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Clinical Psychology Forum is circulated monthly to all members of the Division of Clinical Psychology. It is designed to serve as a discussion forum for any issues of relevance to clinical psychologists. The editorial team welcomes brief articles, reports of events, correspondence, book reviews and announcements.

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Introduction


David's writings were consistently informed by his clinical practice, and place distress firmly in its material context, and recognising how feelings, thoughts and behaviour are shaped by economic and social circumstances. David proposed that to understand why we are unhappy, rather than insight, we must cultivate ‘outsight’ into the world around us. This perspective – which encourages personal modesty, appreciation of luck, compassion, and recognition of our common humanity – is today more relevant than ever.

This exciting interdisciplinary event, inspired by David Smail’s work, was put on for anyone wanting to understand the connections between psychology and disciplines such as sociology, epidemiology, philosophy and cultural studies. In addition, it was a demonstration of the continuing relevance of Smail’s ideas and of the traditions upon which they drew. Our expert speakers informed, enthused and inspired, pointing the way to a sophisticated psychological understanding of clinical distress that is fit for the many challenges facing us today.

What does ‘austerity’ have to do with poor mental health? When psychotherapy is offered, just what is occurring, and how does it work?

How can we understand and work with the meanings of clinical distress across the age range? And how might psychology contribute to efforts to improve the everyday lives of us all?

The two-day conference explored questions such as these with reference to the important writings of David Smail. A series of eminent speakers from psychology and related disciplines discussed some of the issues and concerns raised in David’s work. Their talks showed how his work points to difficult challenges, but also to exciting opportunities. Their contributions demonstrated the significance of David’s work, in psychology and beyond, while also showing how psychology can be greatly enriched by knowledge from other fields.

From outside of psychology, high-profile speakers included Professor Richard Wilkinson (author with Kate Pickett of *The Spirit Level*); Professor Kate Morris and Professor Brid Featherstone (authors with Susan White of *Re-Imagining Child Protection*); Dr Mark Fisher (author, *Capitalist Realism*); and Dr Lisa McKenzie (author, *Getting By: Estates, Class and Culture in Austerity Britain*). And from within psychology, well-known speakers included Professor Dave Pilgrim, Professor Mary Boyle, Dr Lucy Johnstone and Dr Dave Harper. One of the conference sessions was a free public lecture, open to all. In this presentation, Professor David Pilgrim of the University of Liverpool talked about what he calls ‘necessary ambivalence’ in the work of David Smail. Using ideas drawn from critical realist philosophy, Professor Pilgrim explored how David Smail’s ideas about psychological therapy changed over time, and then argued that these changes are in fact reflective of a wider dilemma facing all who work in mental health. Professor Pilgrim is both an accomplished speaker and the author of many highly regarded books and papers, including *Understanding Mental Health: A Critical Realist Exploration*.

This conference was generously supported by the BPS Division of Clinical Psychology.
How inequality hollows out the soul

Richard Wilkinson & Kate Pickett

Using research from around the world published since The Spirit Level, Richard Wilkinson suggests the psychosocial pathways through which inequality reduces the subjective quality of life for a large majority of the population. He shows how it damages the social fabric, increases social anxiety and contributes to mental illness.

The naïve view of inequality is that it only matters if it makes the poor poorer, or if it is unfair. But the truth is that we have deep seated psychological responses to whether we live in a more or less equal society. Our tendency to equate outward wealth with inner worth means that inequality colours our social perception. It invokes the logic of animal dominance hierarchies – feelings of dominance and subordination, superiority and inferiority – and affects the way we see and treat each other.

A few years ago we published evidence that both more and less serious forms of mental illness are three times as common in the rich countries with bigger rather than smaller income differences between rich and poor (Pickett et al., 2006). Compared with someone in Japan or Germany, an American is likely to know three times as many people with depression or anxiety problems. The differences are not a matter of awareness, definitions or treatment. To allow mental illness rates to be compared internationally, the World Health Organisation (WHO) asked questions in each country about things like mood, tiredness, agitation, concentration, sleeping patterns, self-confidence and appetite, which have been found to be good indicators of mental illness.

Two more studies since then have found the same pattern. The first, looking at the 50 US states, found that after taking account of age, income and educational differences, depression is more common in states with bigger income differences. The second, which combined data from over 100 studies of prevalence in 26 countries, found that schizophrenia is around three times as common in more than in less unequal societies.

So what could be happening? In an important research paper, Sheri Johnson, a psychologist at Berkeley, and her colleagues, have reviewed a vast body of evidence from biological, behavioural and self-reported accounts, suggesting that a wide range of mental disorders may originate in a ‘dominance behavioural system’ (Johnson et al., 2012). Part of our evolved psychological make-up, and almost universal in mammals, it is a system for recognising others’ achievements and abilities (Pickett & Whelan, 2013). Another international study found that self-enhancement or self-aggrandisement – presenting an inflated view of yourself – was much more common in more unequal societies (Loughnan et al., 2011). We had predicted several years earlier that if these conditions are to do with dominance and subordination, you might think that one group will be more common at the top of the social hierarchy and the other at the bottom. But though depression is more common lower down the social ladder, it exists at all levels in society: few are immune to feeling defeated or failures. Similarly, you can be narcissistic or strive for dominance at any level in the hierarchy, though psychologist Paul Piff has shown that higher status is associated with more unethical behaviour (Piff et al., 2012). He found that drivers of more expensive cars were less likely to give way to pedestrians or to other cars; higher status people were also more likely to help themselves to candies they had been told were intended for children. They also had a greater sense of entitlement and were less generous in an economic game.

One of the important effects of bigger income differences between rich and poor is to intensify issues of dominance and subordination, superiority and inferiority. Class tightens its grip on us. Although there is always some connection between people’s incomes and the social class they feel they belong to, the connection becomes much closer in societies with bigger income differences between rich and poor (Andersen & Curtis, 2012).

A recent study of 34,000 people in 31 countries found that in countries with bigger income differences, status anxiety was more common at all levels in the social hierarchy (Layte & Whelan, 2013). Another international study found that self-enhancement or self-aggrandisement – presenting an inflated view of yourself – was much more common in more unequal societies (Loughnan et al., 2011). We had predicted several years earlier that because greater inequality increases status insecurity and competition, people in more unequal societies would feel they could no longer afford to be modest about their achievements and abilities (Pickett & Wilkinson, 2010).

Recorded rises in rates of narcissism in the US (as measured by the 41-item Narcissistic Personality Inventory) have coincided with rising income differences (Twenge et al., 2008). Bigger material differences
create bigger social distances. Feelings of superiority and inferiority increase and status becomes more important. As inequality raises the stakes, we judge each other more by status and become more neurotic about how we are seen and judged.

As rising inequality has tightened the grip which status has on us, we should not be surprised by the evidence that social mobility has slowed and equality of opportunity for children has become a more distant dream (Wilkinson & Pickett, 2010; Krueger, 2012).

Almost all the health and social problems more common lower down the social ladder are much more common in more unequal countries. As a result, the US pays a high price for being one of the most unequal of the rich developed societies. Compared with more equal countries, it suffers poorer life expectancy, lower levels of child wellbeing and higher rates of social problems. As well as high rates of mental illness, problems like violence, obesity, teenage births and incarceration are all between twice as common and 10 times as common in the US as in more equal countries. Inequality seems to strengthen the ways in which status and class imprint themselves on us from early childhood onwards (Wilkinson & Pickett, 2010).

Humans have lived in every kind of society, from the most egalitarian hunter-gatherer bands of our pre-history (described by Christopher Boehm in his recent book Moral Origins), to the most brutal tyrannies. We instinctively know how to be caring and sharing, cementing social bonds of friendship, mutuality and co-operation. We also know how to do status competition, how to be snobs, looking up to superiors and down on inferiors, and how to talk ourselves up. We use both social strategies almost every day of our lives, but inequality shifts the balance between them. With more inequality we become more out for ourselves. A study covering 26 European countries found that people in more unequal countries were, even after controlling for education and income, less willing to take action to help others – whether the sick, elderly, disabled or others in the community.

It is hard to avoid the conclusion that people become more anti-social in more unequal societies. One of the better known costs of inequality is that people withdraw from community life and are less likely to feel that they can trust others. This reflects increased status anxiety as we all become more worried about how we are valued by others. And those insecurities then intensify consumerism. As a marker of status, money becomes even more important, so people in more unequal societies work longer hours (Bowles & Park, 2005), get into debt more and are more likely to go bankrupt (Kumhof & Rancière, 2010; Adkisson & Saucedo, 2012).

Good social relationships are key to human well-being. Study after study shows that they are highly protective of health (Holt-Lunstad et al., 2010) and almost essential to happiness (Layard, 2005; Dunn et al., 2008). And now that we can compare countries, research shows what we once knew intuitively – that inequality is divisive and socially corrosive.

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Mark Fisher

Neoliberalism has privatised stress. While working conditions, pay and social security have declined, the therapeutic culture which has aided and abetted neoliberalism has encouraged us not to see these as political problems which can be addressed by collective action, but as forms of individualised stress which must be managed by drugs, positive thinking or mindfulness. In order to overcome this, we need to reverse neoliberalism’s project of responsibilisation. Instead of ‘taking ownership’ of distress that has been imposed upon us, we need to find ways of linking individual suffering to the distal causes which have produced it. The best strategy for doing this is a practice developed by socialist-feminism: consciousness raising. Consciousness raising worked by encouraging people to talk together about their feelings – which had precisely the effect of depersonalising suffering, and directing attention to the power structures which actually produced it. How can we revive consciousness raising in the 21st century?

I CANNOT WRITE HONESTLY about the importance of David Smail’s work without talking about its importance to me. Encountering Smail’s writing and thinking has enabled me to come to a better (and more compassionate) understanding of myself, and it is has done so by allowing me to recognise that what I had previously experienced as a set of ‘personal’ problems had their roots in social power.

I’ve suffered from depression intermittently since I was a teenager. Some of these episodes have been highly debilitating – resulting in self-harm, withdrawal (where I would spend months on end in my own room, only venturing out to sign or to buy the minimal amounts of food I was consuming), and time spent on psychiatric wards. I wouldn’t say I’ve recovered from the condition, but I’m pleased to say that both the incidences and the severity of depressive episodes have greatly lessened in recent years. Partly, that is a consequence of changes in my life situation, but it’s also to do with coming to a different understanding of my depression and what caused it.

Depression is partly constituted by a sneering ‘inner’ voice which accuses you of self-indulgence – you aren’t depressed, you’re just feeling sorry for yourself, pull yourself together – and this voice is liable to be triggered by going public about the condition. Of course, this voice isn’t an ‘inner’ voice at all – it is the internalised expression of actual social forces, some of which have a vested interest in denying any connection between depression and the wider social field.

My depression was always tied up with the conviction that I was literally good for nothing. I spent most of my life up to the age of thirty believing that I would never work. In my twenties I drifted between postgraduate study, periods of unemployment and temporary jobs. In each of these roles, I felt that I didn’t really belong in these office or factory jobs, not because I was ‘too good’ for them, but – very much to the contrary – because I was over-educated and useless, taking the job of someone who needed and deserved it more than I did. Even when I was on a psychiatric ward, I felt I was not really depressed – I was only simulating the condition in order to avoid work, or in the infernally paradoxical logic of depression, I was simulating it in order to conceal the fact that I was not capable of working, and that there was no place at all for me in society.

When I eventually got a job as lecturer in a further education college, I was for a while elated – yet by its very nature this elation showed that I had not shaken off the feelings of worthlessness that would soon lead to further periods of depression. I lacked the calm confidence of one born to the role. At some not very submerged level, I evidently still didn’t believe that I was the kind of person who could do a job like teaching. But where did this belief come from? The dominant school in psychiatry locates the origins of such ‘beliefs’ in malfunctioning brain chemistry, which are to be corrected by pharmaceuticals; psychoanalysis and forms of therapy influenced by it famously look for the roots of mental distress in family background; while cognitive behavioural therapy is less interested in locating the source of negative beliefs than it is in simply replacing them with a set of positive stories. It is not that these models are entirely false, it is that they miss – and must miss – the most likely cause of such feelings of inferiority: social power. The form of social power that had most effect on me was class power, although of course gender, race and other forms of subordination work by producing the same sense of ontological inferiority, which is best expressed in exactly the thought I articulated above: that one is not the kind of person who can fulfil roles which are earmarked for the dominant group.

It was on the urging of one of the readers of my book Capitalist Realism that I started to investigate David Smail’s work. It confirmed the hypotheses about depression that I had stumbled towards in my own thinking. In The Origins of Unhappiness,
Smail describes how the marks of class are designed to be indelible. For those who from birth are taught to think of themselves as lesser, the acquisition of qualifications or wealth will seldom be sufficient to erase – either in their own ‘minds’ or in the minds of others – the primordial sense of worthlessness that marks them so early in life. Someone who moves out of the social sphere they are ‘supposed’ to occupy is always in danger of being overcome by feelings of vertigo, panic and horror:

isolated, cut off, surrounded by hostile space, you are suddenly without connections, without stability, with nothing to hold you upright or in place; a dizzying, sickening unworldly takes possession of you; you are threatened by a complete loss of identity, a sense of utter fraudulence; you have no right to be here, now, inhabiting this body, dressed in this way; you are a nothing, and ‘nothing’ is quite literally what you feel you are about to become.

What Smail offers here is a new and fruitful approach to class politics: an approach that is all the more important given the deflation of class consciousness that has happened over the past 30 years. The deflation of class consciousness has been narrated by the dominant neoliberal discourse as if it were equivalent to the disappearance of class as such. The fact that it could seem even remotely plausible to claim that class has now disappeared is one indication of the scale of the success of the neoliberal project.

It is certainly true that class has been disappeared – in precisely the sense that the term ‘disappeared’ was used to refer to the way in which enemies of some authoritarian states were abducted and killed. But the removal of class from popular consciousness – the disappearance of the concept of class from media discourse – has allowed ruling class power to operate in ever more brutal ways. The deflation of class consciousness has led to the rise of virulent forms of class hatred, as Owen Jones’s book *Chavs: the Demonization of the Working Class* demonstrates.

The popularity of *Chaos* , however, suggests that there is a growing awareness of the ways in which neoliberal media and political discourse has propagated class-based shaming.

It’s not only neoliberals who have retreated from class. In ‘Marx’s Purloined Letter’, an important essay written nearly 20 years ago now, Fredric Jameson pointed out how ‘the denunciation of class – even amongst Marxists – has become an obligatory gesture today, as though we all know that race, gender and ethnicity were more satisfactory concepts or more fundamental, prior, concrete, existential experiences’. Jameson warned that:

*It* would be a great mistake for Marxism to abandon this extraordinarily rich and virtually untouched field of analysis on the grounds that class categories were somehow old-fashioned and Stalinist and needed to be renounced shamefacedly in advance, in order for Marxism to stage a respectable and streamlined reappearance in the field of intellectual debate in the new world system. (Jameson, 1999)

Sadly, this now reads less like a warning than a prophetic account of the emergence of a left which has indeed jettisoned class as an embarrassing relic.

It is worth recalling here that class does not – and cannot – have any sort of official existence in capitalism. Capitalism is supposed to have rid us of feudalism’s encastements. The point of Marx’s critique of the French Revolution was to expose this as an illusion, or, rather, only a partial truth. Instead of delivering the universality it promised, the French Revolution amounted to the takeover by a particular class, the bourgeoisie – and, furthermore, in a certain sense, this class didn’t even act in its own interests, but in the interests of the real ruling power on earth, capital.

Yet a return to the so-called strict Marxist definition of class – the idea that class is determined by relationship to means of production – will not be sufficient. One problem with this definition is that, on its own, it does nothing to counter Capital’s claims to meritocracy and classlessness. It tells us nothing about why there is a class system – why, that is, whole groups of people have their relationship to the ‘means of production’ effectively fixed.

A proper analysis of class demands an account of the forces – cultural, sociological, ‘psychological’ – that perform this fixing. Moreover, far from being the only proper Marxist account of class, the very economism of this definition is opposed to the spirit of Marx’s analysis, which disdained ‘the economic’ as the bourgeois category par excellence. (It’s probably worth also noting in passing here that, at least since the 1970s, the concept of ‘production’ has proved very problematic, for many reasons. All of the current emphases on so-called ‘immaterial labour’ point to the inadequacy of the old concept of ‘means of production’ for grasping the nature of capitalist exploitation today.)

An adequate understanding of class requires us to get to grips with the question of subordination, and how it is produced. Class consciousness, Jameson argued in ‘Marx’s Purloined Letter’, ‘turns first and foremost around the question of subalternity, that is around the experience of inferiority. This means that the ‘lower classes’ carry around within their heads unconscious convictions as to the superiority of hegemonic or ruling-class expressions or values, which they equally transgress and repudiate in ritualistic (and socially and politically ineffective) ways’ (Jameson, 1999). This marking as inferior is fundamental, although we could say that, in the ordinary course of things, the assumption of inferiority isn’t directly ‘experienced’ at all; rather, it functions as an unconscious frame which shapes and conditions all experience.

One of the most powerful and painful explorations of these machineries of inferiority in English literature comes in Dickens’s *Great Expectations*, a novel that has a new relevance in the era of neoliberalism. Pip has been taken to the house of the rich woman, Miss Havisham, and made to play with her ward, the beautiful and haughty Estella. Estella humiliates Pip by mocking his ‘coarse hands’ and ‘common boots’.

*[It] would be a great mistake for Marxism to abandon this extraordinarily rich and virtually untouched field of analysis on the grounds that class categories were somehow old-fashioned and Stalinist and needed to be renounced shamefacedly in advance, in order for Marxism to stage a respectable and streamlined reappearance in the field of intellectual debate in the new world system. (Jameson, 1999)*
Afterwards, when he reflects on the encounter, Pip feels a profound sense of shame.

