political role. In this way, community psychology needs to support and encourage people's activism without seeking to take it over.

The future

Perhaps the greatest danger facing us is that, in accordance with modern business philosophy, we become 'Taylorised' – i.e. reduced to being production-line workers who deliver packages of treatment in accordance with centrally (managerially) authorized notions of what constitutes an 'evidence base' for our practice. This certainly, is the direction advocated most enthusiastically by Richard Layard (2004; 2005) and endorsed by prominent members of the profession (Roth and Stirling 2005; Turpin 2006).

It may be arguable that the role of 'scientist-practitioner' was, in recent times anyway, more rhetorical than actual, but at least it contained an implication that knowledge is something more than an off-the-shelf product to be supplied in controlled doses to operatives. Knowledge, in fact, is something that is made and tested as we go along. Finding out *with* our clients what their difficulties are and how they came about is at least as important as feeling that we have to solve them—indeed the 'therapeutic relationship' has probably had far more value as a site of collaborative investigation into what the world does to people than it has as a vehicle of 'treatment'. What makes clinical psychology truly distinctive (still, just) is that its practice is inseparable from open, informed, intellectually and empirically disciplined enquiry. No one can say exactly where that might lead, but the general direction will almost certainly be out into the social and material world.

References

Bostock, J. & Diamond, B. 2005. The value of community psychology: critical reflections from the NHS. *Clinical Psychology Forum*, 153, 22-25.

Diamond, B., Holmes, G., Hanna, J., Harper, D. & Rufus, M. 2005. Letters. *Clinical Psychology*

Forum, No 153, September, pp 3-5.

Hagan, T. & Smail, D. (1997) Power-mapping - I. Background and basic methodology. *Journal of*

Community and Applied Social Psychology, **7**, 257-267.

Illich, I. 1977. *Disabling Professions*. London: Marion Boyars.

Layard, R. 2004. Mental health: Britain's biggest social problem? Retrievable from:

http://www.strategy.gov.uk/downloads/files/mh_layard.pdf

Layard, R. 2005. Therapy for all on the NHS. Sainsbury Centre Lecture retrievable from:

http://www.scmh.org.uk/

Pilgrim, D. 2005. A case for psychologists becoming clinical supervisors. *Clinical Psychology*

Forum, No 155, November, pp 4-7.

Prilleltensky, I. & Nelson, G. (2002) *Doing Psychology Critically. Making a Difference in Diverse*

Settings. Basingstoke & New York: Palgrave Macmillan.

Roth, T. & Stirling, P. 2005. Expanding the availability of psychological therapy. *Clinical*

Psychology Forum, no.155 (November), 47-50.

Smail, D. 2005. *Power, Interest and Psychology. Elements of a Social Materialist Understanding*

of Distress. Ross-on-Wye: PCCS Books.

Turpin, G. 2006. Responding to Lord Layard. *The Psychologist*, **19**, no. 1 (January), 12.

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