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From Anti-Psychiatry to Critical Psychology

Rachel Cox, clinical psychologist, Shropshire County Primary Care Trust, UK and **Paul Kelly**, clinical psychologist, South Birmingham Mental Health NHS Trust, UK.

This paper presents reflections on how interests in anti-psychiatry changed into a critical psychology stance during clinical psychology training.

In September 1996, the authors of this paper met on the first day of our training course to become clinical psychologists. The current paper represents our reflections on how our interests in the field of anti-psychiatry during training led us into an emerging field of investigation that has become known as critical psychology.

We both entered clinical training with an interest in the work of critics of the psychiatric establishment (e.g., Breggin, 1993; Johnson, 2000; Smail, 1993; Szasz, 1974; 1987). Our interest in these writings had been influenced by our experiences of working within the psychiatric system. We had both witnessed many of the ways in which people were damaged by the practices of psychiatry, yet this was rarely recognised or acknowledged. We would like to make clear that we are not suggesting that individuals who work within the psychiatric system are inherently 'bad' but, rather, that dominant ideas and discourses which are prominent within these systems can often work to blind us to the damage that our actions can cause. However, we both believed that by becoming clinical psychologists we were entering a profession that would encourage us to challenge such ideas and practices through the promotion of critical reflection both on the psychiatric system and on the role of clinical psychology within this system.

During the first two years of clinical training it became clear that the primary role of a trainee psychologist was to absorb 'factual' information, which was supplied by people who were already deemed to be 'experts' in human distress. We were not, however, encouraged to reflect on whether this information was worthy of assimilation. In such an environment of apathy it was tempting to be drawn into a non-critical, non-reflective, mentality.

The anti-psychiatry placement

An oasis in the wilderness of apathy appeared to emerge in the form of the anti-psychiatry placement, with the offer of space for both reading and critically reflecting on the psychiatric system. This placement is offered to third year trainees and at the time was the only placement of its kind in the UK. The anti-psychiatry placement has already been described in some detail (Newnes and MacLachlan, 1996; Newnes, Hagan and Cox, 2000). However, there are two main aspects of the placement that we would like to reflect on. First, the emphasis placed on user views and alternatives to 'the system'. Secondly, we will discuss changes in our thinking, which reflected a transition from the ideology of traditional anti-psychiatry to that of critical psychology (e.g., Fox and

Prilleltensky, 1997; Sloan, 2000). These changes in our thinking began during the anti-psychiatry placement and have continued to evolve and influence our practice since qualifying as clinical psychologists.

User views and alternatives to ‘the system’

An important part of the placement was the opportunity to become members of the Patients’ Council at Shelton Psychiatric Hospital. This is a user led group based within the hospital with the role of visiting inpatients on the wards and encouraging them to anonymously express their views about their time in hospital. As people who were about to enter a profession which perceives itself and is perceived in society as having power and expertise, the experience of leaving that identity and power behind, and walking on to a psychiatric ward as a visitor, was both humbling and inspiring. We recall the first few visits with experienced Patients’ Council visitors (many of whom were ex-patients) and remember the discomfort of being watched by staff with suspicion, and the feelings of powerlessness as we listened to the stories of the patients. We recall the genuine care and support offered by the Patients’ Council members who also shared their stories and took care of us, a touching paradox. We came to see that the care, support and empathy provided by these few visitors (some of whom had to fight their own fears to even walk onto the wards) was more therapeutic than much of what was being offered by ‘the system’. Perhaps one of the most important aspects of our time with the Patients’ Council was the experience of being able to relate to those who use the system as people rather than as clients. This enabled members of the Patients’ Council to openly offer their criticisms, not only of psychiatry but also of clinical psychology and its place in the mental health system. In addition to our experience with the Patients’ Council we became aware of and in touch with other groups of ex-users and system survivors who were campaigning for their rights within the psychiatric system and society at large. We also had the opportunity to see the work of a few of the projects providing alternative places of true asylum outside of the system (see Jenkinson, 1999).

Reflections on clinical psychology

These experiences (especially of the Patients’ Council) promoted reflection on our position as professionals within the mental health system and we also began to reflect on the position held by clinical psychology in the system of abuses we were witnessing. We acknowledge that clinical psychologists have provided useful critiques of harmful psychiatric practices. However, we would argue that in sharing the same underlying philosophical basis as psychiatry, clinical psychology is not an innocuous bystander in a system that often inadvertently harms rather than helps. Psychiatry and clinical psychology are both based on modernist notions of the self, which suggest that individuals can be studied and understood apart from context, culture and history (Gergen, 1999). Once separated from context, culture and history, the modern ‘self’ can then be constructed within discourses of ‘normality’ and subjected to technologies of change without any challenge to the status quo. This allows both psychiatry and psychology to pay lip service to the social and ideological origins of distress, while ignoring the political implications of this by emphasising theories and interventions that are individualistic in nature. The seemingly different positions of psychiatry and clinical psychology become increasingly spurious when one recognises that conceptually there is

little difference between ideas of faulty chemicals (psychiatry), faulty thinking (CBT) and faulty personality (psychodynamic therapy). These therapies require changes to occur within the person (e.g. medication, ECT, cognitive therapy, psychodynamic psychotherapy) or their immediate family (e.g. family therapy) to restore the individual to 'normality', rather than offering any challenge to both the social and ideological conditions that give rise to such distress. Furthermore, psychology and psychiatry fail to recognise how they contribute to and support the maintenance of the very status quo that gives rise to oppression and distress. For example, clinical psychology has followed mainstream psychology's emphasis on individualism and in doing so has de-emphasised 'values related to mutuality, connectedness and a psychological sense of community' (Fox and Prilleltensky, 1997, p.9). It is clear that the emphasis on individualism both reflects and supports ideas within a modern capitalist culture. However, psychology locates itself within a scientist-practitioner discourse that allows it to suggest that the notion of the individual self is an objective truth rather than a cultural construction. We would argue that this is because the success of the social institutions of psychiatry and psychology rely on the continuation of inequality and oppression within society, which are supported by the fragmentation and individualisation of modern Western society. Arguably, the role of such professions is to prevent alternative ways of looking at distress, oppression and inequality and therefore to maintain the interests of the powerful in the status quo.

Clinical psychology does not appear to reflect on how it stands side by side with psychiatry around these issues. This was illustrated in a recent BPS publication (*'Recent advances in understanding mental illness and psychotic experiences'*, Cooke and Kinderman, 2000). While this document offers a useful critique of the psychiatric system, it fails to reflect on clinical psychology's position within it. It draws attention to the idea that mental distress is often related to stressful environmental factors such as poverty, racism, etc. A logical conclusion to this would be to emphasise the importance of addressing these inequalities as a means to both dealing with and preventing such distress. However, the paper goes on to promote the use of individual therapeutic interventions such as CBT while failing to discuss the underlying modernist philosophical basis of this therapeutic approach, which internalises and de-contextualises the solutions to experiences that are labelled as 'psychotic'.

Conclusions

Arguably, such elements of clinical psychology training as the anti psychiatry placement could evolve to encourage more critical and self-reflexive practice. We would argue that such reflexive practice is not only important but is essential for clinical psychology to be classified as 'helpful'. Ultimately our journey has led us to question the way in which clinical psychology and other mental health professionals locate the source of distress within individuals. We would argue that in order to become a truly helping profession clinical psychology needs to turn its gaze outwards and begin to examine the social and political/ ideological conditions that give rise to distress. A result of this could be that psychology would become political and therefore become an agent for social

change/justice rather than social control. However, we can't help wondering whether this would be akin to a high-powered business executive going on an anti-capitalist march!

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