I took the opportunity of being alone in the courtyard to look at my coarse hands and my common boots. My opinion of those accessories was not favourable. They had never troubled me before, but they troubled me now, as vulgar appendages. I determined to ask Joe why he had ever taught me to call those picture-cards jacks, which ought to be called knaves. I wished Joe had been rather more genteelly brought up, and then I should have been so too. (Dickens, 2005)

Here, the sense of shame and inferiority which had previously been in the background of Pip’s experience – a vague frame – comes to the foreground. But this foregrounding is very far from constituting class consciousness. It is more like the opposite of class consciousness. It is more like the opposite of class consciousness in that the structures which produce Pip’s sense of inferiority recede from attention, in the very moment that Pip internalises his feelings of shame and starts to see himself from the perspective of the dominant class. Pip’s shame, and the pursuit of wealth and success he subsequently undertakes in order to ameliorate it, are a kind of parable for what has happened under neoliberalism.

Bevlerly Skeggs has written of the ways in which, under neoliberalism, people from working class backgrounds have been induced to see themselves from the point of view of a ‘bourgeois gaze’, a gaze which constitutes them as notoriously lacking. The widespread recruiting of working class people into identifying with the bourgeois gaze is perhaps the real meaning of New Labour politician John Prescott’s claim that ‘we are all middle-class now’. The feminist philosopher Luce Irigaray once wrote, ‘there is one sex, and it is male’ in order to highlight the ways in which patriarchy closes off the possibility of sexual difference. We might say that, under neoliberalism, ‘there is one class, and it is middle’. The paradoxes of this over-extension of the concept of the middle should be obvious – if ‘everyone’ is middle-class, then what, exactly, are they in the middle of? What imaginary topology is there that could position ‘everyone’ in the ‘middle’ in any case?

One effect of the idea that ‘everyone is middle-class’ is responsibilisation. If ‘everyone is middle-class’, then those who are not wealthy or successful must have failed. Each individual member of the subordinate class is encouraged into feeling that their poverty, lack of opportunities, or unemployment, is their fault and their fault alone. Individuals will blame themselves rather than social structures, which in any case they have been induced into believing do not really exist (they are just excuses, called upon by the weak). What David Smail calls ‘magical voluntarism’ – the belief that it is within every individual’s power to make themselves whatever they want to be – is the dominant ideology and unofficial religion of contemporary capitalist society, pushed by reality TV ‘experts’ and business gurus as much as by politicians. Magical voluntarism is both an effect and a cause of the currently historically low level of class consciousness. It is the flipside of depression – whose underlying conviction is that we are all uniquely responsible for our own misery and therefore deserve it. A particularly vicious double bind is imposed on the long-term unemployed in the UK now: a population that has all its life been sent the message that it is good for nothing is simultaneously told that it can do anything it wants to do.

We must understand the fatalistic submission of the UK’s population to ‘austerity’ as the consequence of a deliberately cultivated depression. This depression is manifested in the acceptance that things will get worse (for all but a small elite), that we are lucky to have a job at all (so we shouldn’t expect wages to keep pace with inflation), that we cannot afford the collective provision of the welfare state. Collective depression is the result of the ruling class project of resubordination. For some time now, we have increasingly accepted the idea that we are not the kind of people who can act. This isn’t a failure of will any more than an individual depressed person can ‘snap themselves out of it’ by ‘pulling their socks up’. The rebuilding of class consciousness is a formidable task indeed, one that cannot be achieved by calling upon ready-made solutions. What Smail’s work encourages us to imagine is some space between therapy and political action; it is perhaps only in such a space that class consciousness can be reflated. Progressive political movements must take seriously the emotional structures that reproduce class power and other forms of political subordination. They must actively confront the ways in which shame and inferiority are engineered by the ruling structures, and internalised by subordinate groups.

A rediscovery of the techniques of consciousness-raising developed by socialist-feminism would be one way in which these machineries of inferiority could be made visible and ultimately dismantled. Consciousness-raising was about bringing into view precisely those structures – capital, patriarchy – which are hidden by and in ‘ordinary experience’. Making the structures appear, allows us to see that we as individuals are not responsible for so much of what happens in our lives. Despite what neoliberal magical voluntarism tells us, it is not our fault. The awareness of the structural causation of much of what we are invited to think of as our ‘internal’ lives can help to engender the ‘compassionate solidarity’ that David Smail rightly called for. And, in a seeming paradox, giving up the fantasy of individual responsibility is the first step to achieving a collective agency: the only agency that will actually succeed in a world dominated by capital.

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Mark Fisher (1968–2017)

We are very sorry to say that Mark Fisher has died since the conference. We extend our condolences to Mark's family, friends and those who knew him and his work. Reading the paper is particularly poignant now as we know that Mark took his own life less than 18 months later. The following piece about Mark has been written by his friend Dr Ray Brassier, Professor of Philosophy, American University of Beirut.

Mark Fisher was a writer, teacher, and activist. After studying English and Philosophy at the University of Hull, he pursued graduate work, first at the university of Birmingham then at the University of Warwick, where he completed his PhD in Philosophy and Literature in 1999. While at Warwick, he became a founding member of the Cybernetic Culture Research Unit, an interdisciplinary collective whose investigations of digital culture later proved to be seminal. In the early 2000s, he taught philosophy at a sixth form college in south London and became known for his influential blog K-Punk [http://k-punk.abstractdynamics.org], writing about music, culture, and politics. As his reputation grew, he became a freelance writer as well as a part-time lecturer at the University East London and Goldsmiths College, where he was eventually appointed to a full-time position in the department of Visual Cultures. In 2008, Fisher co-founded Zero Books with a remit to publish writing that would be ‘intellectual without being academic, popular without being populist’. His first book, Capitalist Realism, helped launch the Zero imprint and confirmed his standing as an important cultural theorist. The follow-up, Ghosts of My Life, also published by Zero, appeared in 2013 and his final book, The Weird and the Eerie, came out in December 2016, just a few weeks before his death.

Fisher’s work is an ambitious synthesis of cultural and political criticism, drawing upon psychoanalysis, Marxism, and post-structuralism. What sets his writing apart from standard academic criticism or journalistic commentary is the sense of political and existential urgency that courses through it. He sought to diagnose neoliberalism’s chokehold on contemporary consciousness and loosen its grip. ‘Capitalist realism’ is his name for the insidious ideological framework through which neoliberalism has narrowed the horizon of cognitive and political possibility and carried out the ‘slow cancellation’ of the future. Fisher refused to accept this annulment. The overarching constant animating all of his writing is the persistent effort to open up existential and political possibilities shut out by capitalism. He pursued this struggle not only in his writing, but also through his teaching and activism, whether by giving classes on ‘popular modernism’, advocating for the politicization of mental health, or protesting against the relentless marketisation of education. The struggle was personal as well as theoretical: in January 2017, suffering from severe depression, Fisher took his own life. The courage with which he resisted the lure of resignation remains an example for all those struggling for another future.
The rich, the rich, we've got to get rid of the rich
Lisa Mckenzie

This is the chant of 1500 protesters marching across Tower Bridge in London on a very wet and very cold Saturday afternoon in January. This was the very boisterous and loud section of the ‘March for Homes’, which started in Shoreditch in east London, led by the Focus E15 campaign – a group of young mothers and their children who were forcibly evicted out of a homeless hostel in 2013. The hostel sits in the shadow of the billion pound developments of the Olympic Park and the Westfield Shopping Centre. The campaign and fight of the Focus E15 mothers is just one example of the terrible and cruel ways that working-class families and young mothers in particular are being treated in austerity Britain. This is the consequence of inequality gone mad, unrestrained markets, and a lack of empathy for those who struggle to survive in a rampant neoliberal campaign for wealth and more wealth to be redistributed upwards. This is my current research: examining what is happening to working class families, and how precarious their lives have become because of the structuring forces of the open market. Drawing upon my previous research in St Ann’s in Nottingham, I show how working-class people and their communities have been devalued to such an extent that the land that they live on is worth more than them.

We are sitting in the back yard of a local pub in East London on a wooden bench with a group of people who have lived within staggering distance of this establishment for either all or most of their lives, as have their families, and friends. We are talking about social class, the state of Britain today, and what is happening in the local neighbourhood. Today’s discussion centres on a new film being made about the Kray Twins, the notorious East-end gangsters, which is being filmed in the café two doors down from the pub, the murder of a local man who is being buried today, and rich people buying jeans for thousands of pounds because the denim has been allegedly distressed by an endangered species of tiger. Peppered throughout this conversation are personal worries and concerns about the public state of the severity of inequality in Britain today.

Although conversations change daily, the constant is the talk about how difficult it is to make ends meet in London; this conversation never changes, and never ends. The people who I am sat with here in this pub, and have known over the last year, are finding themselves in increasingly precarious positions. They do not know how long they have left in their community, rents are rising and the local council, it seems, are putting more and more pressure upon local people to move out of this part of London and move further east into Essex, or even north as far away as Birmingham and Manchester. The talk in this pub is what will happen to them – will they be allowed to stay in this neighbourhood, and if not what will happen to their relatives, particularly the elderly who have more secure social housing and are more difficult to move. There is constant anxiety about what will happen to their friends and neighbours who they fear will become stranded in the middle of East London amongst the sea of hipsters, the middle-class media types, and the workers from the City, London’s financial district – people with whom the Eastenders in this pub have very little in common, people who they don’t know, people who don’t want to know them. This is a very typical conversation in a very typical local pub in the Eastend. The talk is full of fear and anxiety but also a certain amount of ambivalence with a touch of hedonism: let’s make hay while the sun shines, ‘fuck it we might not be here tomorrow’.

The people who I am sat with in this pub are men who work on building sites in London, who are now sub-contractors which equates to self-employed workers. They work precariously, when there is work they work, when there is not they don’t. The women work part-time in the local pubs, or cleaning in the offices of the financial district on their doorstep, all relying at points on the welfare system to top up their rents which are ever-increasing, and working tax credits to top up their hourly rate which is ever-decreasing. Their positions are unstable, leaving them not knowing whether they will be in work, not knowing where they might be living in a year’s time, not knowing whether the new round of welfare benefit cuts linked the Government’s Austerity measures will finally ‘finish them off’. These people are an example of Britain’s Precariat, a growing and distinct group of people at the bottom of our society whose lives are becoming increasingly and frighteningly less secure.

Guy Standing (2011) in his book Precariat, argues that neoliberal policies and institutional changes are producing growing numbers of people with common enough experiences to be called an emerging class. The Precariat are a group of people across the world living and working precariously, usually in a series of short-term jobs, without recourse to stable occupational identities or careers, stable social protection or protective regulations relevant to them. They include migrants but also locals. Guy Standing explains that this class of people are producing new instabilities in society. They are increasingly frustrated and angry but also dangerous because they have no voice, and hence they are vulnerable to the siren calls of extreme political parties. At the same time they are becoming loathed and stigmatised, ridiculed and laughed at for their methods of managing their fear and precariousness. This management of fear comes through closely identify-
ing with the local, tightening their notions of identity through ‘who we are’ and through complicated and voracious notions of belonging. This manifests in distinct cultural forms: what they like, what they wear, how they speak, and their strong connection to community belonging and values. Consequently, they are seen and known as old fashioned, immovable, rigid and unable to bend to the wishes of a changing, globalised market. The ways in which they dress, speak, walk, and how they raise their families come under scrutiny, and they are devalued. When Britain needs a low paid working class, people to serve coffee, clean hotel rooms, and look after their children, there are ‘better’ working-class people from Italy, Poland, Nigeria or Brazil which can be enlisted. As Guy Standing argues, this causes globalised precarity and a global Precariat.

This paper introduces the concept of precarity and the fear that arises from the neoliberal condition of never being valued. There is a distinct group of precarious people in the UK, the people at the bottom who are becoming increasingly unstable and fragile. For generations in the UK, we have debated the ‘state’ of the poorest people: their usefulness, their behaviour, their values and their taste. We have also debated who they are, how we can define them and what we call them. The need for them to be recognisable and definable has always been important. Guy Standing in 2011 was not the first to name this group of people potentially dangerous. There has been a constant anxiety, particularly by the middle-class, regarding the poor, which stretches back to at least 1601 with the introduction of the Poor Law, which was then ramped up in 1834 with the introduction of the revised Poor Law. The Royal Commission, under the chairmanship of the Bishop of London, conducted a detailed survey of the state of poor law administration and prepared a report. This report took the view that poverty was essentially caused by the indigence of individuals rather than economic and social conditions, and if not dealt with, the poor turn into a dangerous and criminal class.

The Royal Commission published its report in March 1834, and made a series of 22 recommendations which were to form the basis of the new legislation that followed in the same year. The subsequent 1834 Poor Law Amendment Act led to a major overhaul of how poor relief was administered, splitting the poor into two distinct groups: the deserving poor, who were deemed respectable, perhaps ‘unlucky’ and undeserving; and those who were considered deviant, problematic and criminal. How we define the poor without further stigmatising their inequality and adding to the ‘dangerous class’ rhetoric, is an ongoing issue.

The Precariat is a group of people that has gone by many names in British social history, and has been known and named in many forms. Charles Booth and Benjamin Seebohm Rowntree, our forefathers in the enquiry of social class, social inequalities, and social policy, used the concepts of ‘underclass’ and the ‘social residuum’. Even Karl Marx was never sure who the poorest in our society were, how they were to be addressed and what their contribution might be when he wrote about the dangerous lumpen proletariat, the lowly section of the working class who would probably never reach a state of political consciousness, and would even be a hindrance to class struggle, fight and victory.

The British Conservative Government led by Margaret Thatcher during the 1980s joined forces with the American neoliberal and right-wing social commentator Charles Murray to create their own theory of the ‘underclass’ with ‘the cycle of deprivation’ – the supposed perverse effects of welfare dependency – in order to implement neo-liberal policies by rolling back welfare and State benefits and focusing upon the family rather than the structural or societal causes of inequality. This was a re-working and re-reading of the early work of Oscar Lewis in 1961, who through his research in Mexico City showed how the practices of the poor become named as ‘deficient’ when trying to cope with the everyday stresses that being poor can bring. Lewis noted that some of the poorest people in Mexico City at the time had regular work, but many survived from day to day through a miscellany of unskilled occupations, child labour, pawning personal goods and borrowing from local money lenders at exorbitant rates of interest. According to Lewis, first and foremost they survived because of their local social networks: family, neighbours and friends. Lewis described the social and psychological characteristics of what he calls the ‘culture of poverty’. He also described other characteristics of this poor neighbourhood, which includes being:

‘... distrustful of the basic institutions of the dominant classes, hatred of the police, and they are aware of middle class values ... but do not live by them.’

What Lewis was attempting with the ‘culture of poverty’ discourse in the 1960s was examining the value systems that the poorest live within, thus attempting to make sense and contextualising those everyday actions of people with limited choices because of the structure and the inequalities within their society, rather than purely examining the behaviour of the poor and blaming them for their situation.

However, Lewis’s theory of the ‘culture of poverty’ was misused by the British Conservative Government and Charles Murray during the 1980s using Lewis’s schema of the poor to perpetuate the notion that the poor are responsible for their own poverty. This narrative was taken up again during the 1990s with New Labour’s social exclusion policies, and has strengthened under the Cameron Conservaties with the Broken Britain narrative.

The poorest people and the neighbourhoods where they live within the UK have already been established and been conceptualised and known through many modalities, and the defini-
tions constantly shift. Those definitions have led to specific and often negative understandings of the Precariat, and it is through those negative namings that there has been growing stigmatisation of the poorest people in the UK. This has manifested itself in the genre of popular television programmes which 'watch the poor' in a pseudo-documentary way – a phenomenon recently known as 'poverty porn'. Programmes like Channel 4's Benefit Street, and the BBC programme We Pay Your Benefits has become an outlet for 'regular people' to become angry, and provide someone to blame for the rising inequalities in Britain. These programmes are based on simple but well-used narratives, the benefit-claiming, young, single mother taking too much from the State, or the lazy benefit family with no intention of ever working. These are myths and stories, rather than coherent narratives. In contrast recent and rigorous research by Shildrick, Macdonald et al. (2012) shows that poverty in the UK is caused by the insecure employment market where people move from no-pay to low-pay, zero-hours contracts, and welfare benefits.

And although the picture seems pretty grim at the bottom for the Precariat, who experience low pay or no pay, insecure housing and being known as dangerous. The truth is that it can become even bleaker. This is because disadvantage does not show itself only through lack of material and economic means. Disadvantage can also be culturally pitched, when a group is lacking or is denied the other resources necessary to live a life with dignity, such as respect and beig valued. What happens to this group of people who have over at least the last 30 years become known and named as those who have little value, and are of little value?

These are only some of the difficulties the Precariat face in modern Britain through media and political rhetoric which has been used unfairly in representing poor working-class people. Steph Lawler (2008) and Les Back (2002) have both argued that working-class people are rarely taken seriously; however, it is often assumed that they are easily 'readable' to middle-class observers. This criticism can also be levelled at the GBCS as it is rarely considered by those who observe working-class people and neighbourhoods that working-class people, and especially the poor working class, the Precariat, can know or understand themselves and can articulate their understandings, perceptions and feelings extremely well (Back 2002; Lawler 2008).

