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Psychology and psychotherapy's potential for countering the medicalization of everything

Craig Newnes

This paper examines the ways in which the professions of clinical psychology and psychotherapy have adopted the powerful discourses of eugenics and medicine. In so doing they have acted in ways which oppress rather than liberate those who require their services. The paper suggests that through emphasising connectedness with clients rather than difference from them these professions might act in a more liberatory way. Some pointers for the future are presented.

Once upon a time I had the answers. Not alone you understand. Even I wasn't that arrogant. No, these answers were provided by my background in psychotherapy and clinical psychology. And the questions? How do you cure schizophrenia? What do depressed people most need? How can you know if someone is dementing rather than depressed? At the centre of all this was my antipathy to the establishment, to institutions, to the medical hegemony of psychiatry. Then something changed. I slowly (and painfully) understood that my profession had few answers, was as corruptible and power-obsessed as psychiatrists could be, and, worse still, had singularly failed, in circumstances almost too good to be true, to provide a real alternative to the diagnostic and treatment excesses of traditional psychiatric practice. Indeed, it gradually dawned on me that it was psychiatry itself, rather than clinical psychology, which had done most to say something about the need for relationships rather than treatment, criticism rather than collusion, and modesty rather than self-congratulation. Many of the most inspirational psychotherapists had been

psychiatrists and most of the worst kinds of psychotherapy had been promulgated by psychologists.

This paper explores the failure and occasional successes of clinical psychology and psychotherapy in their efforts to say something different about the human condition and the ways in which we might help people survive. It asks if it is too late to save clinical psychology and psychotherapy from the pseudo-medical backwater down which they have travelled.

I want to address the part psychology and psychotherapy have played in causing distress; their position as accomplices rather than critics of the psychiatric system and society; and our potential for relieving the plight of oppressed people.

What went wrong? Psychology and psychotherapy were meant to be the link between the ontological question (to be answered by medicine) and the existential question (to be answered by religion). Paul Tillich saw this as psychology's role: medicine couldn't give meaning to our lives and religion couldn't tell us how we had come to the state we were in. Sadly, neither could clinical psychology. Of course psychologists practising psychotherapy could reasonably claim to be addressing both questions, but psychotherapy was not an offshoot of clinical psychology.

Psychotherapy not only predates clinical psychology by three hundred years or so starting with the Lutheran "cure of souls" (Szasz, 1978), but the major theoreticians in psychotherapy have been psychiatrists. Phil Mollon (1989) is not alone in claiming psychotherapy a medical discipline. The problem for clinical psychology is that its parent discipline, psychology, claimed from the outset to be a science. It wasn't permitted to recognise a soul, let alone cure it.

Our position relative to medicine is important. Goldie (1977) suggests that non-medical professions can take three positions in relation to medicine, in this case psychiatry: compliance, eclecticism and radical opposition.

Much of the damage caused by psychotherapy and psychology stems from our unwillingness to reduce compliance and eclecticism in favour of opposition.

Our history might tell us something of why this might be the case. Academic psychology and clinical psychology have their roots in the eugenics movement of the early 20th century. The founding fathers, Spearman, Pearson, Burt and Merrill were all eugenicists. In his introduction to the manual for the Terman-Merrill Intelligence Test, Terman (1916) writes:

Dullness seems to be racial, or at least inherent in family stocks. There will be discovered enormously significant differences in general intelligence, differences that cannot be wiped out by any scheme of mental culture.

He goes on to recommend sterilisation. In 1924 he enthusiastically declared that:

Psychologists and their IQ tests are the beacon light of the eugenics movement.

This eugenic tradition was not limited to statisticians and IQ experts. As recently as 1994 Ray Cattell, progenitor of the 16PF Personality Inventory said:

Hitler actually shared many values of the average American. He aimed at full employment, family values and raising the standard of living, and countless other things, including the Volkswagen, which he designed himself for the average family. (Cattell, 1994, p. 2)

Writing on *Beyondism*, the eugenics movement he founded, Cattell claimed:

...the vast majority of humans on the planet are 'obsolete' and... the earth will be choked with the more primitive forerunners unless a way is found to eliminate themClarity of discussion...would be greatly aided if genocide were reserved for a literal killing off of all living members of a people...and euthanasia for what has been above called 'phasing out', in which a moribund culture is ended, by educational and birth control measures... (Cattell, 1972, p. 220)

This ideological backdrop prepared psychology well as the producers of psychometric tests aimed at identifying fault, failure and degeneration when compared to the white, educated male norm. It is a tradition that allowed psychologists to help psychiatrists as they legitimised their own practice via the adoption of a vast diagnostic system that soon incorporated virtually all human conduct, enabling them to classify people and claim that deviance was rooted in genetics and biology.

