

Austerity, Power and CAT's Opportunity for Change

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Since coming to power in 2010 (firstly as part of the CON-DEM coalition then as a majority Conservative government) the government has suggested that only through 'efficiency' savings and workforce adaptation can the National Health Service (NHS) be sustained. This article will suggest that if this is the case (and it is not everyone agrees that it is), then mental health practitioners have a duty as part of the NHS to be bold and ask for true change. Change that will impact our clients and working practices like no other; we should seek to undo the damage of the psychiatric domination of mental health. We should develop client led, client produced, recovery-focused interventions that do away with the arbitrary, archaic diagnostic system and focus instead on the person in front of us, their lives, their culture and their experiences. This may seem idealist, but as will be described in this article behind our current system there is already idealism at play, which may be serving the wrong interests. It is therefore the duty of mental health practitioners to understand this idealism, reflect on it and assess its impact on our society and the way we provide care.

What idealism currently dominates mental health provision?

In his book *The Therapy Industry* (2013) counselling psychologist Paul Moloney describes the historical influences on our modern mental health service. He tracks its development from the eighteenth century when mental health difficulties were understood as daemonic possession, forward to the late eighteenth and early nineteenth century when explanations and

treatment of distress developed from 'moral management' of distress to mental health difficulties being due to tainted heredity, or degenerate habits. He makes the point that although systemic mental healthcare initially started as a compassionate calling for a few well-meaning lay people, these people were quickly displaced by a medical profession that felt called upon to explain away the experiences of people who could not function in a new industrial age. We still do this today; we ask our medical professionals to create categories of experience that separate 'those who suffer' from 'we who are normal', and this medicalisation of distress enshrines the medical model as THE model for understanding distress.

A good example of this enshrinement of the medical model is that of the psychiatric diagnostic system in mental health services. The Diagnostic and Statistical Manual of Mental Disorder (DSM, APA, 1952), initially developed in the 1920s, is the most prominent guide for the UK diagnostic system. At its inception it was tiny, holding only 182 separate mental disorders. The DSM-IV-TR lists a whopping 374 (APA, 2000), and its replacement (DSM-5) added another 15 (APA, 2013).

This massive increase in diagnoses may suggest to some that we live in an era of unprecedented scientific discovery, however, there may be a less noble explanation; aside from the social implications of this categorisation of distress, the costs involved in treating social and psychological 'ills' through predominantly medical means are astronomical, and the profits involved are equally so.

Mental health diagnoses are not like those of the physical health profession; there is no test that can identify a 'schizophrenia' from a 'schizo-affective disorder'. Instead medical professionals are called upon to make a moral judgement about the behaviour of the clients they see, and judge whether their reactions 'fit' with that expected in the current society. DSM is then used as a checklist those in the medical profession can turn to justify their decisions. This subjectivity alone could be understood to have resulted in the expansion of diagnoses available in today's DSM; however there may be more to the story.

If psychiatric diagnoses were 'real', i.e. had a firm basis in science, then we could assume that the treatment of these disorders would have no correlation with the interests of the professionals, drug manufacturers and service users. But according to David Healy (Healy, 2012), this is not the case; diagnoses follow the market. The marketisation of distress as 'anxiety' or 'depression' for which there were chemical cures, resulted in a huge swell in pharmaceutical company profits, so much so that many of the world's largest companies are pharmacological companies. This in itself leads to a loop of greater financial power, which leads to greater expenditure on marketing more products, producing flawed research supporting pharmacotherapy and lobbying governments to legislate in favour of pharmacological cures.

Supporters of the categorical system currently employed by the majority of western countries suggest that diagnoses are important in directing

attention to difficult experiences and thereby drawing funding and research into that area. They even suggest that treatment efficacy is based in this diagnostic system; drug x is developed to treat symptom y. This is true to some extent, in that in medicine the validity of a physician's diagnosis is determined by its ability to specify future symptoms, their duration, the best treatments and likely results. This, however, does not hold true for mental health. Looking specifically at 'schizophrenia' about a third of clients recover completely, a third recovery somewhat and a third may remain distressed for the rest of their lives, but the symptoms do not give a reliable prediction as to which third any patient could belong. Furthermore, despite decades of research conducted based on these diagnostic categories, the act of diagnosis remains far less reliable than in physical medicine; inter-rater reliability remains poorer for psychiatric diagnoses than for physical medicine diagnoses for people with skin, kidney, or heart complaints.

It is the vested interest of pharmaceutical companies (as well as managed health care systems, and some relatives and carers) that continues to support the categorisation of mental distress as if it were physical, because if the distress can be given a physical/organic cause then that justifies a physical/organic treatment. This sort of logical efficiency was an argument championed and expanded by the late David Smail (Smail 1991, 1992, 1993a & b, 1994, 1995a & b, 1998, 2002, 2004) through his description of the 'psy-industry' and understanding of distress as relating to power, and the use of the latter to further one's self interest. As can be readily understood, those with the most power are most able to advance their interests to the potential detriment of others.