Unfair and mean representations of poor working-class people, and the places where they live, are everywhere in the UK and have been documented in the work of Skeggs (1997, 2004, 2009), Nayak (2009), Lawler (2002, 2008), Ray (2000, 2002, 2004), Haylett (2000, 2001, 2003), Munt (2000) and Sibley (1995). Lawler (2008) argues that working-class people are rarely named as class subjects but are often known and reproduced as ‘disgusting subjects’, usually through targeting descriptions of bodies and clothing (shell suits and large gold earrings, for instance), which are often used as shorthand descriptions in recognising working-class people. On the social networking site Facebook there is a facility where you can send ‘council estate gifts’ to your friends. The most popular council estate gift is an image of a group of young people in sportswear titled ‘mob of chav scum’: 824,000 people have sent this ‘gift’ to their friends on the site. The next most popular are images titled ‘a piss stained phone box’, and ‘a run-down community centre’. There are other ‘council estate gifts’ such as ‘over-the-top Christmas lights’, and ‘balcony draped with washing’. Lawler (2008) argues that cultural references can invoke signifiers, which do a great deal of work in coding a way of life which has been deemed valueless and repulsive. Bodies, their appearance, their bearing and their adornment, are also central to coding the poor, and when those codes are joined up with living space and in particular the term ‘council estate’, the reader or the viewer are left to ‘join up the dots of pathologisation’ in order to see and understand the picture: that certain ways of dressing and speaking, and living in certain places indicate a despised ‘class position but also an underlying pathology’ (Lawler, 2008, p.133; Skeggs, 2004, p.37). This underlying pathology that Lawler (2008) and Skeggs (2004) uncover is also about taste, or the lack of it. They use the work of Pierre Bourdieu to argue that those with the most power get to decide what cultural resources are tasteful regarding ways of dressing, personal styling, music, art, speaking and social pursuits. However, what Bourdieu (1986) argues is that, while the culture of the middle class is deemed legitimate and tasteful, it is the culture of the working class which is lacking in ‘taste’ and illegitimate. Lawler (2008) and Skeggs (2004) transport this argument further by exclaiming that the cultural practices of the working class are not only ‘tasteless’, but are also pathologised; coded as immoral, wrong and criminal.

Precarious and valueless
In 2013, I became part of the team working on the Great British Class Survey with the role of finding the Precariat for the purposes of the survey (Savage, 2015). This distinct group were underrepresented in the Great British Class Survey as they did not take the online survey in any significant numbers. It appears that the class calculator on the BBC website was also not taken by the Precariat unlike the Elite class, who found the experience flattering, interesting and fun. This is hardly surprising, as the other chapters in this book have shown that the survey was used by other groups as a way of confidently self-expressing their cultural knowledge and their superiority. The Precariat are placed at the bottom, and no one wants to come last, so it was expected that this group would not be as visible to the GBCS as other groups.

My part in the survey team was to try to understand more deeply why this group had not engaged in the original survey but also what they thought about the
survey, and how they were positioned within it. I was brought into the team because of my previous work relating to mothers who lived on a council estate in Nottingham, and then later work which I had undertaken with a group of young men living on the same council estate who were unemployed.

When it comes to working-class ‘taste’, I have always known there are complexities that social surveys and social research have failed to do justice. In the 1950s, Richard Hoggart in his book The uses of literacy critiqued how the working-classes were becoming sentimentalised in and through popular media. This, he argued, did a great injustice to those who suffered under unfair structural social systems. Hoggart pointed out that the pain and emotional hardships of material inequality which are manifested through cultural practice were seldom captured through research.

Consequently, I decided to use the GBCS as a tool in a more qualitative ethnographic way by doing the survey with my respondents and by also noting what they thought of the survey as we did it. I took the class survey in paper form to some of the respondents who had been part of my previous research in Nottingham, and to some of the respondents in my current research in East London.

One of the groups I met up with were women who were connected with a drop-in centre for street prostitutes in Nottingham. I had strong connections with the women which I had built up over many years, and we spent the afternoon ‘doing the GBCS’ together as a group. The GBCS proved to be a great tool and opened up many hours of discussion and laughter about ‘us’ what ‘we like to do’, and ‘them’ and why ‘they’ do what ‘they do’.

The women from Nottingham were undoubtedly in a precarious position; their lives where filled with insecurities, from where they might get their next meal, to where they would be living next week. However, some of the women had some security – they had council tenancies so they knew at least for now they were ‘safe’. However, all of the women never doubted for one minute where they might be placed within this survey. When I asked which class they thought they might be in, in unison they shouted ‘at the bottom’.

I later did a similar activity with a group of men in the pub in East London. Their reaction to the questions directly asking about ‘class’ were very different. Initially, they thought I was ‘out of order’ for thinking they were in any social class, though they knew what I was ‘getting at’. However, they relented to saying that, although they hadn’t really thought about it and didn’t really care, they were probably ‘somewhere in the middle’. There was a clear pattern between men and women; women had no doubts or illusions where in society they were situated, while the men were more resistant about where they thought they were situated.

Richard from Nottingham was 27 and had only been in paid work over the last year and was a building sub-contractor, self-employed and doing whatever work came his way, either as he said through ‘word of mouth’ or through agency work. He thought he was definitely middle-class, and estimated his earnings at over £50,000 a year. When I asked him to qualify this he told me that one week he had earned almost £700, so he multiplied this by 52. Although he recognised that this was ‘a very good week’, he was adamant that ‘potentially’ that is what he could earn. We did the class calculator which looked at his earnings and the people he knew in his life – Richard knew a wide range of people from DJs which he considered as ‘artists’ to lawyers who had represented him in court in the past, and university lecturers, which was me. Consequently, his result was ‘elite’ which he was quite happy about. If he had been ‘elite’ he might have wanted to tweet his result, however sadly for Richard he was not elite and did not have a Twitter account.

It was this level of interpretation which I most enjoyed about the Great British Class Survey and my group of respondents; they gave thoughtful and interesting answers to the questions and enjoyed thinking about the things they liked, and the things they should perhaps do more of. Within the survey there is a set of questions which asks about cultural activities with which you engage. My respondents gave wide ranging examples of activities they took part in. When I asked about visiting stately homes, museums, and going to the theatre, my respondents interpreted those questions through what they liked to do. They talked about visiting Madame Tussaud’s Waxwork Museum, taking their children to the Dr Who Museum in Blackpool, and going to see the live shows for Mrs Brown’s Boys, a popular BBC comedy about a working-class Irish family. As they talked to me about these activities which they enjoyed, I imagined the sniggers and wry smiles from those with enough cultural capital to know this was not what we were really asking, and that they had ‘got it wrong’. They talked about going to ‘real’ museums as children when they were at school; they reminisced about their school trips to stately homes and to local museums. However, these were not activities that they continued to do as adults, these were childhood memories of ‘the school trip’.

What was striking within this section of the survey, was that they knew that they were getting it wrong, and they knew what I was really asking in terms of class, culture and value. However, they explained that humour, community and collectivism, and most of all fun, was what was really important to them. Going on day trips with family, or as in the East London group, the coach trips from the pub to the Kent Coast, was what my respondents valued. They knew these were not valued cultural pursuits, and couldn’t really understand why liking the opera ‘got you more points’ than liking Mrs Brown’s Boys, to them one was funny and one was boring.

I have been asked many times over the years by people in my community, my friends and neighbours who suspect that I might know something
about these matters, why are some things more valued than others? And why are other things de-valued even though you like them? One of the most common questions women ask in my research is about the way they dress, and why they are ‘looked down on’ for wearing big hooped gold earrings, and why women on television shows are represented in a particular way: pony tails, track suits and wearing loads of gold when the storyline wants to show quickly how ‘common’ the character is. In all honesty and if I think rationally, I do not know why one arbitrary style is valued over another arbitrary style, apart from the fact that distinct people look, like and dress that way.

This is the cultural element to being the Precariat, and is as significant to class inequality as the economic material forces which produce it. Bev Skeggs (2005) has argued that the consequences of stigmatisation, and re-branding the poor working class as valueless, have been central in producing new ways of exploitation through the fields of culture and media, inventing new forms of class differentiation which are being produced through processes of what Pierre Bourdieu would term symbolic violence.

Being a person of value is important. Why else would some groups proudly tweet their class status, while others know already where they will be placed? Nevertheless, that does not mean that this group of people are not proud of who they are; they tell me constantly they are proud of their communities and families, and the adversities they recognise from being positioned where they are. Enduring hardship is always listed as a personal achievement. They know they are ‘looked down on’ and ridiculed, which is why they say they would rather stay among ‘their own’. It was always more important to this group of people to be liked and respected within their own community and from among people like them, which makes the instability and the precariousness of the Precariat the most cruel. Their resilience and resistance are mis-recognised as crassness, their protection of their profiles is known as ‘bad taste’, and their sense of communitarianism is seen as ‘bad judgement’ and rigidity. Although the Precariat are highly visible with their ‘bad taste’, the rationale behind their practice, and the value they have remains invisible.

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References

Understanding power in order to share hope: A tribute to David Smail

Jan Bostock

The psychological consequences of poverty, abuse and discrimination are palpable and debilitating, and clinical and community psychologists are in a position to represent this in our research and practice. We can account for how economic, social and organisational inequalities and deprivation influence communities and individuals, and understand how social processes can be undermining and also how they can generate resilience. We can also use our resources to work with others actively and publicly.

While recognising that psychological interventions are inherently limited and problematic, I would like to suggest that they may share hopeful ways forward with individuals, organisations and communities. Acknowledging and understanding the overwhelming physical and emotional consequences of the misuse of power can be a validating process that generates collaborative alliances. We can draw on David Smail’s framework for analysing people’s proximal powers in the context of distal forces to consider the scope people have to act individually or collectively, and to be open about the limitations and potential of psychological interventions.

I HAVE VALUED David Smail’s interest and influence in my working life since meeting him as an undergraduate over 30 years ago, and I have also appreciated his significant impact on clinical and community psychology. He always insisted that those who worked with him in the Nottingham Department of Clinical Psychology accounted for our views and practice through presenting and discussing our work. It is important to continue this discipline. So, in this paper, I aim to illustrate how I have used David’s analyses of the role of proximal and distal powers to inform my work in mental health and community settings. While psychological practice can be problematic, and may undermine and further pathologise individuals and communities, I aim to show that it can share hopeful ways forward. The potential for benign impact depends on taking account of how power is brokered within and beyond people’s individual lives.

David’s work suggests particular tasks that we should seek to address:

- To understand how experiences of wellbeing and distress are linked with the operation of power.
- To share understanding and ‘outsight’ as a means of furthering personal and social change.
- To act with common humanity and compassion to ‘mitigate suffering in others as in ourselves’ (Smail, 2004).

Understanding how experiences of wellbeing and distress are linked with the operation of power

Understanding our experiences of wellbeing and suffering requires the analysis of our current and historical access to power and resources. We are affected by where we are located in hierarchies of status, and our social positions are defined by such conditions as our class, gender, age and sexuality, as well as the status of our employment or whether we use mental health services, or live in a particular area. Power may be used benignly or maliciously and, confusingly, it may not be immediately apparent to us how power is being deployed now or in the past.

Powerful influences operate at different distances from us and are well represented in David Smail’s Impress of Power (1996). For example, we are all affected by cuts to funding in public services that are decided in Whitehall. The impact is felt through redundancies, job changes or important services becoming unavailable. The consequences of a policy change are dealt with and experienced locally to us via managers or local service providers, and it is often these more proximal players who affect our wellbeing.

Richard Wilkinson’s work (2003; 2004) links the universally consistent findings of inequalities in health outcomes with the following: low social status (which is experienced more negatively in proportion to the extent of income inequality); weak social affiliations and poor social support; and childhood adversity. We can combine David’s social-materialist and Wilkinson’s psychosocial analyses to develop accounts with people about prevailing influences on community and individual wellbeing.

To do this, we need to consider: (1) public and personal status often signified in individuals’ age, class, gender, race, mental health status, and their social position in their families; (2) access to a range of resources that Hagan and Smail (1997) have mapped out and which include past and current access to support, control, education, physical health assets, psychological resources (such as problem-solving skills); and finances; and (3) exposure in the past and currently to life events, long-term difficulties, and critical incidents that put pressure on individuals.

Occupational psychology research has revealed key characteristics of our environments that, if present, reflect high levels of wellbeing and functioning in organisations, e.g. employment demands, how much control we can exert, the clarity and value
of roles we hold and access to support (Health and Safety Executive, 2005).

The three elements of social position, access to resources and exposure to adversity (Figure 1), are linked. Poverty affects our status, our access to sources of support, and the likelihood of ourselves or those around us experiencing pressures such as health crises. The more stratified and unequal we are, the more potent the effects of disadvantage. Aspects of our status affect our access to a range of educational, cultural, occupational, social and economic resources, and the quality of our contact with others. Social solidarity is threatened in a society where people are set against each other, particularly those who are less advantaged. For example, political and media messages amplify divisions between poor, employed people and those who are poor and unemployed.

In seeking to highlight the impact of inequality and poverty, we need also to understand that people sense and react to injustice, both material unfairness and discriminatory attitudes. We compare ourselves with others, particularly those who are visible to us. Loss or threat to status affects us, as does the sheer drudgery of trying to live on insufficient money with the endless challenges this brings, such as not being able to buy clothes for the children, not being able to entertain the children’s friends, not having a smart set of clothes to go to a job interview, or not being able to fix an electrical appliance when it breaks down. Not being able to do the things that other around us are doing is powerfully undermining.

**Figure 1: What influences our wellbeing?**

In 2015, 39 per cent of families in the UK were living below the poverty line, and the percentage of adults whose income is below 60 per cent of median income has increased despite net disposable income reducing (Marmot, 2015). We need psychological approaches that appreciate the scale of the challenge of coping with ongoing hardship and restricted opportunities, and address the associated difficulties.

Five key questions that are pertinent to initiating and evaluating social and psychological interventions emerge from David’s work (1993, 2004, 2005):

1. What resources are available to this person/family/community?
2. What material, social and economic power is accessible to them?
3. What are their experiences of organisations, services and systems?
4. What possibilities for change are afforded by their situations and environments?
5. In whose interests is this intervention? Will potential change for this person be affected by the interests of others?

These questions can orientate our work with individuals and communities. They urge us to look from the outside in to gauge the scope for people to act on their situations.

**Sharing understanding and ‘outsight’ as a means of furthering personal and social change**

In mental health services, psychologists often seek to influence practice that tends to individualise and medicalise distress. Promoting formulation as a process of sharing understanding can help people consider the possible origins of their distress and options that may be open to them (Johnstone & Dallos, 2014).

In adult community services in Northumberland Tyne and Wear NHS Foundation Trust (NTW), we have suggested that formulations should be directly undertaken with service users and those multidisciplinary staff involved with them, and we have called our approach to formulation the 5Ps+Plan. This incorporates an understanding of: Presenting issues; Pre-disposing factors; Precipitating factors; Perpetuating factors; Protective factors, followed by a Plan of who is going to do what and when.

**Figure 2: 5 Ps + Plan.**
Using formulations with service users is a way to improve the quality of community mental health services. One advantage of a formulation-based approach is that it can accommodate different theoretical approaches and multidisciplinary perspectives.

In order to facilitate the incorporation of formulation in routine practice, a programme consisting of two half-days of training is being rolled out across all six localities in NTW which include services for adults, older adults and people with learning disabilities. So far, we have completed the full training with 265 staff. The two half-day training sessions have been well received and 60 per cent of the participants have said that they have since tried using 5Ps+Plan formulations with a service user.

In the training, we discuss how exploring formulation can improve our alliances with service users and their families in order to promote effective inter-}

ration can improve our alliances with service users using 5Ps+Plan formulations with a service user. The 5Ps+Plan offers a consistent format which draws on individuals’ strengths and needs, to aid communication and planning across pathways. We also outline what formulation is not, for example a list of symptoms or goals, a summary of the past, or static and unchangeable.

The 5Ps+Plan aims to enable a formulation to evolve in partnership with the service user to inform a shared understanding of current issues, and agree goals which inform intervention plans. A number of staff have identified themselves as ‘formulation champions’ and are keen to develop and progress the work meaningfully.

Service users have strongly supported and influenced this work, and the 5Ps+Plan training has been produced with service users who also co-facilitate the training. Inevitably, in delivering the training and supporting materials, there are biases to address, such as being very problem-focused, or assuming that ‘pre-disposing’ issues suggest an inevitable individual determinism in the onset of difficulties.

However, in some practice we find that the repercussions of historical trauma are underestimated, and we are assuming that a sensitive formulation process that includes reference to past experiences enables a more empathic and compassionate understanding from staff and service users themselves.

We plan to continue to roll out the formulation-based approach and training, and to encourage live supervision of formulation discussion in Pathway meetings with reference to a checklist which emphasises the engagement and involvement of service users; describing their strengths, validating their concerns, considering the possible impact of trauma and abuse, suggesting how interventions may help or hinder, and being sensitive to ongoing pressures in their lives. We are planning to further evaluate the impact of this work from service users’ perspectives.

This quote from Albert Einstein about formulation captures what I think we can achieve through adopting a meaningful and enquiring formulation-based approach:

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\text{The mere formulation of a problem is often far more essential than its solution, which may be merely a matter of mathematical or experimental skill. To raise new questions, new possibilities, to regard old problems from a new angle requires creative imagination and marks real advances in science. Albert Einstein, 1938.}
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To act with common humanity and compassion to ‘mitigate suffering in others as in ourselves’ (Smail, 2004).

People’s histories cannot be un-lived, but the effects can be ameliorated according to the resources that are available to them. A psychologist’s job is to identify the potential for individuals and communities to act on situations and for power dynamics to shift. David instigated the innovative blend of clinical and community psychology roles which developed in Nottingham in the 1990s which enabled clinical psychologists to work with others and have an active presence in local communities (Fatumirehin & Coleman, 1999; Fenner, 1999; Melluish & Bulmer, 1999). Local participative action research about the community and GP practices generated ongoing support groups and a network of campaigning groups, such as for the development of a play area (Bostock & Beck, 1993). This work was collaborative but such work always risks the charge of colonisation by clinical psychologists. Although our practice improves with more outward-facing roles, we need to be mindful of imposing psychological frameworks on communities (Orford, 2008).

A participatory approach to research set the scene for later work in Northumberland which involved young people working to improve their services (Bostock & Freeman, 2003); work with voluntary agencies and women who had experienced domestic abuse (Bostock et al., 2009); and a qualitative study of influences on wellbeing in a particular locality (Bostock & Ridley-Dash, 2008). We also developed a wellbeing programme which had a positive impact on the attitudes of fire-service managers to mental health, and generated suggestions for improvements to the working environment (Moffatt et al., 2014).