As psychologists moved into a phase of eclecticism, joining with psychotherapists in their attempts to change people, they maintained this psychiatric nomenclature and did little to challenge either its validity or reliability (with some notable exceptions: see Marshall, 1990). Practitioners who retained the idea that people were inherently flawed, to be repaired by psychology and psychotherapy, didn't dispute the diagnostic system. From even a cursory glance at the literature it seems that we are pretty much in this same state today. The best-selling *What Works for Whom?* (Roth & Fonagy, 1996) is marked by its use of psychiatric diagnostic categories in its trawl through the literature to discover which approaches work best for people's distress; distress which is redefined as conditions. This has been an enormously useful position for psychology and psychotherapy, enabling us to take our market share without upsetting the medical hierarchy too much or betraying those eugenic academic roots.

We contribute to distress, and become part of the problem through a use of language that obscures what is going on in people's real lives. We talk

of anxiety, not fear, depression not misery, ego strength, projective identification, graded exposure, collaborative empiricism and so on. The new holy grail of British clinical psychology is formulation, which seems to mean thinking about things. And of course, we still use psychiatric diagnoses. We too easily forget that there is no validity in psychiatric diagnosis (Boyle, 2002: Kutchins & Kirk, 1999).

Attention Deficit/Hyperactivity Disorder, for example, barely existed ten years ago. Ritalin, meanwhile, had been used since the 1960s and drug companies need a niche for drugs. We now find ourselves with 80,000 British children following two million American children to psychiatric and psychological clinics for Ritalin and Adderall. There have been some critics of this expansionism, especially Peter Breggin (2001) and Steve Baldwin (2001), but again it looks suspiciously like the psy-world has jumped on the bandwagon. Even what little criticism there has been is unbearable to some. The International Consensus Statement on ADHD has been circulating since January 2002. Signed by 74 mental health specialists, including over 30 psychologists and two heads of clinical psychology training programs in the US, it attempts to bury dispute and dissent about the validity of ADHD as a legitimate disorder. Dissenters to this view are dismissed as “a handful of non-expert doctors.” It cites the leading American psychiatric and psychological bodies as supporters of the diagnosis. In an increasingly polemical style with vague references to “hundreds of scientific studies,” it asserts that people not agreeing with the position that ADHD is a legitimate, genetically determined, neurologically based condition are fringe doctors who should keep quiet. Crucially the statement claims that people suffer from ADHD through no fault of their own or their parents or teachers. We have been here before; see schizophrenia circa 1970 to the present.

Similarly, in the gathering furore in the UK about Measles Mumps Rubella (MMR) vaccine, clinical psychologists might have various roles to play, not least of which could be questioning the validity of the autism diagnosis. We have been silent. Meanwhile an MRC review on the subject

has concluded that the increase in prevalence for so called autistic spectrum disorders is due, in part, to changes in case definition, a fact of life for autism since Kanner first coined the term.

The role of the drug industry in all of this can't be overstated. Drug companies sponsor and control research, researchers and research journals. A British government publication, *Effective Health Care*, in reviewing the newest so-called anti-psychotic medication, concluded, "Most relevant trials are undertaken by those with clear pecuniary interest in the results." Drug industry press releases are a continuous source of easy copy for newspapers; their resources phenomenal: in the first half of 1997 the drug sales for Prozac rose 14% to \$917 million, Zoloft sales grew 12% to \$588 million and sales of Paxil, another anti-depressant, grew 46% to \$449 million (Los Angeles Times, 23 August 1997).

Psychotherapists have an unfortunate habit of pretending this doesn't matter – counselling courses don't cover psychopharmacology in much detail – but it affects our work in at least two ways: our clients are often drugged and they have already had their human problems relanguaged as medical disorders.

Labels, even medical labels, are useful, in fact inevitable. The public embrace the medical discourse at every turn. In psychology, psychiatry and psychotherapy, labelling distances us from distress and positions us as experts. Labelling might momentarily make patients feel understood; disillusionment sets in when people realise that renaming something necessarily leads neither to understanding nor change (e.g., Levy, 1992).