So what's the alternative?
Divesting ourselves of historical

shackles of an archaic and dehumanising diagnostic system would send shockwaves across the mental healthcare industry, but that may be just what is needed. Medicalising mental distress obfuscates the connection between life experiences, our environment and our understanding of ourselves. It also undermines the vitally important support available from social networks, family and local communities. Noting the human misery inherent in the individualised society of the west could be a catalyst to societal change.

Looking back on his career as a clinical psychologist, David Smail argued that 'critical and community psychology' should not 'appropriate the citizen's political role' in addressing social failings. He suggested to do so would lead to offering or coming to see themselves as 'knowing what to do about it'. (Moloney, 2016).

Smail's description of citizen's political role as removed from the roles of professionals involved in critical and community psychology seemed to me a false dichotomy; surely those citizens with interests in critical and community psychology remain citizens despite this interest? It also seemed to represent a nihilistic acceptance of our helplessness as helpers, which was at odds with my understanding of Smail's previous work; his career might be said to have focused on enabling helping professionals to understand and display the limitations and resources available to individuals seeking change (Hagan & Smail, 1997a & b).

Wilkinson and Pickett (2009) showed that for each of eleven different health and social problems: physical health, mental health, drug abuse, education, imprisonment, obesity, social mobility, trust and community life, violence, teenage pregnancies, and child well-being, outcomes are significantly worse in more unequal rich countries. To my mind systemic

change away from diagnostically led services could be a humanising influence great enough to encourage engagement with this evidence. We could reconnect with our political, social and environmental crises, and in doing so hold ourselves in greater esteem, hold the factors keeping us miserable in greater contempt and push for a great rebalancing of equality within society.

One alternative to the medicalisation of distress was suggested by Ryle & Kerr (2002). In considering why societal influences were not considered more often in psychotherapy he suggested that psychotherapists seldom spell out how damaging individual values and assumptions derived from past and present interests. However he suggested also that those with ability to explain have a duty to do so, because in acknowledging the ways in which authoritarian power shapes the qualities seen in citizens of a society, psychotherapists could offer opportunity for changed perspective, and perhaps thereby changed experience.

This contrasts with Smail's retrospective look back at his career but not the body of his work, offering hope for intervention at the individual level that might marry the two approaches.

Cognitive Analytic Therapy (CAT, Ryle & Kerr, 2002) is one of several therapeutic models that offer a broadening of our understanding of ourselves. This development of what Smail referred to as 'outsight' (2006), or in CAT language a reformulation that acknowledges the impact of culture and society on the values and ideas held by an individual, could be what is needed; by reflecting honestly on the developing reciprocal roles in relationships between people, institutions and cultures we are able to recognise negative or harmful relational dynamics (e.g. those found in both the current diagnostic system and the psy-industry

more generally) and offer choice in continuing in these relationships or adopting new healthier ones.

Creating services that critically reflect on what the helper (individual/institution/culture) and the helped bring, using formulations that acknowledge the distal pressures on both could also be transformative. Perrin (2012) suggested services could be built around an acknowledgement of different forms of traumatic experience, that through this, services could offer a healthy, reliable relationship to people who may not have ever experienced this before.

By designing services appropriate to the needs of traumatised individuals, therapy can be understood as one form of help, accessible to some (but importantly not all) of our clients. This humility in intervention might then prevent psychotherapy from following the medical model into the trap of positioning itself as holding the answers while providing space for others to offer healing relationships.

In CAT terms, services could offer alternative reciprocal roles providing new perspectives on old values and beliefs, while acknowledging that these are held jointly between addressee (e.g. therapist/institution/culture) and addresser (e.g. client). These reciprocal roles could reflect the narratives enforced by powerful cultural and societal others. Therapist and client could critically discuss the appropriateness of these narratives thereby encouraging engagement with distal events and providing the oversight into distress felt by the individual.

Services could be arranged to back away first from psychiatric help, encouraging psychological formulation of difficulties that acknowledge the events in a person's life more proximally and distally. Pathways could reflect a process from formal psychological intervention eventually

to peer support. In doing so, services could save money through divestment from the psychiatric system, and rely more on the recovery potential of those with lived experience.

Of course these ideas of service design and 'recovery' are ideological and so must be considered in light of their limitations or potential failings. For example, recent critiques of the recovery movement suggest three key issues. Firstly, debates about how to define recovery parallel those about the nature of mental health more generally. The vagueness of these concepts and implicit assumptions within dominant recovery and resilience narratives mean problems regarding the individualisation of social problems go unaddressed. Secondly, these narratives, despite being seen as markedly different from those of the medical model are conceptually dependent on a deficit model; focus on the "positives" and "strengths" implies the existence of "negatives" and "weaknesses". Harper & Speed (2012) argue that this does little to substantially transform dominant understandings of psychological distress. Thirdly, the combination of these issues reduces the progressive potential of recovery. Through the ignorance of these issues, recovery may come to be seen as an individualistic experiential narrative supplement to a medical understanding, leaving the systemic, social or structural causes of distress obscured (Harper & Speed, 2012).

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