Qualitative research with women living in rural Northumberland who had experienced domestic abuse, identified how various systems reinforced abuse through ineffective protection, failing to address the women’s fear associated with abuse, or take account of the emotional and financial costs of leaving abusive relationships. Crucially, service providers also did not recognise the unacceptability of abuse. Services which took the victim’s side, offered a common bond (by offering solidarity and a chance to learn from others in similar situations), and made effective, practical help available, enabled the abuse to be challenged. But the effects of the abuse were often long-lived and pervasive, and influenced later experiences of relationships with children, partners and friends.
This research was used to inform workplace wellbeing policies about domestic abuse and as part of a regular training programme run by the local authority. It was also used as the basis of a self-help booklet, and is a specific topic in a suite of booklets concerned with general mental health problems.

The Psychologists Against Austerity initiative is an inspiring example of community activism by psychologists. In their briefing paper, they identify the indicators of a healthy society as providing opportunities for agency, security, connection to others, meaning and trust (McGrath et al., 2015). These indicators give a good basis for promoting societal change, as well as highlighting the damaging effects of current economic policies. This is a refreshing alternative to the usual focus of psychology which tends to be on individual psychological therapy.

Encouragement to act for individuals means understanding the balance between agency and lack of control for people in constrained situations. This is central in David’s writing and is a core dilemma for psychologists.

We continually underestimate what we need to overcome abusive or traumatic situations – the physical stamina and good health, the recognition of demands and threats, social skills, being able to voice one’s thoughts and express one-self clearly, self-belief, a composed appearance, practical and emotional support, money and doggedness. Even all these resources are of limited effectiveness in the face of persistent material disadvantage and ongoing abuse, injustice or discrimination. Generally, the resources we have can be deployed and sustained only if there are sufficient supportive people around us in our private and public lives who also have some resources and authority to share. We need ‘fertile soil in order to thrive’ (Perkins, 2015), and where people have robust connections to others who rate and support them, they are much more likely to find ways forward through adverse or traumatic situations.

The public generally, and clinical psychologists in particular, overestimate the power of individual therapy to help people overcome the psychological legacies of historical disempowerment and marginalisation that are often exacerbated by current pressures. We cite evidence-based practice, yet seem to ignore that even in trial-based therapy, average recovery rates are 58 per cent and therapists tend to be over optimistic about their impact (Lambert, 2011). But I take a more compromising view than David’s about the potential for psychological therapy and psychologically informed interventions to be helpful and helpful with individuals. Service users respond to the chance to establish trusting relationships, a shared understanding of the tasks of the intervention, and agreed therapy goals. Approaches that are structured, collaborative, consistent, validating, motivating and encourage self-observation are linked with more favourable outcomes (Castonguay & Beutler, 2006).

Enabling socially and psychologically informed practice needs to take a broader view than formal branded therapies. In my experience, service users, mental health practitioners, and community and clinical psychologists can draw on some established therapies (Gilbert, 2009; Ryle, 1990) These can inform specific interventions in mental health settings and can take account of the power imbalances that I have outlined.

Cognitive analytic therapy offers the concept of reciprocal roles and patterns of relating that can help people define in their own terms the positions that they and others take (Ryle, 1990). These may put them in constrained or more empowered relationships, and naming them can illuminate some of the perpetuating forces that make some situations so immobilising. Common patterns linked with abusive histories often involve roles and behaviours which are crushing/abusing, controlling, belittling and intimidating. These engender related survival strategies to ward off further danger, to manage overwhelming emotions, and thus gain as much control as possible. This was apparent in the Northumberland domestic abuse research (Bostock et al., 2009) in the active and passive ‘status quo strategies’ the women used in living with abuse.

Gilbert (2009) elaborates on the importance of status and the destructive consequences of sustained interpersonal competitiveness and acquisitiveness. Compassion-focused therapy provides carefully argued physiological evidence for the importance of comfort and breaks from threat and incentive-focused behaviour. Understanding the impact of past and current events on our emotions and how this may link with affiliative, incentive-focused or protection-seeking behaviours is both clarifying and validating, and leads to the sharing of ways to de-escalate distressing feelings.

Comfort comes from being heard and respected, and from experiencing the compassionate solidarity that David describes. Therapy is limited and potentially harmful if the challenging nature of people’s circumstances is insufficiently understood. Validation is a crucial aspect of contact between service users and providers, as is accepting that confusing and distressing thoughts and feelings can be considered for their meaning and relevance.

We need to get a balance between idealism and pragmatism. We need to be critically aware of the limitations of available psychological insights which tend towards the individualistic and politically blind, while also continuing to find ways to improve current practices in psychology and mental health and more widely. David encouraged us to work alongside people in individual, group and community settings, while always questioning our motives and impact. This is never a comfortable balance.

Alisdair Cameron from Launchpad, an organisation for mental health service users in Newcastle, urges us to hold the world to account and argues:
We need, more than ever, public professionals who can help us to understand and public professionals who can help support the legitimacy of the problems raised with society from those with least power and with least other forms of influence.

We need clinical psychology to get out of the office and beyond the therapy room because we need someone to help make the case for those who are losing out. To do that we need a clinical psychology that has political understandings but which also is close enough to people to be able to offer pragmatic support, too. Alisdair Cameron, Launchpad, Newcastle, September 2015.

Our legacy from David is to foster effective collaborative relationships with stakeholders at all levels; to hold compassion as decent human beings; and to go beyond individualistic and voluntaristic concepts for understanding and working with people and communities who are distressed or marginalised. I treasure memories of David’s kindness and warmth and also his tough insistence that we engage with burning issues of injustice, build connections between people, inspire debate, question, demystify, and address the causes of psychological struggles.

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Compassionate solidarity: Drawing links between the work of David Smail and Cuban psychology

Steve Melluish

David Smail, in his book Power, Interest and Psychology suggests that: ‘[w]e are not bound to accept the ‘real world’ as one in which the ‘bottom line’ defines right and wrong. We do not have to acquiesce in the impoverished vocabulary and banal ideological apparatus of institutional business.’ He proposes that that the kind of world we want is an ethical choice; one founded on the notion of compassionate solidarity with others and therefore, perhaps, ‘a better world is possible’.

UN MUNDO MEJOR ES POSIBLE’ (a better world is possible) is a phrase attributed to Fidel Castro and is a slogan visible on billboards and posters throughout Cuba. It may not be immediately obvious that such a slogan would have resonance with the work of David Smail, as David’s work has often been criticised for not offering solutions or even optimism. As David stated in his book The Origins of Unhappiness: ‘people… as far as I can see, tend to equate a lack of answers with pessimism or even depression’ (Smail, 1993; p.8). In my view, David’s work, while not offering solutions in any simple way, does hold out the possibility that ‘another world is possible’, and in doing so, offers a story of resistance and also one of hope.

In his book Power, Interest and Psychology, David states:

What kind of world we want is an ethical choice… just as the ruthless world may be chosen – as it is by the current rulers of the globalised neoliberal market – so it may also be rejected. (Smail, 2005, p.v)

He goes on to state that:

‘I’m siding with the wimps. We are not bound to accept the ‘real world’ as one in which the ‘bottom line’ defines right and wrong. We do not have to acquiesce in the impoverished vocabulary and banal ideological apparatus of institutional business culture. We do not, furthermore, have to be intimidated by the more sophisticated apologists of postmodernism and the free market to be found in the various academic nests like London School of Economics. Our undertaking, in contrast, rests on compassionate solidarity with others, and the fact that this is fundamentally and irreducibly an ethical choice does not mean it is irrational. (Smail, 2005, p.v)

It is this ethical stance and ‘compassionate solidarity’ that is evident in Cuba’s approach to its internationalism, its model of healthcare and its psychology. The origins of this ‘compassionate solidarity’ are, I believe, inextricably linked to Cuba’s history and in particular to the process of decolonisation, a social struggle that can be seen as catalysing the development of critical ideas. It is these two themes of compassionate solidarity and decolonisation that I want to explore in this paper1.

With recent fluctuations in US-Cuban relations, there is increased speculation as to Cuba’s future and whether Cuba’s isolation as a result of the US embargo is coming to an end. It is, however, this isolation over the past 56 years that has created a unique social context. Cuba has existed uniquely isolated from an increasingly globalised world and the dominant neoliberal economic model that has spread individualism and consumerism around the globe. Cuba’s isolation can, therefore, tell us something about how a different world is possible outside the globalised neoliberal system. Perhaps also, for us as psychologists, it may tell us something about how the nature of psychology as a discipline may differ in a different socio-political context. Before going on to talk about these aspects of Cuba, I will very briefly provide some historical context.

Brief history of Cuba

For all but the last 56 years, Cuba has been a colony, or neocolony, first under Spanish rule and then US domination (except for a few months under the British). This history of colonisation and domination by European powers and North America is key to understanding Cuba and the origins of its ‘compassionate solidarity’.

For writers such as Enrique Dussel, European colonisation of the Americas led to an entirely new set of relationships between people in Europe and the rest of the world (Alcoff & Medieta, 2000). This colonisation provided the wealth on which European capitalism was built and at the same time created a new way of looking at the ‘other’

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1 I do this from the perspective of a Western psychologist, whose connection and knowledge of Cuba has been gained as part of a long-standing exchange programme between the University of Leicester, where I work on the clinical psychology programme, and the University of Holguin, Cuba.
as inferior or subhuman. In many ways, the cultures of the Americas were destroyed or subordinated by colonialism and within these subaltern areas, new hierarchies were constructed. The Cuban revolution can be understood as part of an ongoing struggle against this colonial history, as was evident in the earliest speeches of the Cuban leaders after the revolution in 1959.

*What is Cuba’s history but that of Latin America? What is the history of Latin America but the history of Asia, Africa and Oceania? And what is the history of these peoples but the history of the cruellest exploitation of the world by imperialism.*

(Fidel Castro – Second Declaration of Havana, 1962)

The Cuban revolution identified itself in compassionate solidarity with those people who had suffered colonisation; and with subaltern populations across the globe. The revolution can therefore be viewed as a struggle for both independence and decolonisation.

Colonialism has been inextricably linked with the development of capitalism and in its process of decolonisation Cuba developed a non-capitalist/socialist economic model that is based in the absence of exploitation, a high degree of social fairness and the widest possibilities for access to culture and education (Martinez, 2007).

The Cuban revolution can be seen as a striving to shape a new social consciousness and set of relationships founded on humanistic values, Che Guevara spoke of a ‘new human’ (Guevara, 1971) where people valued social relations and these were given priority over productive or economic forces. This social consciousness is the foundation of compassionate solidarity and was at the heart of the process of decolonisation. For the leaders of the Cuban revolution, this was not seen as something to be limited to Cuba and the Cuban people, but rather something to be extended to all disempowered people across the globe.

**Internationalism**

Following the revolution, compassionate solidarity became central to Cuba’s relationship with the wider world, and Cuban medical internationalism was a key part of its support for anti-colonial struggles. In 1963, the first Cuban medical brigade was sent to Algeria during its war of independence. Since then, Cuban medical missions have involved ‘135,000 Cuban health workers working in 37 Latin American countries, 33 African countries, and 24 Asian countries’ (De Vos et al., 2007, 772). Most recently, Cuban medical teams have worked in Haiti after the earthquake (Castro et al., 2015) and in West Africa during the Ebola crisis.

A key aspect of Cuban internationalism is that local problems are seen as global; as problems for all. In other words, peoples’ suffering (regardless of their governments’ politics and policies) is something the Cuban people have an ethical obligation to respond to. This ethical approach is at the core of the training of health professionals offered by the Latin American Medical School (Escuela Latino Americana de Medicina, ELAM). ELAM in Havana is the world’s largest medical school and has trained doctors from 29 countries (including the US), mostly selected from impoverished backgrounds, mostly from countries across Latin America and lower- and middle-income countries (LMIC), as it is considered that they will have a better understanding of working in poorer communities (Huish & Kirk, 2007). The Cuban State covers tuition costs, accommodation, sustenance and a small stipend over the six-year training period but students are required to make a commitment to return to their countries and work with the underprivileged and those most in need.

Cuba’s medical internationalism has provided significant support to many countries and has been widely acknowledged, for example by President Rousseff in Brazil:

*Cuba is the only country in the world capable of sending a contingent of a 1000 doctors in rapid time to areas of most need.* (Ravsberg, 2013)

Nelson Mandela’s first port of call on being released was Havana in 1991, where he paid homage to the Cuban people. He stated:

*We come here with a sense of great debt that is owed to the people of Cuba…What other country can point to a record of greater selflessness than Cuba has displayed in its relations to Africa?* (Ali, 2006, p.117)

**Cuban psychology**

We have seen how compassionate solidarity is evident in Cuban internationalism, but what of psychology? What would psychology look like under the Cuban system? We may even wonder whether psychology would exist at all. In *Power, Interest and Psychology*, David Smail hints at his disillusionment with the discipline, seeing it as a central tool of ideological power that diverts people from criticising the material conditions of their lives (Smail, 2005, p.ii). However, in a system that acknowledges such materiality, what role would psychology play?

Before the revolution, psychology in Cuba was just an academic subject among many others in the university, while in practice, there were a few psychologists trained in the US, Europe or Mexico who were working but reproducing the main theoretical trends of US psychology. These psychologists had little contact with one another and did not see their role as addressing the social needs of poorer Cuban communities (Lacerda, 2015).

The Cuban revolution created a new context. Many of the existing Cuban psychologists left the country, leaving a vacuum. Perhaps surprisingly, after the revolution it was Che Guevara who was keen to develop psychology. Che dispatched Cuban psychologists and health professionals to visit various
countries such as the US, Mexico, the Soviet Union, Hungary and the UK to research how psychology was organised (Yaffe, 2009).

The revolution saw psychology as having a key social role: firstly, in developing an understanding of the social conditions of the Cuban people; secondly, in helping to develop literacy campaigns in poor communities; and thirdly, in working to promote health. Psychology was to be a public service, free of charges and available in public spaces. Psychology was seen as having an important role in building the conditions in which a socialist society could flourish, and in creating a new social consciousness, a compassionate solidarity (Corral, 2011).

Psychologists were employed to develop an understanding of the social conditions by undertaking surveys and research to shed light on Cuban society and provide grounds for making political and economic plans (Rodriguez, 1990). These surveys examined factors such as housing conditions, women’s roles and religious practices, as well as working conditions in sugar mills.

The work of psychologists in literacy campaigns was part of an attempt to empower the Cuban people and to construct a new culture and identity. Surveys after the revolution showed that the subjective representations Cubans had about themselves as a consequence of colonialism were characterised by inferiority and insecurity (Corral, 2011; De la Torre, 1997). Interestingly, in subsequent decades, studies of Cuban people using questionnaires, action research and analysis of dreams showed the emergence of a new identity, qualitatively different from other countries in Latin America. While for many people in Latin America identity was associated with feelings of inferiority, Cubans showed confidence, a sense of solidarity and co-operation (De la Torre, 1995, 1997; Díaz Bravo, 1995).

Psychologists were also employed to promote health through the development of ‘health psychology’. Health psychology was defined as a field that spans the health–disease continuum, pursuing both health promotion and disease prevention (Lacerda, 2015, p.310). The aims were: to understand health as a process instead of a state; to focus on the social determinants of health; to give attention to educational processes and promote social research; to have a commitment to poorer communities, and to encourage active participation (Morales, 2011).

Thus, Cuban psychology was initially employed as a device in the service of social and political needs, and was very much part of the Cuban ‘national project’. Cuban psychology was seen as a tool for developing a social consciousness and as part of tackling social injustices. It was characterised by pragmatic eclecticism with diverse roots that reflected Cuba’s history, with an appropriation of ideas and techniques from North American psychology and European models.

A significant part of Cuba’s history that I have not discussed so far, is the Soviet influence from 1962 up until the euphemistically termed ‘special period’ in 1989 when the Soviet bloc collapsed. Over this period, Cuba’s economic isolation as a result of the US blockade led to economic dependence on the Soviet bloc. As the Soviet economy influenced the Cuban economy, so too was culture and science influenced. While the Soviet influence facilitated the diffusion of Marxist ideas and a critique of capitalism and imperialism, it also meant external domination by another country and a further form of colonisation. Some Cuban psychologists such as De la Torre (2009), as reported by Lacerda, acknowledged this cultural impact:

> While Cuban psychologists criticised Latin American psychologists for reproducing the psychology made in the USA, they were repeating the same error with the Soviet union. (Lacerda, 2015, p.314)

With the fall of the Soviet bloc in 1989, Cuban psychologists began questioning the Soviet influence. None the less, Marxist ideas were retained along with the idea that psychology could be used as a tool to eliminate unjust social conditions. De la Torre (2009) refers to ‘critical assimilation’ as a device to overcome coloniality in psychology.

> Instead of an importation of external knowledge or the mechanical rejection of foreign theories, critical assimilation entailed a conscious search for critical recovery of any theoretical or practical contribution that can be useful to Cuban Psychology. (De la Torre, 2009)

In practice, this ‘critical assimilation’ is evident in the influential legacy of Vygotsky’s cultural historic focus (CHF) approach which underpins much of the Cuban approach to psychology today. The CHF approach is not a direct imitation of Soviet psychology, but has been adapted to fit within a Cuban context and acts as an umbrella or frame within which many models are incorporated, such as CBT, and psychodynamic and humanistic approaches. It is important to note that while there may appear to be resemblances with psychology in the West, the CHF approach means that these models are used in a different way in practice.