This positioning as expert, labelling of others and the distancing from distress is another way in which we might harm people (see for example, Honos-Webb & Leitner, 2001). It is a criticism easily applied to psychology but also one levelled at the more technological schools of psychotherapy. We detach ourselves from others at our peril, not least because the expert approach can hamper empathy and our potential for real therapeutic alliance with people, as people. Elsewhere, I have written:

We are parents, lovers, partners, children, men and women as well as psychologists. We will have loved, lost, betrayed, envied, suffered and survived. We have all used the health service. We are gendered and politicised. We will have used, or love people, who use services like the ones we offer. We may have been diagnosed. We are all oppressed. We can hurt others deeply and wish our children ill. We may have been criminals, miserable or hopelessly out of touch with what others call reality. We may be single parents or children of single parents. Our parents may be happy, divorced, adoptive or dead. Our sexuality, consumption of alcohol or use of drugs may be regarded as deviant or excessive..... We may be considered mean or may think ourselves shy. We may hear voices or believe in the risen god; may struggle in relationships or live contentedly alone. We may be moved by the doctors Dre, Faustus or Doolittle; by Prokoviev, Picasso or the Pixies and prefer Lucien to Sigmund in the Freud family. We may have been born on farms, live on council estates or in deepest suburbia. We may have learned that dishonesty and the willingness to run away are important to survival.

(Newnes, 2001, p. 8)

This kind of potential connectedness with others led Einstein to suggest that, “individuality is an illusion created by skin.” Despite this, we act as if, people are all terribly different, a function perhaps of our role in what Foucault described as the gaze, the way the clinic defines and prescribes normality. And yet, imagine your first encounter with a new client. You may have read a referral letter or an account of the client’s life from themselves or another source. There may be psychiatric case-notes available or a general medical history. You have prepared the room. Just before the client arrives you take a phone call from a distressed colleague who can’t make a meeting later that day and then you bump into someone in the corridor you hadn’t seen for ages. Slightly flustered you welcome the client, noticing immediately the scuffed, muddy shoes and the torn coat. The latter vaguely reminds you that you need to go to the Oxfam shop later and, then, from seemingly nowhere you remember that you

didn't lock your front door. Thoughts, fantasies, memories, anxieties old and new continue for the next hour. No doubt the client is experiencing something similar as they monitor what they say, how you react, what you are wearing, your age, sex, ethnicity and the mud on your carpet. They will be making guesses at your sexuality and whether you seem like you can help. They are also horribly conscious that they have left the front door unlocked. Meanwhile you are both realising that this isn't your first encounter. You are both regulars at a local pizza takeaway.

We are multiply identified. We might say that we have multiple selves. Miller Mair (1977) has discussed the idea of a community of selves and John Rowan (1990) the presence of sub-personalities. Our experience of ourselves in any given situation is not static; it is fluid and changing. The vignette includes many identities: professional, client, helper, helped, friend, the person who is eager to please, the homeowner, the potential lover, neighbour and so on. We can appear reasonably solid in our professional identity but our experience within that identity is one of constantly switching through other selves.

Our mutuality as human beings with the potential for multiple identities brings the human dimension into the counselling room, whether or not we actually know whom the client knows or have met them in a different setting.

My experience of staff counselling services has offered many opportunities to appreciate connectedness as inner worlds and the shared outer world collide. A far from comprehensive list of these opportunities might include:

- Being referred to someone you know.
- Seeing someone who identifies one of your (previous or current) actions as a part of the problem.
- Seeing someone with difficulties you share due to the same organisational changes affecting you.

- Being supervised by someone whom your client has identified as part of the problem.

It really couldn't be clearer how important the client's external world and relationships are and how entwined we are with each other.

Staff counselling is a microcosm of the counselling and psychotherapy world. A psychoanalyst in a supermarket may not speak directly to a client at the checkout but may live in the same street as the client's brother, or sing in the same choir as the client's mom. A client may read an article about marriage guidance written by their counsellor or stating views opposite to those expressed by the counsellor in therapy. A counsellor and her client may witness a road accident: one wonders how many New Yorker therapists and clients were in session when the twin towers were struck. This kind of connectedness should not be denied, nor should our mutual experiences of distress and madness. We share the distress of our clients in a very real way. It is something of a dead end to act as if their distress is like a foreign country to us, only accessible through exploration of their inner worlds, to be ameliorated through variations on chatting. David Smail (1993) highlights the importance of comforting people and clarifying the source of their distress. Once we have done that, what then?