Within the CHF approach, symptoms are understood as disruptions in the network of social relationships within an individual’s life. The work of the psychologist is seen as an ethical intervention that facilitates a person to think about why and how the symptom has occurred and how it relates to their social history, as well as how it is related to the wider cultural and political context. Symptoms are, therefore, not seen as simply happening, but are understood through the person questioning the social structure and the place they have as part of that system. As the Cuban psychologists Otto Vasquez and Ana Gutierrez explain:

> From this perspective, the clinical situation presents an ethical dilemma: how can we help people to change the society when the relationship between society and...
the individual is the source of the problem? From a pragmatic position we apply therapies, rehabilitation, preventative and promotion strategies from different points of view, but all along trying to remember that we are all in social contexts that involve injustices. (Vasquez & Gutierrez, 2010, p.43)

The critical assimilation of De la Torre meant that elements from the ideas and writings of indigenous thinker-activists such as José Martí were also incorporated into Cuban psychology. José Martí is the Cuban national hero who led Cuba’s independence from Spain in 1900. The Cuban psychologist González Serra draws links between the thinking of Martí and Vygotsky stating that:

We estimate that both thinkers give us the theoretical and ethical foundations of the cultural historical Cuban psychology… The elective thought of Martí is essentially dialectical. Martí and Vygotsky point out the historical character of the human psyche. Martí said that the human being is a reflection of his society. Martí and Vygotsky want to create a spiritually superior human. Martí wants to forge an altruistic human being, creative and independent. (Gonzalez Serra, 2003, p.167)

Since the beginning of the new millennium, Cuban psychology has started to develop closer ties with critical psychologists in Latin America. There was a renewed interest in rebuilding a psychology from indigenous sources and in developing an understanding of psychology as part of a wider theoretical decolonisation and transformation process within Latin America (Quintana, 2013). The pragmatic eclecticism of Cuban psychology, where practice has tended to dictate theory rather than the other way round, has been likened by Mark Burton to the approach of Martín Baró, the founder of liberation psychology (Burton, 2011).

It shouldn’t be theories that define the problems of our situation, but rather the problems that demand, and so to speak, select, their own theorisation. (Martín-Baró, 1998, p.314)

Today, Cuban psychology is very much integrated into Cuba’s national health strategy and inextricably linked to working towards the goals of prevention of illness and promotion of health. Cuban psychology is also very much part of the social context of Cuban society.

For psychologists in Cuba, their context has been shaped by the cultural and political discourse about revolutionary change and by the revolutionary project to build a more equitable and just world. This context has in turn clearly shaped their practice and their theoretical perspective. While Cuban psychology has been very much part of the revolutionary project, and some may argue it has been a ‘tool of ideological power’, it has also played a critical role in making visible some of the contradictions and hidden aspects of Cuban society such as domestic violence, machismo and gender issues.

In thinking about Cuba today, my sense is that while the revolution seems a distant event and the imagery and slogans associated with it seem somewhat stale and outdated, there remains a revolutionary legacy among many Cuban people that is manifest in a social consciousness and a spirit of compassionate solidarity. While many Cuban people are understandably desperate to overcome the many economic problems they face, it seems many also want to make ‘an ethical choice… to reject the ruthless world… based on the globalised neoliberal market’ (Smail, 1993, p.v). For many, ethics continues to be at the heart of the Cuban psyche as well as the Cuban model of healthcare, its internationalism and its psychology.

In conclusion, Cuban psychology does demonstrate that a different psychology can and would exist in a different social political context. Furthermore, for the outsider, Cuban society and the ‘Cuban psyche’ does provide glimpses of an alternative way of being as a self in a social world, and Cuban psychological practice does indicate that another psychology is possible, just as another world is possible.

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The promise (and potential pitfalls) of a public health approach in clinical psychology

David Harper

David Smail’s work provided an excellent example of how one might view individual distress within its social context, a context which ranged from the level of interpersonal relationships to the forces of global capital. In this paper, I review how individualised solutions to emotional distress are increasingly preferred over collective or structural approaches. Within medicine the discipline of public health has proved to be a useful counter-balance to this tendency. I discuss some of the benefits offered by adopting such an approach in mental health, while also acknowledging the need to address some of its problems (e.g. the rather uncritical use of heterogeneous diagnostic categories of varied validity and reliability).

The increasing use of individualised and reactive mental health interventions

Throughout the last three decades, prescriptions of psychiatric medication have been increasing, both for adults and children, well above the rates of growth of the population. Figure 1 shows how the costs of prescription for two classes of drugs rose in the 1990s, especially anti-depressants – well above the rate of inflation. Ilyas and Moncrieff (2012) report that in England, prescriptions of anti-depressants alone rose from 15,000 in 1998 to over 40,000 in 2010. Prescriptions of methylphenidate (trade name: Ritalin) rose from 6000 in 1994 (Timimi, 2004) to just under a million in 2014 (Health & Social Care Information Centre, 2015).

If we treat the numbers of clinical psychologists as a proxy measure, there has also been a large increase in the amount of individual psychological therapy received. Figure 2 shows the increase in membership of the Division of Clinical Psychology (DCP) over the last few decades. There were 362 members in 1970 (Hall et al., 2002) and 10,202 by 2011 (British Psychological Society, 2012). There were 11,279 clinical psychologists registered with the Health and Care Professions Council in January 2015 (HCPC, 2015). Despite this, the demand for psychological therapy continues to outstrip...
supply (Mental Health Taskforce, 2016; We Need to Talk Coalition, 2013). For example, although the NICE guideline for schizophrenia recommends that all those with this diagnosis should be offered cognitive behavioural therapy (CBT), the National Audit of Schizophrenia found that, even when using a very inclusive definition of CBT, only 18 per cent of service users reported having received it (Royal College of Psychiatrists, 2014).

What might account for such increases in demand? Certainly, one explanation is that, over time, problems of living have become increasingly medicalised (Illich, 1976). Is there now just more psychological distress? Busfield (2012) argues that there is little evidence of change when similar data sets are examined over long periods of time. She notes, however, that changes in diagnostic thresholds (for example, the lowering of thresholds in the revisions of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders or DSM) have large effects. Rose (2006, p.479) suggests that each of a number of potential hypotheses play a part, including the way in which mental health professionals act as ‘moral entrepreneurs’ advocating for new diagnoses and new treatments, the role of the pharmaceutical industry in constructing the way we view distress and the best way to address it and what he terms ‘the psychiatric reshaping of discontents’. Busfield (2010) suggests that the increasing use of psychiatric medication can be accounted for by the strategies the pharmaceutical industry deploys to generate demand for their products, the role of doctors as researchers of – and gatekeepers to – medicines, the role of the public as consumers of medicines, and the way in which the actions of governments and insurance companies indirectly facilitate such expansion.

Bracken et al. (2012) argue that the popularity of both biomedical and cognitive psychotherapeutic interventions reflect the assumptions of what they term a ‘technological paradigm’ which assumes that distress arises from ‘faulty mechanisms or processes of some sort, involving abnormal physiological or psychological events occurring within the individual’, that ‘these mechanisms or processes can be modelled in causal terms’ which are not viewed as context-dependent, and that these technological interventions are ‘instrumental and can be designed and studied independently of relationships and values’ (p.430).

This is not a new critique. Indeed, a number of scholars, including, of course, David Smail, have made similar arguments over the last few decades. In the US, for example, the late George Albee (1986, 1990, 1999) and Seymour Sarason (1981) criticised clinical psychology for its focus on the individual rather than the social, and for its failure to move towards a more preventative focus. As Sarason has argued:

*The therapeutic endeavour needs no justification, but when that endeavour becomes nearly all-encompassing in focus and policy, one must suspect not only the crippling role of parochial thinking but also the failure to examine and confront the nature of the society itself.*

(Sarason, 1981, p.835)

Individual therapy focuses on resolving problems at an individual level rather than at the level of the population as a whole. Similarly, it is reactive – it addresses problems once they have arisen – rather than preventative. Where preventative approaches are adopted in clinical psychology, they tend to be in the domain of secondary prevention – targeting intervention through the early identification of problems rather than in the domain of primary prevention, i.e. addressing the primary causes of distress so that problems do not arise (Harper, 2016). In the 1990s, Keith Humphreys made similar criticisms:
If we were to sit down with a blank sheet of paper and decide on the best way to reduce population-wide distress with the most urgency, would the best solution be individual psychological therapy? Albee (1999) would argue not: ‘[i]ndividual psychotherapy is available to a small number only. No mass disorder has ever been eliminated by treating one person at a time’ (p.133). Although the Increasing Access to Psychological Therapies project has increased the numbers of people receiving psychological therapy, the therapy offered is relatively short-term and its design necessitates this otherwise the service would grind to a halt due to increasing demand. Is it ethically and economically feasible to continue to expand the use of medication and therapy?

Figure 3: Graphic at Tent City University’ at Occupy London, St Paul’s (2011-2012). Photograph by Helen Spandler.

If we are to try to find a different way of thinking about and responding to psychological distress beyond individual therapy, there is a range of potential alternatives within psychotherapeutic traditions, including interpersonal and group therapy approaches, systemic family therapy and narrative therapy, especially its community work inflection (Denborough, 2008; Freedman & Combs, 2009; White, 2003). There is also innovative work going on in the service user movement – see the range of perspectives in the 30th anniversary issue of the independent mental health magazine Asylum: An International Magazine for Democratic Psychiatry (http://www.asylumonline.net/). For clinical psychologists, one of the most obvious alternative traditions is that of community psychology. We could also look outside the discipline of psychology for inspiration. Within medicine, the tradition of public health aims to target interventions at the level of the population and to develop primary preventative approaches. Thus, rather than simply treat the health effects of smoking, we aim to prevent people taking up smoking or encourage smokers to give up. What might be the mental health analogues of such an approach?

Potential benefits of a public health approach

Public health practitioners tend to have initial trainings in other professions (e.g. medicine, nursing, etc.) followed by further post-graduate training in public health (e.g. a Master’s degree in Public Health). Previously, they worked in Public Health departments in Strategic Health Authorities, informing the commissioning of services. Following the 2012 Health and Social Care Act, commissioning and public health are now clearly separated. Public health is now the responsibility of local authorities, whereas health services are now commissioned by clinical commissioning groups (CCGs). Commissioning is supposed to be informed by local Health and Wellbeing Boards which include representatives from social services, the CCG, the public health department and others.

Peter Kinderman (2014) has critiqued the continued dominance of a medical approach to mental health in the NHS and has advocated that clinical psychologists might be better placed in local authorities and thus be more able to develop a psychosocial approach in collaboration with other agencies – an approach first developed in the UK by Mike Bender and colleagues in Newham Social Services department over 30 years ago (Bender et al., 1983; Burton & Kagan, 2003; Burton et al., 2007). Now that public health is located within local authorities there is, perhaps, much more of an opportunity to focus on the social context of psychological distress given the well-established links between distress and inequality (e.g. Friedli, 2009; Psychologists Against Austerity, 2015; Social Exclusion Unit, 2004; Wilkinson & Pickett, 2009). Public health practitioners are used to identifying social causal influences on physical health and using evidence of this to change policy and legislation (e.g. the 2007 ban on smoking in enclosed public spaces). There are a number of ways in which clinical psychologists might help in such an endeavour (Harper, 2016).

The public health tradition has previously had little impact on British clinical psychology. A few years ago, I searched for this topic in back issues of Clinical Psychology Forum but identified only two relevant articles: a review of the Black report on health inequalities (Black, 1982) by Peter Stur-}

**The effectiveness of psychotherapy for most of those who receive it is no longer in doubt but neither is the fact that psychotherapy can only reach a small portion of society.**

(Humphreys, 1996, p.193)
(Bostock, Noble & Winter, 1999; Cromby, Harper & Reavey, 2013; Holland, 1991, 1992; Holmes, 2010; Kagan et al., 2011; Orford, 1992), and recent new innovations, including liberation psychology (Afuaa & Hughes, 2015). These approaches could be combined with insights from researchers who are experienced in considering population-level health interventions (e.g. Hepworth, 2004). Moreover, there are a range of well-evidenced interventions to improve public mental health (Division of Clinical Psychology, 2014; Friedli, 2009; Newton, 2013; Taylor et al., 2007), including improving the quality of life in neighbourhoods (Biglan & Hinds, 2009) – a major causal influence on distress at community level. Such a move would also be timely as public mental health has been seen as a recent government priority (as evidenced by, for example, Public Health England, 2015).

**Potential obstacles to adopting a public mental health approach**

There are, however, a number of objections which are often raised in discussions about clinical psychology adopting a more preventative, psychosocial, population-level focus:

**Clinical psychologists are primarily individual psychological therapists and don’t have the skills for this work**

This ignores the fact that many psychological skills are transferable and generalisable. Many clinical psychology programmes include teaching on a range of interventions beyond psychological therapy – like community psychology – and many foster placements where trainees can learn how to work with a range of bodies – for example in the third sector. Indeed, an increasing number of clinical psychology programmes are placing trainees in public health departments (Jenkins & Ronald, 2015), some in specialist public mental health placements.

Many clinical psychologists see the profession as synonymous with the provision of individual therapy, and yet the focus on this as our main intervention has arisen gradually over recent decades and results from a number of influences: the wish to develop non-medical interventions autonomously from psychiatry (moving away from the profession’s initial role in providing technical support to the diagnostic process); the increasing popularity of psychological, especially cognitive behavioural, therapies in popular culture; the continued failure of biomedical psychiatry to find simple bio-genetic explanations of, and interventions for, distress; government acknowledgement of the rise of consumerism and the service-user movement, a major demand of which has been access to talking therapies and choice of treatments; and the way in which the rise of the evidence-based practice movement coincided with the availability of the results of randomised controlled trials for a number of, predominantly cognitive behavioural, individual therapies.

British clinical psychology has traditionally adopted a pluralistic approach to psychological therapies. Even with the increasing dominance of CBT, clinical psychology training accreditation guidelines promote the learning of CBT plus an additional approach. This enables clinical psychologists to innovate, drawing on a range of theories. The report by the Management Advisory Service (1989) introduced the idea of there being three levels of psychological skill. Single-model therapy would belong at Level 2 but adopting a public health approach would require the employment of skills associated with the third level in this hierarchy. For example, clinical psychologists could integrate epidemiological and population-level data with models from community psychology, systemic approaches, interpersonal and intra-psychic traditions together with insights gained from clinical practice to develop more sophisticated models and interventions. Of course, with increasing numbers of people trained on single-model training programmes (e.g. Master’s degrees in CBT) there will be increasing competition for Level 2 work.

**Figure 4: Management Advisory Service levels of psychological skill**

<table>
<thead>
<tr>
<th>Level</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Basic ‘psychology’ – activities such as establishing, maintaining and supporting relationships with patients and relatives, and using some simple, often intuitive techniques, such as counselling and stress management.</td>
</tr>
<tr>
<td>Level 2</td>
<td>Undertaking circumscribed psychological activities (such as behaviour modification). These activities may be described by protocol. At this level, there should be awareness of the criteria for referral to a psychologist.</td>
</tr>
<tr>
<td>Level 3</td>
<td>Activities which require specialist psychological intervention, in circumstances where there are deep-rooted underlying influences, or which call for the discretionary capacity to draw on a multiple theoretical base, to devise an individually tailored strategy for a complicated presenting problem. Flexibility to adapt and combine approaches is the key to competence at this level, which comes from a broad, thorough and sophisticated understanding of the various psychological theories.</td>
</tr>
</tbody>
</table>

*Adapted from Management Advisory Service (1989, p.6).
This is community development/social work/economics, not psychology

This is a related objection but it rather begs the question of who gets to define the nature of ‘psychology’. For example, if we were to ask a clinical psychologist for their definition of the discipline in the 1950s it might have been almost entirely focused on psychometrics and diagnosis. Disciplines evolve over time and respond to changing circumstances. Indeed, clinical psychology has shown remarkable adaptability over time and has moved through a variety of stages like psychometrics (1950s), behaviour therapy (1960s), psychotherapeutic eclecticism (1970s) and managerialism in the 1980s (Pilgrim & Treacher, 1992). It could, therefore, develop a public health approach given the right conditions. Interestingly, although we might view income inequality; for example, simply as a matter of economics, some researchers argue that economic policies are driven by assumptions and beliefs, concepts which are arguably well within the domain of psychology:

In the world’s richest countries injustice is caused less and less by having too few resources to share around fairly and it is increasingly being maintained by widespread adherence to beliefs that actually propagate it. (Dorling 2011, p.1)

Of course, if we are to do anything about the structural causes of inequality, we need policies to achieve this. Given the extent to which many members of the public have inaccurate perceptions of poverty and inequality and accept many myths (for instance, that welfare benefit fraud is widespread) there is a need for campaigns to address these perceptions. Social and psychological research may be of use in such a venture (Bamfield & Horton, 2009; Delvaux & Rinne, 2009; Harper, 2016; Psychologists Against Austerity, 2016).

Clinical psychologists are paid to provide therapy, not engage in community psychology or develop preventative mental health interventions

The introduction in the NHS of Payment by Results and other commissioning initiatives means that, increasingly, clinical psychology services are paid only for the provision of direct psychological therapy. In correspondence in the American Psychologist following Humphreys’ (1996) article (e.g. Hamburg, 1997; Lieberman, 1997), the question was raised: who would pay for clinical psychologists adopting a more community preventative focus? Clearly, the development of a new approach will require a significant change in commissioning arrangements and incentives. Of course, the provision of individual psychological therapy didn’t just happen. Indeed, in the UK, the increased provision of psychological therapy has been the result of concerted lobbying by alliances like the New Savoy Partnership and the We Need to Talk Coalition both of which the British Psychological Society is a member. Humphreys (1997) suggests that we need to advocate within the policy arena for funding in these areas, much as we and others did to raise the profile of psychological therapies. We need advocacy for a psychosocial approach to public mental health. As Jim White has argued, psychologists ‘are worth the money as long as we exploit all our skills, not just the therapeutic ones’ (White, 2008, p.847).

It is frustrating that, just at the time that we need to be moving beyond a reactive and individual focus, services are increasingly focused on this work because of perverse commissioning priorities. Senior clinical psychology posts, especially those involved in management, consultation, community liaison, service development and innovative projects have been cut and a whole layer of institutional memory about the shaping of policy has been lost. In contrast, clinical psychology posts at band 7 are much less likely to be cut. As clinical psychology is increasingly being seen as synonymous with the provision of individual therapy, the danger is that only those interested in individual therapy will apply to train as clinical psychologists.