What can psychologists and psychotherapists do?

Far more of us need to embrace Goldie's (1977) third position: radical opposition. I believe we need to offer less of a balanced view on issues like diagnosis and the causes of distress and more of a balancing view. The vast machinery of capitalism, in league with self-interest, will always ensure more than enough voices that proclaim the need for technological solutions to change inherently flawed individuals. Only a few voices can be heard regularly challenging this view or promoting alternative understandings of distress. If I were Eli Lilly, I might be tempted to organise a conference featuring these well-known critics and then lock the

doors for ten years. It is not apparent to me that there are many people standing by as the debates go on, who would be prepared to step into the ring when needed. This is ironic in the extreme for those of us claiming some kind of scientist practitioner status for ourselves. For clinical psychologists in particular who claim to be scientists we should be constantly prepared to critique assumptions, methodology, research conclusions and so on. What appears to happen is that trainees in counselling, psychotherapy, clinical psychology and some radical therapists are rarely introduced to their political role, the forces that have shaped their chosen profession or even the possibility that they might do more harm than good. Instead training is a process of socialisation into the profession's mores and an enthusiastic presentation of the overwhelming desirability of one's calling. Of course, trainees don't experience themselves as necessarily good and helpful, but are consistently bombarded with the idea that psychological skill acquisition will sort this out. Counselling students should be exposed to more critical perspectives on their role. Staff counselling, for example, can be a band-aid, allowing the organization to appear caring while preventing real change in workers' circumstances. The cloak of confidentiality prevents counsellors discovering that people are oppressed rather than depressed. Some would go further. Baritz (1960) has argued that occupational psychology and its poor relation, counselling, have been the means by which industry learned how to control its work force. Psychology, too, has been systematically used by big business to develop means of rewarding and controlling workers just sufficiently to prevent rebellion while maximizing production. In doing so, psychology has been a significant weapon in the fight against unionism.

As part of a number of doctoral clinical psychology courses I run a one-day seminar called "Harmful Clinical Psychology." To date only one trainee cohort has said that they have experienced anything like this before, despite over two years of supposedly academically rich presentations on a plethora of therapies and numerous experiences of what appear to be less than helpful interventions, systems, supervisors

and other health professional practice. These trainees don't receive a balancing view – they get me, one voice amongst dozens promoting the party line.

Another part of my own efforts to provide a space for critical analysis of the psy-complex has been a critical clinical psychology internship established in 1994. Clinical psychology trainees critically examine the psychiatric system and clinical psychology's place within it (Newnes & MacLachlan, 1996; Newnes, Hagan & Cox, 2000) via reading, discussion, video material, research, supervision and membership of our local psychiatric hospital's patients' council. There is a thorough examination of the role that clinical psychology and psychotherapy play in the psy-complex and the policing of society (Cox & Kelly, 2002). The internship is only one aspect of local attempts to speak out about the mental health system. It is popular with trainees but an exception and can hardly be judged at all by the usual criteria. The assessor's question, "Has the trainee developed assessment, formulation, and intervention skills?" is met with the response, "Thankfully not."

Confronting and balancing the prevalent medical discourse cannot be limited to training courses. But, sadly, there are many qualified practitioners failing to speak up at case conferences or team meetings about diagnosis, medication, ECT or whatever. Individuals are unwilling to rock the medical boat, using medical terminology without apology, willingly doing assessments and writing reports that position people as different and other; relanguaging their distress as psychiatric problems no less readily than medics. This can be especially true in services for less powerful people, like children and the frail elderly, where, despite the overwhelming power imbalance, psychologists add to the chorus supporting medication and do not speak out about ECT. The British Psychological Society conference this year featured an entire Division of Clinical Psychology (DCP) seminar on *Computerised CBT for Anxiety and Depression* and another on *The Assessment and Prevalence of Personality Disorder in Primary and Secondary Care*. Despite our

academic background there are no critical presentations on either issue. It shouldn't be that difficult for more psychologists and psychotherapists to seek support in speaking out at case conferences, writing reports in ordinary English or putting on more challenging conference presentations.

In terms of the psychiatric system, clinical psychologists in Britain show all the signs of become gaolers like their psychiatric counterparts. There is considerable discussion within the profession about the desirability of clinical psychologists having "supervisor" status, and thus ability to commit people, under sections of England's new Mental Health Act (Holmes, 2002). A majority appear to want this power and an argument is brewing between the forensic and clinical divisions as to which group would be best suited to the role. The fact that many psychiatrists are all too happy to pass these responsibilities over has not alerted anyone to the possibility that this is a poison chalice. Worse, at one committee, the discussion included lobbying that we should take it on because we could then charge for home visits. Clinical psychologists need to be prepared to debate this more rigorously and should use our status as scientists to address the question of committing people. We might take a lead here from the consumer movement. The Madness Group (1998) website lists their priority areas for research as follows:

What are the longer-term effects of forced interventions and coercive treatments? How does coercion affect compliance? Is there an increase in non-compliance after patients have been coerced? Is there an increase in treatment avoidance among people who have been coerced?

(<http://www.peoplewho.org/Projects/Research.htm>)

Before we start committing people into psychiatric facilities we should address this research agenda. It is an agenda clearly rooted in the experience of psychiatric survivors, driven by anger and the need to balance the system rather than the imperatives of clinicians.

These kinds of research projects illustrate another way forward for psychology, collaboration with service users as researchers not research subjects. Viv Lindow (2001) suggests a continuum of survivor and service user participation in research from the common “Absent survivor” type, where professionals dictate the agenda, define the desired outcomes and judge outcome on behalf of the client, to “Survivor controlled,” where service users control all parts of the research from writing the funding proposal to disseminating findings. Research is still dominated by the former. Psychologists could do more to help shift the balance along this continuum.

Our research and the explication of distress needs to be more firmly rooted in our experience and the stories our clients tell us. If we take seriously the evidence of our senses then there are paradoxes to be found at every turn: physicians don’t tend to take legal drugs (other than alcohol) but willingly give out repeat prescriptions of major tranquillisers; psychologists claim, publicly, to work as evidence-based scientist practitioners, but in private admit that they have little evidence for anything; people espouse the benefits of multi-disciplinary teams but protect their clients from team members they don’t trust.

Contradictory and confusing experiences abound in clinical psychology. Clinical psychology trainees rapidly discover that some psychotherapeutic techniques work quite well. More confusingly, they also discover that some clients seem to feel better after only one or two sessions of what the trainee had seen as a rather stumbling attempt at assessment, so much better, in fact, that the client no longer wants appointments. Listening seems to help, without the paraphernalia of formulation and CBT. Psychologists, psychotherapists and counsellors in training can be warned against consciously using personal experience in case it makes us less objective or emerges as counter-transference. We need to recognise and utilise our subjectivity, however, and listen more carefully to what our clients say. We are likely to find that clinical notes are full of material, never cross-referenced, about common factors in human misery. We notice, again and again, that people taking so-called anti-depressants

are still depressed, or people taking major tranquillisers are out of it most of the time. We notice the smell on wards and feel frightened when visiting institutions for the first time. We feel confused at ward rounds and can't follow the logic of organic theorizing. Conversations with colleagues about the terrible circumstances of people's lives, the frequent remarks about so-and-so's parents in the waiting room, the way a supervisor respects colleagues or upsets supervisees: this is all evidence. Of course the truth is that there isn't that much research necessary. We know what hurts people: exploitation, humiliation, cruelty, inflexible ideologies, torture, starvation and the substitution of hate for love. In fact, pretty much everything that is taken for granted in the English public school system, should be banned in the real world to give people a greater chance in life.

Much of this awareness comes from listening to people in trouble in some way. In our clinical work we should remain attentive; we should constantly ask if we could cope with the families, jobs, childhoods, relationships and class-rooms we hear described; we should bear in mind the dispositional/situational attribution phenomenon – that we tend to locate other people's distress in their dispositions and our own distress in our situations; the inclination is always to blame the victim, unless we are the victim; we should ask people who labelled them in particular ways, not label them ourselves. Teresa Hagan and David Smail (1997), in their work on power-mapping suggest that we should help people identify sources of power and support in their lives. It is no less important to help people identify the toxic powers in their lives, including the drugs taken because their doctors say they will help. It is critical to indicate to people how much of their unhappiness is normal, widespread and caused by powers way beyond their control. In doing so we might try Sue Holland's approach of moving people from an intra-psychic understanding of their problems to a political understanding implying social and collective action (Holland, 1989). Much of the time I'm just grateful when clients stop taking the meds and stop believing in doctors – manning the barricades seems a long way distant. I am less keen on community psychology than might be implied by an acknowledgement that external forces create distress.