Mental health prevention and promotion are not sufficiently evidence-based

The government’s Chief Medical Officer has recently suggested that there is an insufficient evidence base for preventative approaches in mental health (Davis, 2014). This ignores the fact that there is some good evidence out there (Friedli, 2009; Newton, 2013; Taylor et al., 2007). It is, perhaps, no surprise that there is less literature on prevention than on individual treatment, when one examines the priorities of research funders. One recent report examined the relative amounts spent on research on depression and psychosis (MQ, 2015). For depression, £2.71m was spent on aetiology, £1.05m on treatment but only £0.3m on prevention. For psychosis, £1.67m was spent on aetiology, £0.3m on treatment but only £0.19m on prevention. Clearly, there is a significant mismatch here. One suspects that much of the aetiological research consists of fairly speculative bio-genetic research rather than being based on the much firmer evidence for social causal influences on distress.

This sounds too political. Psychologists aren’t allowed to be political

Psychologists tend to be comfortable in looking at what David Smail called the proximal causes of distress but, as he often argued, they are less comfortable in examining distal causes like poverty and inequality, despite the substantial evidence base which exists (e.g. Friedli, 2009; Psychologists Against Austerity, 2015; Social Exclusion Unit, 2004; Wilkinson & Pickett, 2009), and Mary Boyle (2011) has documented the varied ways in which the discipline of clinical psychology has tended to avoid the social context. This is illustrated by debates within the Brit-
ish Psychological Society about the extent to which it can become involved in influencing policy, a situation complicated by the Society’s composition of a variety of sub-disciplines, some of which (e.g. practitioners) are keen to influence policy-makers. It is also complicated by the fact that the Society is governed by regulations relating to its status as an organisation with a Royal Charter and its status as a charity regulated by the Charities Commission. One or both of these aspects is often referred to in Society debates where a common refrain has been whether a proposed action is ‘ultra vires’ – i.e. beyond the Society’s authority. This refers to whether the action is consistent with the Society’s aim, as stated in its Royal Charter:

(i) to promote the advancement and diffusion of a knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of Members of the Society by setting up a high standard of professional education and knowledge. (British Psychological Society, 2002, p.3)

As the Society is both a charity and a professional organisation recognised by the Privy Council, its policy work also needs to be consistent with this aim. The discussion and dissemination of research evidence on the social context of distress, including the effects of inequality seems to me, to be well within the objects of the Society, specifically the ‘advance-ment and diffusion of knowledge of psychology pure and applied’. The Society has, in the past, provided information on the psychological effects of a whole range of social issues – for example, it commissioned and published James Thompson’s (1985) Psychological aspects of nuclear war at the height of the Cold War. Moreover, the DCP website refers to the International Union of Psychological Science’s (2008) Universal Declaration of Ethical Principles for Psychologists. Principle IV (Professional and Scientific Responsibilities to Society) includes the following statement:

Psychology functions as a discipline within the context of human society. As a science and a profession, it has responsibilities to society. These responsibilities include contributing to the knowledge about human behavior and to persons’ understanding of themselves and others, and using such knowledge to improve the condition of individuals, families, groups, communities, and society. [emphasis added]

The Universal Declaration also refers to the discipline’s ‘responsibility to increase scientific and professional knowledge in ways that allow the promotion of the wellbeing of society and all its members’. It seems to me that policy advocacy in pursuit of improving the psychological wellbeing of the population is consistent both with the Society’s aims and with international psychological ethical standards. Of course, this does not necessitate campaigning for or against a particular political party but it does require us to act not only as individual citizens, but also as part of our public duty. The DCP’s statement about the core purpose of the profession, for example, includes this aim:

Clinical psychology aims to reduce psychological distress and to enhance and promote psychological wellbeing by the systematic application of knowledge derived from psychological theory and data. (Division of Clinical Psychology, 2010, p.2)

Potential pitfalls of a public health approach

There are likely to be challenges in adopting a new orientation in clinical psychology and I’ll focus on three potential pitfalls in particular.

Uncritical use of diagnostic categories

No doubt because it is still largely a medical discipline, the literature in public health tends to adopt a somewhat uncritical approach to psychiatric diagnostic categories, despite the fact that many functional psychiatric categories are heavily contested. As Bentall (2004) has noted, for example, the diagnosis of schizophrenia does not predict prognosis, outcome or treatment. Moreover, while many assume that reliability problems with psychiatric diagnosis lie in the past, the field trials of DSM-5 tell a different story with an editorial in the American Journal of Psychiatry accepting far lower levels of reliability than would previously have been the case, with agreement 50 per cent of the time presented as ‘good agreement’ (Freedman et al., 2013). Allen Frances (Chair of the committee which drafted DSM-IV) has commented:

[The American Psychiatric Association] flunked – instead of admitting that its reliability results were unacceptable …. the goalposts were moved. Declaring by fiat that previous expectations were too high, DSM-5 announced it would accept agreements among raters that were sometimes barely better than two monkeys throwing darts at a diagnostic board. (Frances, 2013, p.175)

Some other examples of the reliability and validity problems of these categories can be seen in Figure 5. Unfortunately, much epidemiological research uses these categories fairly uncritically but this need not necessarily be the case as many of the national epidemiological surveys collect data on particular experiences (or ‘complaints’ or ‘symptoms’) which could be analysed at this level rather than grouped into the more problematic heterogeneous categories. Moreover, clinical psychologists could improve the situation by conducting epidemiological research with constructs with good reliability and validity, taking account of population base rates and so on (Harper, 2016). A related problem is the problematic concept of ‘psychiatric literacy’ (or ‘mental health literacy’) which appears implicitly to assume a biomedical model of psychological distress. Of course, clinical psychologists could contribute to the development of a more psychosocially informed approach.
Figure 5: Some problems with ‘functional’ psychiatric diagnostic categories.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliability</td>
<td><em>DSM-5</em> field trial results report low inter-rater reliabilities. For example, the diagnosis of schizophrenia had a K value of 0.46 (Freedman et al., 2013).</td>
</tr>
<tr>
<td><strong>Validity</strong></td>
<td></td>
</tr>
<tr>
<td>Diagnostic thresholds not based on empirical analysis of base rates</td>
<td>Delusions still regarded as major indicators of psychosis and yet Van Os et al. (2000) found 3.3 per cent of 7000 Dutch general population sample met all diagnostic criteria for a delusion.</td>
</tr>
<tr>
<td>Grant et al (2004) state that '[o]verall 14.79 per cent of adult Americans … or 30.8 million, had at least one personality disorder’ (p.948). This seems high for phenomena regarded as a ‘disorder’.</td>
<td></td>
</tr>
<tr>
<td>Categories lack clear boundaries</td>
<td>Cluster analyses of population-wide symptom surveys do not map onto psychiatric diagnostic categories (Mirowsky &amp; Ross, 2003).</td>
</tr>
<tr>
<td>Heterogeneity of categories: two people with the same diagnosis can present with totally different symptom profiles.</td>
<td></td>
</tr>
<tr>
<td>High co-morbidity of categories (e.g. approximately 50 per cent of those with a diagnosis of major depression also meet the criteria for anxiety: Hirschfield, 2001).</td>
<td></td>
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</tbody>
</table>

**Problematic concepts**

Another area of concern lies in the way in which certain concepts have been taken up in public health, particularly notions of ‘vulnerability’, ‘empowerment’ and salutogenic (i.e. focusing on determinants of health rather than illness), asset-based approaches typified, for example, by notions like ‘resilience’. There is insufficient space to deal with these concepts in detail but, in short, notions of vulnerability run the risk of focusing on the victims of harm rather than the systems, people and processes that do the damage (Boyle, 2003), while notions of resilience can obscure structural causes and collective solutions (Friedli, 2013; Harper & Speed, 2012). David Smail (1994) warned of the dangers of psychologising empowerment – in some articles, for example, it seems to be a gloss for simply feeling better about oneself rather than reflecting any actual change in power relationships. Of course, these problematic concepts are also present in clinical psychology itself and, once again, psychologists can engage in research, scholarship and debate to help develop more useful approaches.

**Reductions in public expenditure**

Moving responsibility for public health from the NHS to local authorities could have been a transformative move had it not been simultaneously accompanied by substantial cuts to central government funding for Councils (on a much larger scale than cuts experienced in the NHS). In a study of public health departments a year after their move into local authorities, over half of respondents reported that their budgets were not ring-fenced in practice and they were being affected by cuts to Council budgets (Royal Society for Public Health, 2014). Given the announcement to cut spending on public health by £200m in 2015–2016 (Price, 2016), it seems this situation is likely to worsen.

While the time is perhaps not yet right for a wholesale move of clinical psychologists into public health departments or, as Kinderman (2014) suggests, into local authorities, if psychologists successfully advocated for a change in commissioning and research priorities, then they could begin to adopt a much more preventative role from within the NHS. It should be noted here that I am not necessarily arguing that there should be no funding for individual psychological therapy. Rather, I am arguing for a new funding stream explicitly focused on prevention. If the Greater Manchester trial of integrating health and social care services (BBC News online, 2015) works, then the direction of travel may be towards greater integration with potentially more opportunity to engage in more preventative work, though only if there are sufficient resources allocated.

Governmental policies often include contradictory imperatives and priorities, giving mixed messages. Public Health England (2015), for example, appears to signal clearly that prevention is a priority while cuts to public health budgets give the opposite impression. Psychologists and others need to advocate for more consistency so that we can develop a more psychosocially informed approach to public mental health. To prepare for this, we need to consider how we train the workforce. In the final section of this article, then, I’ll focus on this important aspect.
How do we take things forward? Implications for policy advocacy and for training

Surprisingly, there is relatively little focus on mental health within public health, with only some departments having a public mental health specialist. An indication of mental health’s relatively low priority in the public health system can be seen in the content of public health curricula:

There are academic courses at both undergraduate and postgraduate level for public health specialists and practitioners. However, our desktop study found that only 45 per cent of undergraduate and 20 per cent of postgraduate courses have a public health curriculum that clearly includes mental health. (Public Health England, 2015, p.7)

Given the potential to make a difference at scale to populations, there is clearly a significant need for psychologists to become much more engaged both with public health departments and with the training of public health practitioners.

If we are to facilitate the development of preventative approaches, there are implications for the training of clinical psychologists. Humphreys (2000) noted that most US clinical psychology internships (i.e. placements) were in traditional clinical settings, and he suggested that programmes offer internships in new settings: preventative interventions; public policy; and community service and action. There are examples of clinical psychology programmes organising such placements – Jenkins and Ronald (2015) describe their experience as trainee clinical psychologists on placement in a public health department, and a number of clinical psychology programmes are currently organising placements in public health departments including in public mental health specialisms. These are exciting developments. Moreover, given the relative lack of focus on mental health in public health departments, a clinical psychology training placement could be mutually beneficial for those departments (who can learn what clinical psychology has to offer on a low- or no-cost basis) and for trainee clinical psychologists. Such placements would enable trainees to use their skills in gathering and disseminating useful research. They would also enable trainees to learn new skills in working with policy-makers. A number of public health researchers have noted that influencing policy in this arena requires the development of pragmatic advocacy skills (Carey & Crammond, 2015; Humphreys & Piot, 2012; Wardle & Steptoe, 2005). Indeed, Mallinckrodt et al (2014) have recently described the scientist-practitioner-advocate model of training. Such models have the potential to equip a new generation of clinical psychologists with the skills to advocate for greater social justice and so shape a more psychosocially informed approach to public mental health.

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We Need to Talk Coalition (2013). *We still need to talk: A report on access to talking therapies.* London: Mind.


The necessary ambivalence of David Smail: A critical realist reflection

David Pilgrim

CERTAIN TRENDS and seeming contradictions can be spotted in the work of David Smail. His early work focused heavily upon justifying and offering a humanistic form of psychotherapy. Later, he began to question whether therapy was over-valued and possibly largely futile. Eventually, he located mental health status firmly in proximal and distal material social conditions. In this presentation, that ambivalence will be summarised as an example of a collective dilemma about psychosocial complexity. That dilemma was not David’s alone but was, and is, present for anyone in the mental health industry, whether we are therapists, researchers or service users. My paper draws upon the philosophy of critical realism to illuminate that shared ambivalence for us all.

David’s work moved over time from emphasising the unique dimension to personal experience, when working with people in distress, to the material conditions, past and present, relevant to their particular lives. His work also was infused with an ethical dimension: he returned often to the matters of power and human agency. As he knew, at all times we live in a world that is not a level playing field. This means that ambivalence or equivocation is present in the work of any serious-minded approach to lived experience, which is situated in time and place because we are dealing with extensive complexity about a triangle of factors in dynamic flux over time.

Everyone speaking at David’s commemorative conference explored the precarious ambivalence we all necessarily experience when doing our best with the complexity he suggested. All of us have a limited capacity to deal with its totality. Each point and relationship between the points is a seductive resting place for our attention. We can offset this risk though.

**Figure 1: Complexity over time.**

First we can be honest self-critics within the iterative process of research or writing. Stop and think: ‘What did I miss out?’ Second, work with others – ask them why for them the whole triangle is not in full view. Third, explore topics that demand multi-factorial causal reasoning, which is about people, their construal of the world and the particular material conditions of their bodies and social settings, past and present. Moreover, that reasoning must include not exclude values (the error of naïve realism or positivism). We live in a moral order and human science is necessarily a moral science (Brinkman, 2011). Human scientists are part of what they study – they cannot be ‘disinterested’. We need to be mindful of what we study and why, as well as what we ignore. An omissive critique is about our silences not only our research activity (Bhaskar, 2009): why do we study some aspects of reality and not others?

**Multiple factors: George Albee’s two formulae**

Picking up on my third injunction, here are some examples which test our ability to expect and respect complexity. The first is the work of George Albee. For those who find arithmetical metaphors useful, here is his take on the relationship between the prevention of mental illness (MI) and the promotion of mental health (MHP) (Albee, 1993).

\[
\begin{align*}
\text{MI} &= \text{stress} + \text{exploitation} + \text{organic factors} + \text{support} + \text{self-esteem} + \text{coping skills} \\
\text{MHP} &= \text{coping skills} + \text{benign env.} + \text{self-esteem} + \text{stress} + \text{exploitation} + \text{organic factors}
\end{align*}
\]

Notice how in his attempt to be comprehensive, Albee has done a fair job. The material context is there in buckets, and so is conduct. He recognises experience in its inner and interpersonal sense. He does not deny our biological reality. He does not avoid the value judgements that must come with human science (‘exploitation’ is there to be seen). All good stuff – except that he has no conceptual or pre-empirical reflections about what he means by MI and MHP. Nonetheless, his formulae are very helpful and illuminating.

**Reformist mental health promotion**

Here is another example from some health economists (Knapp et al., 2011) about complexity when empirically calculating the cost-effectiveness of public mental health initiatives. They found that the three highest ‘pay offs’ were: the prevention of dysfunctional conduct through social and emotional learning programmes; suicide prevention through bridge safety barriers; and suicide prevention training in primary care. The three poorest interventions were: early intervention for depression in diabetes; befriending of older adults; and health visitor efforts to reduce post-natal depression.
This health economic approach is necessarily about limited resource allocation within the welfare state arrangements of capitalist economies. That context of realpolitik, so loved by neo-liberal politicians, constrains what is possible but it still prompts us to think of structures outside of people and their distress. Maybe it is a good idea to have safety barriers on bridges, just like it is a good idea to take guns out of society; suicide and homicide rates would be affected dramatically in countries like the US.

Layar's own goals

Here is another example that prompts us to think about multiple factors and ethics in context: the work of the labour economist Richard Layard. Basically, he points out that miserable people make poor workers and they are thus an impediment to socio-economic efficiency. Consequently, he argues that it is cost-effective for governments to treat mental illness in order to remove the burden it creates in lost productivity, poor fitness for work and the costs of long-term health care access. The ear of Gordon Brown meant Layard's Improving Access to Psychological Therapy initiative, which placed cognitive behaviour therapy centrally, became public policy under New Labour (Layard et al., 2006). Layard's book on happiness pointed out that the 'hedonic treadmill' and social inequality have led to no improvement in the mental health of developed societies of Western Europe, North America and Australasia, despite overall GDP increases in the past 50 years (Layard, 2005).

Layar's class background (public school and Oxbridge) and his coming into confident adulthood in the post-Second World War period (with a common cultural belief at the time in the 'technological fix') meant that he believed there could be an expert fix for any problem provided the right expert could be found. That is how he proceeded when faced with the social problem he called 'mental illness'. His chosen advisory group of psychiatrists and one clinical psychologist from his nearby metropolitan elite offered their solution: the mass availability of CBT. Unlike anti-depressants, CBT could not be put into the water supply but it could be made widely available on the NHS. This was linked to the Pathways to Work initiative, offering Gordon Brown the promise of fiscal savings, which he gladly and naively embraced.

This was all before the downturn of international capitalism in 2008. Gordon Brown and the metropolitan elite of the IAPT group and 'The Depression Report' were impotent in the face of the impact of the neo-liberal project, in a world in which the sub-prime mortgage crisis in the US rendered the poor of the UK and other countries even poorer. What we now have, post-2008, is a world of insecure employment; the very scenario which impacts negatively on mental health even more harshly than chronic unemployment (Kasl et al., 1998).

Layar scored a few truly dazzling goals in his upstream analysis about the emergence of misery in unequal societies that fetishise conspicuous consumption. Sadly, though, these were cancelled out completely. He offered us 'howlers' of 'own goals', when believing in a 'technological fix' for human misery. Worse than that, his commitment to the view that mental illness was the cause (sic) of misery, rather than being co-constituted by it, was flawed logic. This meant that the real causes of misery (childhood adversity, current poverty, bullying at work, domestic violence, status envy, etc.) could be expunged from his analysis. Moreover, the naive realism of CBT, within IAPT, with its conveyor-belt reliance on a treatment-of-a-diagnosed-disorder approach (rather than one of rich formulations), also scorned a realist account of the insults and adversities that underpin distress. IAPT and CBT are yoked in a world which is out of touch with the complex reality of our mental health and our distress.