Identifying these forces is a role for psychology and psychotherapy but does not qualify us to change that environment. We might use our power to side with clients seeking better housing; our role as citizens, town councillors, school governors and so on might make a difference to more people's lives.

We need to open doors for people; doing so requires professionals to develop a "there but for the grace of god go I" position. We act as if users of services are somehow radically different from ourselves but, of course, any mental health professional might also have been or become a user of services. We need to think about what we want from services and would want should we find ourselves in the system. There is a growing literature from professionals who use mental health services; a group to whom fellow professionals seem inclined to listen (e.g., Bassman, 2001). We should read it.

Professionals need to learn more about advocacy and the user movement. We need to be clear about the role and rights of advocates and encourage speaking out whenever we can, even if that means speaking out about psychotherapy and psychology services. We need to get to know local advocates and promote structures which support advocacy. This might mean providing meeting rooms and other resources for advocates or user meetings. It may mean ensuring that clients know about the availability of local advocacy. We must be prepared to lose arguments with users and their advocates and use our knowledge of the system to help them through it. If we are engaged in actively promoting user involvement or advocacy, we need to be prepared to stay in the background and avoid the too pervasive tendency to take over.

The current state of psychiatry and psychotherapy offers some hope of change. There is some real possibility of debate. More than at any other time in the history of psychiatry, it is not clinicians fuelling or guiding that energy. Ideas from government frequently conflict with the experience of service users,

opening up the possibility of debate. The concept of informed consent (see, for example, Cohen & Jacobs, 2000) in medicine in general is almost constantly being aired in public debate. In the age of the Internet, people have access to information previously kept from them. Knowledge is power, and medical paternalism seems antiquated in the 21st Century. We should ensure people have access to alternative discourses; our psychological therapies department waiting rooms have Internet access for clients, for example. In addition to reading the latest news from the UK Department of Health's National Institute for Clinical Excellence, they can visit the *Critical Psychiatry* sites and link to the wisdom of David Smail, Peter Breggin and Dorothy Rowe. On the one hand the stigma of mental health seems to be reducing: people are more accepting that at times in their life they might break down, have crises, and need help. People speak openly about being depressed, having counselling or psychotherapy and taking drugs. On the other hand the stigma of a diagnosis of schizophrenia, with media and government propaganda about its links with violence, and the stigma of the psychiatric hospital has increased. Similarly, ideas that mental health problems are physical and genetic and need medical treatment seem accepted in society at large. We should do more to help journalists and other potential critics to challenge these views.

Language is critical in this endeavour. On one hand the government and mental health professionals are speaking a new language – of clinical governance, evidence-based practice and risk assessment – and are creating new ways of categorising people (through DSM and more general categories like “severe and enduring mental illness”, without defining what those categories mean). On the other hand, the service user/survivor movement is returning to old language – breakdown, madness, crisis, recovery – language that brings fresh ways of thinking to the area of mental health, language that does not emphasise ‘otherness’, language which holds out hope (see Wallcraft & Michaelson, 2001). Along with different language, there is a creativity and an openness to new ways of helping people.

I work in a psychiatric system that can seem crazy. People want help but are given something called a risk assessment. People want a short break

from their responsibilities and find themselves in a psychiatric hospital for weeks. People want someone to talk to, and instead get drugs, or even electro-convulsive therapy, a treatment banned in several countries. The craziness in the system is explored in *This is Madness* (Newnes, Holmes & Dunn, 1999). *This is Madness Too* (Newnes, Holmes & Dunn, 2001) calls for many of the changes I have outlined, particularly the need to abandon medical ways of looking at distress: if you are depressed, it's not your head that's the problem, it's almost certainly something in your life, often something you don't feel you can change. Drugs certainly won't change it (see Breggin & Cohen, 2001). The pharmaceutical industry is so strong now in influencing medical education and government policy that finding non-drug alternatives is a real problem. The public needs to know more about drugs and the reasons they are prescribed, so *This is Madness Too* calls for informed consent and advocacy in psychiatry. Psychiatry should come clean about its conflicting roles in society. Sometimes the psychiatric system is there to offer therapy and help. At other times it is there to protect society or make anxious relatives feel better by treating members of the family they are worried about but who don't want treatment. Psychology and psychotherapy need to take more of a stand against this kind of coercion.