'Poverty Sucks' but 'Money Can't Buy Me Love'

My next example of a challenge in which we have to keep many balls in the air, or plates spinning, relates to the matter of money. A part of the current body of knowledge we have about the social context of mental health relates to wealth. The happiest countries are those in which 'post-materialist values' predominate (Richard Wilkinson's excellent contribution in this document elaborates why). The US is the richest country in the world but by no means the happiest. The relationship between gross national product (GNP) and happiness is not linear but curvilinear. Beyond a certain level of GNP, there is a flattening about happiness: slight ups and downs in wealth make no difference. For example, even with dramatic negative changes in economic circumstances, after years of growth in the 'noughties', there were only slight declines measured in self-rated happiness among the Irish.

However, in Europe there do remain variations between nation states. The European Social Survey shows that individuals in one of the richer countries, Denmark, report the highest level of happiness. By contrast, those in Bulgaria have the lowest because of its brutal transition to capitalism in the early 1990s. This savaged its welfare and educational systems and created an amplifying gap between the richest and the poorest.

The World Happiness Index is noteworthy because of the absence in the top-ranked countries of both the USA and the UK. The repeated measure of the global trends about happiness note that those in absolute poverty are certainly the most miserable but...
The authors also noted (this was pre-2008) that globally happiness had increased gradually since 1980, and they suggest that this was a function of three intersecting processes: increasing wealth, democratisation, and greater social tolerance. Conspicuous consumption diminishes the quality of our lives, but the prioritisation of mutually intimate relationships does the reverse, as does belonging to a faith group. Suddenly getting much richer does not generally make us happier (Brickman et al., 1978). Although richer people in a particular society are generally happier than poorer people, increasing one’s personal wealth does not increase subjective wellbeing (Diener & Biswas-Diener, 2002).

Sen (1998) notes that routine and stable daily access to a set of benign experiences at home, in public spaces and at work, along with confidence in an adequate welfare state for when and if we become poor, sick or disabled, all underpin our wellbeing. By implication, the converse is true: domestic violence, crime (or fear of it), noise pollution and bullying at work, or poor task control in one’s job all have a negative impact on our mental health.

Sen’s assumptions about direct and contemporary environmental circumstances, are reinforced by studies of extreme events: being homeless impacts negatively, as does being tortured, sexually assaulted or raped. Floods, hurricanes, earthquakes or genocide leave measurable impacts, and the most obvious and common direct external impact comes from warfare (Keane, 1998).

In addition to poverty reduction and the closing of social inequalities, warfare remains one of the most important political challenges in improving mental health for us all. The wave of refugees from war-torn, post-colonial settings to Europe now means that we have to re-conceptualise our service philosophies about mental health. In the UK, our current approaches were predicated on 50 years’ worth of political stability in the Western world. However, global war and 35 years of the neo-liberal project have left us having to start all over again in our thinking about what needs to be done.

Apart from the physical shock of sudden environmental events outside of the person’s control, biographical disruption has both inner and outer impacts. A traumatised person may be impaired in their ability to trust others and may lose confidence in their ability to work. These inner aspects of life may be combined with external dislocation and loss. A person may lose their job and livelihood and with it their identity and social status.

The luck of the draw
From conception onwards, our chances of good mental health are inflected by social context. We do not decide whether to be born here and now or there and then. Our gender, class and race are wholly or overwhelmingly determined by the accident of our birth. We do not choose our parents, and we are lucky if we have ones that treat us lovingly and with respect and do not emotionally, physically or sexually abuse us. Some of us are simply luckier than others in all of these regards.

Warfare is probably the most horrible contingency for any of us but especially if we are civilians not combatants (Goldson, 1993). Our evolution and our early forms of societal organisation, based on hunting and gathering, had low levels of both competitive aggression and lethal technology. Once we settled rather than wandered, and territory and prized mates were protected by the willingness of men to be violent to other men, then our collective slow suicide as a species began, spurred on in its scale by the invention of distal weapons of mass destruction.

The power hierarchies that ensued with the transition from feudalism to capitalism, based on class and gender, and the colonial military adventures that wove casual racism into our social organisation and everyday norms of thought and action, ensured multiple forms of inequality. For this reason, when faced with a live person who is distressed or dysfunctional by their own admission or according to others, we have to formulate their problems using intersectionality.

The intersection of class, race, gender, age and sexuality will all inflect our particular experience of mental health. Social class is by far the strongest of these predictors but it is not the only one; other social group memberships have to be considered and they will vary in their salience from one person to another (Rogers & Pilgrim, 2014). Moreover, even the inclusive sociological notion of intersecting forms of ‘social group membership’ does not do the job fully. When we trace the role of childhood adversity in inflecting adult mental health status, we come to recognise that an actual social group (those with abusive experiences in childhood) are not empirically recorded in social epidemiology.

A final critical realist reflection
I have explored all of the above examples elsewhere in book-length detail (Pilgrim, 2015). There, I tried to summarise in tabular form the complexities of the triangle I introduced at the outset. The first table sets out the internal factors that increase or decrease our luck in life and the second sets out the factors which are external to our existence and often out of our control or awareness. Both are aspects of reality: this is not an ‘either/or’ logic but one of ‘both/and’. We are both determined and determining beings.

With the summary implications of these tables in mind, I want to end on some points from the philosophy of critical realism (Bhaskar, 1986). This philosophy rejects the naïve realism of positivist natural science and social science and also highlights the perils of strong social constructionism from within idealist philosophy (traceable via Foucault to Nietzsche).

Critical realism is committed to the primacy of ontological realism (the world exists and it is mind-independent). It also recognises that...
we individually and collectively, across time and space, construe that reality in variable ways (epistemological relativism). And at the end of it all, we can do our best in good faith to make sense about what is true (judgmental rationality). One of the early speakers at this conference emphasised how David’s work impressed him so much because it told the truth about a complex and oppressive world in flux. All of us would do well to follow David’s example.

<table>
<thead>
<tr>
<th>Table 1: Self factors (modified from Pilgrim, 2015).</th>
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</thead>
<tbody>
<tr>
<td><strong>INTERNAL REALITY</strong></td>
</tr>
<tr>
<td>Acceptance of given reality</td>
</tr>
<tr>
<td>Stability of self</td>
</tr>
<tr>
<td>Trust in self and others</td>
</tr>
<tr>
<td>Tolerance of change</td>
</tr>
<tr>
<td>Meaning as process and outcome</td>
</tr>
<tr>
<td>Free of bodily pain</td>
</tr>
<tr>
<td>Control over movement</td>
</tr>
<tr>
<td>Can enjoy pleasure as it arises</td>
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</tbody>
</table>

| **EXTERNAL REALITY**                      | **Life affirming factors** | **Life negating factors** |
| Stable peace                               | Warfare                    |
| Participatory democracy                    | Lack of participatory democracy |
| Bodily health                              | Bodily disease             |
| Adequate welfare safety net               | Inadequate welfare safety net |
| Adequate diet                              | Inadequate diet            |
| Stable shelter                             | Unstable shelter           |
| Religious or other existential ordering   | Poor existential ordering  |
| Benign neighbourhood                      | Malign neighbourhood       |

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References
Schools, wellbeing and clinical psychology

Julia Faulconbridge

Working in a consultation role in a large secondary school over the last few years has provided me with a window into that world. In this paper, I will discuss my observations on the impact of political and social changes on students and staff and how the culture within a school can have both positive and negative impacts on psychological wellbeing. I will consider the opportunities for whole-school community engagement in making change happen.

1. Introduction and background

I wanted to give a brief talk at this memorial conference as I worked closely with David from when I started work in his department as a probationer clinical psychologist in 1975 through to his retirement, and remained friends with him after that. I cannot overstate his influence upon me.

As Jim Meikle and I wrote in the introduction to the reissued 2003 DCP Forum:

As Head of Service, David was our ‘line manager’ but he rarely told anyone directly what to do. Rather he took time to communicate a framework in which we should be seeking to work with patients – a framework of morality and scientific honesty about the nature of distress which should underpin our interventions.

In David’s department, the discipline of clinical psychology was seen as fundamentally an intellectual enterprise rather than just an exercise in pragmatism. Each week ended with a Friday afternoon seminar which we all took turns to present. The younger members of the department often dreaded these because of the rigour with which clinical issues were addressed at a theoretical and philosophical level but these seminars are the ground on which my practice of clinical psychology has been based and I know that others who passed through the department also share that retrospective sense of the crucial importance of those and similar discussions within the department.

I left the NHS in 2007 when my community-based child and adolescent service was disbanded. Since then, I have been working at a national level to try to bring about change.

For the last eight years, I have worked one day every fortnight with a colleague in a large comprehensive school with a rural catchment area which also takes students from a deprived area of the City. My paper is based on observations I have made in my work in that school and with policy-makers, together with discussions with young people and my colleagues, and in it, I will give a brief snapshot of some of the distal and proximal forces at play. I will also talk about some positive steps that can be made.

2. Child mental health

Perfect storm

The psychological wellbeing of our children and young people and the services available to them are widely acknowledged to be in crisis. Money was taken out of the system and services devoted to promoting psychological wellbeing and intervening early were lost or severely depleted. The evidence indicates rising levels of psychological difficulties and, with less available to help children and families in the early stages, referrals to child and adolescent mental health services (CAMHS) increased while these services too were often coping with reduced funding. They responded by raising thresholds for accepting referrals with the result that problems had to be serious and entrenched before children were accepted, and even then children sat on long waiting lists while resources were taken up by those in crisis. The easiest way to get seen has become an admission to A&E for self-harm.

Basic statistics

Around one in three young people will experience a mental health problem before they reach 16 and the rates are much higher in other groups, such as those young people in social care or involved with the criminal justice system. Only a quarter of these will get any help. Unsurprisingly, 75 per cent of adult mental health problems begin before those experiencing them reach adulthood.

In the general population, England was ranked 14th out of 15 countries in a recent international survey for children’s life satisfaction.

The Health Select Committee report on Children’s and Young people’s Mental Health and CAMHS in November 2014 stated:

There are serious and deeply ingrained problems with the commissioning and provision of children’s and adolescent’s mental health services.

The Coalition Government Task Force led by the DH and the NHSE produced ‘Future in Mind’ a report which analyses problems and describes changes which need to be made through local transformation plans.
Yet the separation between rhetoric and reality, between aspiration and resources, continues to be stark.

3. Teachers
Schools are now required to promote the psychological wellbeing of their students. Teachers are seen as key to this and yet most have had no significant training in psychological development or in how to identify and help children with difficulties. And teachers themselves are suffering from very high levels of psychological distress:
- HSE found teaching to be the most stressful occupation in UK.
- Suicide rates within the teaching profession are 40 per cent above that of general population.

In my work with schools, I see every day the stress that teachers are under. Academic workloads keep increasing and the pastoral needs of students are yet another pressure. In the past, teachers would come back refreshed after holidays but frequently now work through those holidays. The approach of the GCSE and A-level results used to be a time of anxiety for young people; the anxiety of the teachers is now as bad, if not worse. Individual teachers, heads of department and the senior team are judged on the results their students achieve, and their jobs may depend upon achieving the targets.

The vast majority of teachers I meet continue to show an impressive level of commitment to their students. However, I know from the testimony of many young people that the ineptitude and sometimes lack of care they experience in schools causes significant further harm. In many ways, the easiest way to handle those with difficult behaviour is to allow the situation to escalate until the child is excluded.

4. Current Department for Education (DfE) policy
While the DfE has a mental health strategy and has stated its commitment to this, it appears to have a circumscribed understanding of psychological wellbeing and seems to work from a model that sees problems as residing in children rather than being the result of a complex web of children’s experiences and relationships. As examples, this means the DfE:
- Consider that children can be educated to be psychologically healthy and that part of a school’s role is to instill ‘character’ and ‘grit’ in students. They will talk about the importance of reducing stigma but not recognise that this is at odds with their model of ‘character-building’ which implies that if you have problems, it is because you have insufficient strength of character.
- They see provision of a (fairly small) pupil premium to the school for each child coming from a low income home as addressing the issues, rather than addressing poverty and lack of opportunity for these children.
- They also have a very narrow attitude to what a good outcome is for children, focusing on a limited definition of academic achievement, which means that:
  - Teaching is narrowed to what a child needs to pass an exam with narrowed curricula, which do not value creativity and practical skills, and prioritise old-fashioned models of learning.
  - Assessment is focused on SATs and other criteria-based tests and the aggregated scores are then used to judge the success of the school. However, assessment is of value to the individual child only if it is used in their interests, to understand the causes of areas of difficulty, e.g. if they are struggling with reading and teaching is adapted accordingly.
  - Everything happening in the school has to be couched in terms of what it contributes to academic attainment; even investment in mental health has to be described in terms of students being better able to learn, rather than being of value in its own right.

This mind-set results in policies like parents being fined for taking their children out of school in term times. DfE said:

‘It is a myth that missing school even for a short time is harmless to a child’s education. Our evidence shows missing the equivalent of just one week a year from school can mean a child is significantly less likely to achieve good GCSE grades, having a lasting effect on their life chances.’

This assumes that life chances for young people are only to do with school attainment and not all their other life experiences, especially those with their families.

Social world of the school
Schools are identified as a key area where psychological wellbeing could be addressed, and research shows that a positive school experience can mitigate other adverse circumstances. Yet they are actually a significant cause of some of the problems. In addition to the academic pressures, schools must be one of the most intensive social experiences in existence. Social media have markedly amplified this as the school relationships now continue in both positive and negative ways outside of the school gates.

The impact of bullying on short- and long-term psychological wellbeing is well documented and the use of social media has added new and damaging layers to this. Social media is a pervasive and often positive part of young people’s lives but the interaction with developing sexuality is a real concern. Attitudes, particularly of boys to girls, are being influenced by widespread access to pornography, and ‘everyday sexism’ is common.

An article in The Guardian reported findings that sexting is becoming normal among young people, and quoted a 15-year-old girl:
It’s so common nowadays that no one sees it as a bad thing anymore, it happens so often. But if you are one of the girls who don’t send them, you are seen as frigid and scared. If you are one of the girls who do send them, you end up being seen as one of the slags or sluts of the year.

We have also encountered several examples of online grooming and exploitation, often involving more than one student.

**Family and environmental factors**

The problems outlined above are having a significant impact on our young people but so too do the difficulties that they have in their lives outside the school.

Common backgrounds for the young people we discuss are:
- bereavement and suicide in the family;
- acrimonious family breakdown;
- parental ill health and mental health problems;
- poverty;
- living in areas with high levels of crime and neglect;
- emotional, physical and sexual abuse;
- domestic violence.

Interestingly, we also know that many children with background like this never get referred to CAMHS-type services.

We both had many years of prior experience in Nottinghamshire community-based mental health services, including consultation and work with schools. However, actually working in schools added a level of complexity and challenge:
- We could see first-hand how a student’s psychological difficulties place major limitations on their ability to engage with teachers and other students in a positive way.
- Often their difficulties affect everyone in their classes as teachers try to deal with the difficulties while continuing to teach.
- Children with difficulties interact with each other, often exacerbating situations.

**Summary**

Schools are, therefore, extremely complex organisations, and I have tried to highlight some of the proximal and distal pressures that are operating on them. The distal pressures are powerful but can we bring about some change by taking a whole-school approach?

One option is to site mental health services in schools, and this is being done successfully in some places, particularly in London, but this takes a level of resources that don’t exist at present.

What else can be done in schools themselves?

**Helping teachers to help young people**

**The Consultation Model**

It became apparent very early on that teachers who had great commitment to the wellbeing of their students were often lacking in the knowledge required to understand why pupils behaved in problematic ways in school and saw it as somehow ‘just behaviour’ which needed to be managed via discipline, sanctions, etc. While they recognised the difficult circumstances that many of these children were living in, they did not necessarily see the connection between that and the behaviour. Children who had emotional difficulties often gained a more sympathetic hearing but patience tended to run out quickly, and descriptions of students being or becoming ‘attention-seeking’ were common.

The consultation model aims to develop an understanding of a young person’s behaviour and the factors which lie beneath it, and then to develop appropriate ways to help. The aim is early intervention and the prevention of more serious problems wherever possible.

The process of consultation is very important. We work with a core group of staff and having two psychologists means that our thinking is out loud and collaborative. This has the following effect:
- it allows disagreement and makes thought processes explicit;
- it allows multiple perspectives to be considered;
- it allows non-psychologist perspectives to hold equal weight;
- it promotes a non-expert model even though we are bringing our expertise and experience.

The focus is on understanding the multiple perspectives contributing to the young person’s difficulties.

This is an ongoing and developmental process and most young people are discussed on a regular basis, sometimes for more than a year while we continue to work out how to understand and best help them over time. We do refer young people on to other appropriate services, and also support the school counsellor to provide the direct work that some young people and families need.

**Evaluation of the consultation model**

**For young people**

On average we have discussed 67 young people/year 63 to 75 per cent showing improvement.

**For staff**

Staff felt they had a better understanding of factors that might underlie behavior, with increased insight into the difficulties faced by some young people, including how complex their lives are. Staff were more likely to think about issues of emotional health and wellbeing as explanations for a young person’s behaviour.

They said their work had changed as a result of consultation; they felt affirmation for their work and felt more confident in being able to help students in difficulty. They became committed to trying to improve emotional health and wellbeing in the school not just to help those in difficulty.
Helping young people to help young people
In this paper, I have focused on the problems but there are a great many positives about being a young person today, and the majority will come through adolescence relatively unscathed! I also meet many amazing young people who are really trying to make a difference in the lives of those around them and in the wider world. Their knowledge, energy and commitment can be used to create positive change.

ABC – Anti-bullying campaign
The school wished to redevelop a scheme I had helped them with previously which was basically a peer-mentoring scheme to help with bullying. The mentors were Year 10 pupils who provided support to students who had been bullied, and also set up some social activities. The scheme had dropped away after the original, very committed teacher retired.