Psychology and psychotherapy should align themselves with the oppressed and speak out about injustice. There is room for comfort and clarification but no room for collaboration with the oppressor in theory or practice. We need to stand alongside people as similar to ourselves, not emphasize their difference and dysfunction. Distress is part of the human condition. We can help people bear it by acknowledging it in ourselves too; our struggles, our mistakes, our humanity. We might then have some chance of helping people change the circumstances of their lives, lives that we would almost certainly find intolerable.

Psychotherapists would do well to examine the Manifesto for Psychotherapy in *This is Madness Too*. It includes aims of collaborative power and the demand that we organise ourselves in challenging

oppressive institutions (Sanders & Tudor, 2001). This manifesto is not so far removed from the Survivors Speak Out Charter of 1987 which demanded, amongst other things, the provision of free counselling for all in the context of self-advocacy and the recognition that people's first hand experience of emotional distress should be used for the good of others.

Resistance

We shouldn't underestimate the resistance to these ideas. Clinical psychology, for example, makes bold claims to be a scientist practitioner profession. It finds itself in the invidious position of also claiming expertise in human relationships whilst psychologists are not noticeably better at human relationships than members of other professions. The particular combination of wanting to appear scientists and experts in people makes the profession vulnerable to criticism concerning both aspirations. The Division of Clinical Psychology of the British Psychological Society has embraced much of the rhetoric typical of professions (the need to "protect the public," for "accountability," etc.). In doing so, the Division has failed to examine scientifically whether this rhetoric translates into reality. The surge towards statutory registration of psychologists in Britain has, for example, been accompanied by no data indicating that the public would be protected through registering clinicians. In agreeing, virtually without debate, to embark on various UK government-backed projects the profession has abrogated both its scientific responsibility and its pretensions to understanding.

In my capacity of editor of the Clinical Division's newsletter I made the professional mistake ten years ago of publishing an article by a service recipient objecting to the Electro-Convulsive Therapy (ECT) she had been given (Kelmsley, 1991) and another by me calling on the profession for support in speaking out about ECT and other treatments (Newnes, 1991). To its credit, the executive committee of the Division ratified the right of the editor to publish articles of this type. The process took some two hours, however, and my wisdom in publishing a service user's account

was put under scrutiny. Critically, the committee failed to respond to the appeal for its help in speaking out about ECT. Given that it had just spent a great deal of energy debating whether freedom of speech in its own journal was permissible, this came as no surprise. The messenger had been aimed at, if not shot, and the message ignored altogether (Newnes, 1995). If you chose to challenge people's livelihoods, don't expect your profession to thank you for it (although my own profession did not balk at asking me to edit a special edition of *Clinical Psychology Forum* on user involvement when user involvement was finally acceptable).

Nor should you attempt to stand alone. Many organizations now exist to encourage collective action in the world of psychology, psychotherapy and psychiatry. In Britain the Psychology and Psychotherapy Association, the Mental Health Alliance and Psychology, Politics and Resistance are all collaborative ventures by service users and professionals saying something about the current state of affairs. Professionals can also ally to Survivors Speak Out. In the US Dendron (<http://mindfreedom.org>) is a group of predominantly survivor activists and the Center for the Study of Psychology and Psychiatry is another venture involving an astonishingly active network of psychiatric critics.

Toward radical opposition

We need more psychologists and psychotherapists to take arms against the sea of troubles afflicting people. We need to move beyond compliance and eclecticism into radical opposition. Personal experiences of distress, survival and connectedness and attention to the real lives of our clients should lead us to speak out about suffering and the cause of suffering, especially when we believe that our disciplines may be part of the problem. Our position should be more one of balancing the tendency to internalise and medicalize distress, not add to it. We won't win, but we will have demonstrated a degree of academic and clinical freedom of which our parent discipline, and indeed our parents, really ought to be proud.

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Reprint requests:

Craig Newnes,
 Psychology Consultancy Service,
 130, Abbey Foregate,
 Shrewsbury, UK, SY4 3RY
craignewnes@aol.com