There was significant difficulty in setting the scheme up due to problems with finding a teacher who had the time and commitment to support it. I feel strongly that such schemes must have very active support from teachers to safeguard both the mentors and the young people who they talk to. The scheme did not take off in the same way as before mainly as a result of the lack of time and continuity from staff. The young people were really engaged and positive about this with great ideas for how it would best run based on their understanding of the social world they inhabit. In the end, they could run social sessions only two lunch-times a week which, while valuable, was much less than they wanted to do.

We are planning to develop this again this year once the correct level of staff input has been identified.

Helping teachers and young people to work together to make schools a psychologically beneficial place to be
Real change can come from teachers and young people working together to make changes.

We have discussed developing the ABC scheme further to form a Student Council who will lead on developing a whole-school psychological well-being strategy. The school would really like to take this on but currently cannot find the resources to support its development.

Conclusion
In conclusion, I want to say that there are great things that can be done, especially when you harness the drive, interest and creativity of the young people themselves. But they cannot do it without the teaching staff having the time and energy to work in partnership with them, and that is the greatest challenge. The difference between rhetoric and reality has to be addressed.

From my own experience, I know how very complex the task that schools are facing is, and how much knowledge and expertise is needed if we are to meet the needs of our young people in schools. The school I work in can afford to have us there only one day every fortnight but that has produced real culture change and expanded their capacity to hold onto and support many of the young people in the most difficult circumstances – young people for whom school can actually be a lifeline. I am left wondering how on earth schools that do not have any support of this kind cope, and what lasting damage is being done to young people as a result.

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Working across boundaries in services for children, young people and families

Iyabo Fatimilehin

My experience of working with children, young people and families has been one of crossing ‘boundaries’. These boundaries are multifaceted and impacted by cultural contexts, service contexts, economic and political imperatives, organisational structures and personal and professional values. This talk will take a brief look at the implications of these boundaries for working with children and families in contemporary British society.

MY IDENTITY as a clinical psychologist has often been questioned by others because of the focus of my work and the way in which I choose to work. In this talk, I explore how the development of my professional and personal identity has led me to work across boundaries and contexts. I refer to service contexts, cultural contexts, professional contexts, personal values and economic and political influences. I will also reflect on the influence that David Smail had on my ideas and thinking in the early stages of my career.

Service contexts
In the beginning of my professional journey (as a psychology technician), I started off working not in clinics but in home settings – both residential and community/own homes. As an example, at that time, the work with children with intellectual difficulties was either home- or hospital-ward-based. I went to where the people were, and when things became more clinic- or office-based, whether I saw children and families in the clinic or their homes depended on my assessment, taking into account such things as practicalities for the family (number of children, transport routes, etc.). Ultimately, I felt I understood more about the difficulties they were seeking help with by being with them in their own environment. This flexibility was influenced greatly by working in the Nottingham department where David regularly challenged us to consider the power dynamics that were at play in our relationships with clients/service users. I also benefited from working in a psychology department where fellow psychologists were working with adults, older adults or people with intellectual difficulties. This created a context for being able to think about and address the needs of both the children and adults in one service rather than in separate services, as has become the norm.

Over time, my work took an increasingly collaborative, community-based focus. I believe that in order to understand more about the lives of the people we work with, we have to move into their spaces and not expect them to overcome barriers to accessing our own. We talk about the fact that some groups of people do not access our services and describe them as ‘hard to reach’. We are quite happy to endorse time taken to engage in cultural tourism, travelling to other countries in an attempt to enlighten our minds, and yet we cannot engage with communities who live less than an hour’s journey from our homes. In the case of some black and minority ethnic (BME) communities, people who have recently migrated will have travelled thousands of miles crossing social, cultural, national and political boundaries. We live in cultural silos that are maintained by technological innovation such as satellite television, internet channels, mobile phone technology and social media. Power dynamics are inherent in the question of who is hard to reach or engage – professionals or people in communities? Are clinical psychologists ‘hard to reach’ professionals?

Cultural contexts
My personal identity and experiences with understanding issues of race and culture and exclusion meant that right from the beginning of my training I had questions about the universality of concepts, ideas and theories. What I was being taught did not always resonate with my personal experiences and with those of my extended family and close friends. This was not just about politics and ideology but about observations of interpersonal relationships and family dynamics, such as parenting and what is healthy or harmful (sleeping routines), or adolescence and what is healthy or harmful (independence vs dependence). There is a difference between what you know and what you’re taught is the right way to think (for example, think about the Ken Saro-wiwa phone-in on Radio 5. On the panel a right wing newspaper editor said there was nothing in Nigeria before colonisation and expressed other views not backed up by knowledge of the history of Nigeria before colonisation – the Benin Empire, Songhai Empire, Yoruba empire, etc.). Experiences similar to these in academia led me to work and explore beyond white Western middle-class norms of behaviour, expectations and relationships.

Cultural professional context
Clinical psychology puts the emphasis on the clinical and therapy aspects of the profession, and arguably this is increasingly so. I learned in David Smail’s department that we draw on the whole of the psychological knowledge base in order to practise as clinical psychologists, and we are not...
confined to individual or group therapy. Unfortunately, the economic and political context of the NHS means that clinical psychology has become increasingly aligned with individualised understandings of people’s distress, with a corresponding increase in more and more rigid, manualised styles of working. The space given to the issues I have raised decreased rapidly during my NHS career, and it was no longer possible for me to remain within the NHS if I was to do work that I believed was important. This is almost certainly linked to the kind of self-interest that David talked and wrote about and I’m sure it’s not entirely altruistic!

I left the NHS in 2008 to work independently, initially doing expert witness assessments in family law proceedings. This was arguably a move from the frying pan into the fire but there was also some scope for practising in a way that attempted to take account of social inequalities in the assessments that I undertook. The power differentials were even greater as the majority of the professionals (expert witnesses, judges, solicitors, barristers, etc.) are from white, middle-class backgrounds and make life-changing decisions about families that are predominantly from extremely poor, working-class backgrounds and/or people who have been marginalised and whose lives bear virtually no resemblance to their own. In these settings, the power differential was rarely acknowledged, never mind taken into account.

Eventually, with a number of co-conspirators, I founded a not-for-profit social enterprise – Just Psychology. We aim to address the causes and effects of poor psychological health with an emphasis on cultural diversity, cultural competence and social justice. Our vision is modest – the full participation of all BME children and their families in an equal and fair society through the achievement of a significant improvement in psychological health and mental wellbeing, and the prevention of problems with mental health. We work with children, young people, adults, families and communities.

However, this is not the easy or straightforward option that it might appear to be. While it is possible to have clear values and principles that are consistent with notions of social justice and cultural competence, and to be less constrained by the directives of public sector employment, the increasing privatisation of public services is leading to a fragmented context in which to work with or deliver services to children and families. My suspicion is that services being tendered out to charities and social enterprises could be the slippery slope that allows large international private companies in, such as Virgin, Core Assets, etc. Devolution may present opportunities to develop local responses to this fragmentation but that remains to be seen.

It is also a significant challenge to adhere to the principles and values of Just Psychology while building a sustainable organisation – certainly this cannot be achieved alone, and I have benefited considerably from the support of like-minded people with the same commitment to social justice, and by engaging with other social enterprises and social enterprise support organisations.

While some of the work that we do in Just Psychology fits neatly into the ‘clinical psychology’ box (e.g. therapy, assessment), there are other streams of work that we have developed as a result of our commitment to social justice. For example, we developed a cultural consultants project to enable local people to provide cultural consultation to professionals – an example of building capacity and deploying the resources of the local communities. This work is now moving into a phase of collaborating with community members to ensure a sustained and robust integration of cultural difference in the services with which we engage. We also deliver family group conferences for Manchester City Council. This is consistent with our emphasis on empowering and facilitating families to identify their own solutions to problems through acknowledging and working with the strengths and resources that exist in communities.

A question that pops up from time to time is whether what I do is ‘clinical psychology’ or not. Indeed, I had the experience many years ago of a newly recruited assistant psychologist informing me that I didn’t know what clinical psychology was and I was not delivering a clinical psychology service. This was when I was service lead for a specialist CAMHS service for BME children and their families. Some people have asked whether I’m really a community psychologist. I don’t really care whether I am clinical or community (in much the same way that I stopped trying to answer the question of whether I am Nigerian or British many years ago). Those may be questions for other people to ponder if they care to do so. What I am most concerned with is pursuing ways of working with people that reduce power differentials and assist, enable or facilitate their ability to take control of their own solutions. In this, I am indebted to David for providing the context in which I was able to grow and develop the values and principles that now guide my work.

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Putting Smail's ideas into practice: Introducing MAC-UK and the INTEGRATE approach


MAC-UK is a charity which was founded in 2008 to change radically the way in which mental health services are delivered to our most excluded young people. In this paper, youth trainers and practitioners from MAC-UK, share their ways of working with excluded young people in the community, based on MAC-UK’s INTEGRATE approach. The INTEGRATE approach is a set of service design and practice principles that have been co-produced with young people to reach out to, and effectively support, multiply excluded young people who otherwise find it difficult to access services.

In this model, mental health, understood using the ecological systems framework, is at the heart of the approach. As a result of working within this framework, MAC-UK projects seek not only to change the systems and services around young people, building community cohesion, access to resources and services, but also support young people to create change for themselves and improve their emotional wellbeing and resilience. The INTEGRATE model encourages youth-led practice and co-production across all aspects of service development and design, from employing those with lived experience in projects, to asking for young people’s help to plan youth-led activities. This paper aims to further understanding of the needs of this group and provide a different way of conceptualising mental health services that moves us a step closer towards David Smail’s ideas.

‘Have you ever sold drugs so that you can make enough money to survive? Or known someone who sells drugs?’

‘Have you ever spent a night in a cell?’

‘Have you ever been to prison? Or had someone close to you go to prison?’

‘Have you ever been stabbed? Or known someone who has been stabbed?’

These kinds of questions highlight the complex challenges inherent in the lives of the young people we work alongside at MAC-UK. Many of these young people have been described as ‘gang associated’, or have been involved in serious criminal offending, for a significant proportion of their lives. Many would answer ‘yes’ to every question above, assuming they trusted you enough to give an honest answer.

Living lives punctuated by these experiences has a significant psychological impact. Indeed, evidence is accumulating about the unmet mental health needs of this group of young people, and suggests they experience mental health difficulties far more frequently than the general population (Coid, 2013; Corcoran, 2005; Home Affairs Committee, 2015; Madden, 2013). Recent research shows this group are significantly more likely to attract diagnoses of ‘conduct disorder’, ‘alcohol dependence’, ‘psychosis’, ‘depression’, ‘anxiety disorder’ and ‘post-traumatic stress disorder’ (Coid, 2013; Corcoran, 2005; Madden, 2013).

At MAC-UK, we recognise that the difficulties these young people face are not best understood by what is in their heads, but by what is in their worlds; and we try to offer our support from this position. We would very much agree with Smail (2003) when he said that:

*If we need to change anything it is the social environment in which we are all located and embodied.*

Drawing on the theory and values of David Smail’s work, and also that of community psychology, MAC-UK has developed the INTEGRATE approach. This approach was co-produced in partnership with ‘gang-affected’ young people, with the intention of offering a different type of psychological ‘intervention’ (Zlotowitz et al., 2015). This approach intervenes at multiple levels, including with individual young people, their peer group and their wider community and context. The aim is to address simultaneously the material and psychological needs of excluded young people, recognising the impact of one on the other.

The approach was inspired by the recognition that, despite apparently high levels of need, this cohort was not typically engaging with services (Barrett et al., 2006; Chitsabesan et al., 2006). MAC-UK recognised the need to do things differently, and to bring mental health interventions out of the clinic and onto the street in a way that made sense to excluded young people. The best way to do that was to ask young people for their help and
to draw on the strengths, assets and resources of the community we are joining (Foot, 2012).

The INTEGRATE approach begins with HANGING OUT and ASKING FOR YOUNG PEOPLE’s HELP. This means finding opportunities to spend time with those we seek to support in a non-problem defined space. Very often it means going to the young people where they like to spend time, and asking them for help to design a project which appeals to their needs and interests and then to help lead it. During this time, clinicians are focused on developing trusted relationships, often initially with community gatekeepers. We are helped in this work by a peer-referral system, which encourages young people to bring friends who might also benefit from support, and by working closely with ‘experts by experience’, often young men who have already been through an INTEGRATE project, who are able to form relationships, build trust, and encourage young people to interact with ‘professionals’.

Figure 1: Key Features of the INTEGRATE approach.

The next phase is YOUTH-LED ACTIVITIES. We support the young people to choose and lead any activity; this might be a music or gym project, faith group, or a trip out of the area. We are focused on the process, not the outcome of these activities. During the planning phase of such activities, we encourage young people to think about their needs, and to situate these needs in the context of their lives. This process shares conceptual links with Hagan and Smail’s (1997) power mapping. We have found that offering authentic opportunities for youth leadership generates a sense of ownership over the project, and improvements in wellbeing. Young people also benefit from having opportunities to develop ‘professional’ skills, like planning, budgeting and formal modes of communication.

The next phase, STREET THERAPY, often runs alongside the previous two phases, and throughout the whole approach. The basic premise is to draw upon psychological theory to inform our ‘mapping’ (clinical formulation) of young people, and the conversations project staff have with young people, in order to support their mental wellbeing. We have found that often young people need time and space to make sense of any personal emotional challenges, whether that includes anger, anxiety, depression, paranoia, or something else, before they feel ready to face up to the material challenges of their lives (although sometimes the inverse is true, and material challenges take precedence). To do so, we might draw upon a range of approaches, from narrative therapy to CBT, but most broadly we employ AMBIT, a mentalisation-based approach, which encourages development of the capacity to think about the minds of others (Bevington et al., 2013). We also draw on the assets and strengths of young people within the group, so that young people begin to support each other.

The next phase is BUILDING BRIDGES. INTEGRATE aims to support young people to access services and opportunities, not to reproduce them. We try to get young people to a place where they feel able to engage with available services, and to break down any barriers that might prevent this. Often this means working with services to think about how they can adjust their ways of working to enable a young person to engage. We have supported young people to connect with mental health, housing, employment, immigration and criminal justice services, to name just a few.

The next phase is YOUTH-LED TRAINING. Working together, we aim to change the systems around the young people through delivering training to relevant organisations and agencies, always employing young people to co-lead the sessions. For example, young people have been invited to co-lead teaching sessions on clinical psychology doctoral
courses, and been involved with training other agencies, such as staff working in young people’s hostels. This allows young people to have their voices heard, to develop professional skills, and to start to feel that they can be effective agents of social change.

The final phase is YOUTH SOCIAL ACTION. INTEGRATE practitioners help to give young people a voice in the wider community through offering opportunities to engage in various forms of social action. This might mean presenting at conferences, to funders, or to local or national government agencies. We have also supported young people to start their own projects, addressing the challenges of their communities by drawing on their own hard-won expertise. As professionals, we have found that working together with formally marginalised young people leads to a mutual boost to social capital, enabling us together to be more effective in driving changes in the social environment that might improve the lives of many young people living in similar situations to those with whom we have directly engaged.

As in so many psychological models, it is probably best not to think about these phases as strictly sequential. In our experience, individual young people have quite different journeys, and can easily be in more than one phase at one time. While the INTEGRATE model has been useful in guiding the work we do at MAC-UK, we recognise that it is bound to a particular context, and working with a particular group. None the less, we believe that the insights from INTEGRATE have more generalisable utility, and to this end have started to work towards a set of INTEGRATE principles, such as ‘embracing everything as an opportunity’, ‘co-producing services with excluded groups’, and creating ‘flexible and responsive’ ‘psychologically informed’ services.

This approach is clearly a fairly fundamental shift in how psychological services are traditionally delivered. However, we have found that we are able to draw on our skills and training as clinicians in this work, as long as we allow ourselves to work flexibly. What is required is an organisational service context which allows such novel ways of working, and this must be fought for.

Finally, we invite you to help us build a movement ‘towards putting social justice at the heart of our work within mental health’. How might you incorporate co-production and the transformation of the social determinants of mental health into your work? You can make a start right now by joining the BPS Community Psychology Section, and if you or your organisation are interested in learning more about INTEGRATE and our ways of working, take a look at our website: http://www.mac-uk.org. Or get in contact with MAC-UK’s training and consultancy partner The Integrate Movement: http://www.integratemovement.org/

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References


Join the BPS Community Psychology Section
http://www.bps.org.uk/networks-and-communities/member-networks/community-psychology-section

Join the Community Psychology UK Community Platform
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Speaking our minds as clinical psychologists

Lucy Johnstone

A combination of international debates about psychiatric diagnosis, failure to find biomarkers to validate the ‘illness’ model, and emerging evidence on the role of trauma, abuse and social inequality in mental distress, is creating the possibility of fundamental change in mental health systems. However, despite the recent ‘Position Statement on Classification’, clinical psychologists have always had an ambivalent attitude to challenging psychiatric power and influence. This tension will be explored in relation to key areas of theory and practice.

It has never been more important to speak our minds as clinical psychologists. David Smail was certainly not afraid to do so. In fact, his statement ‘I just know that the biological approach to psychological distress is bollocks’ (Smail, 1996) is increasingly relevant as this entire paradigm comes under threat.

Much of this controversy was brought to a head with the publishing of DSM-5. Chairs of current and former DSM committees and of the National Institute of Mental Health (NIMH) queued up to express their disapproval in the strongest terms. ‘There is no reason to believe that DSM-5 is safe or scientifically sound… The science simply isn’t there now… A research dead end’, said Dr Allen Frances, Chair of the DSM-IV Task Force. Dr Steven Hyman, former NIMH director, said DSM was ‘totally wrong, an absolute scientific nightmare’. Dr Thomas Insel, another former director of NIMH, stated ‘Patients… deserve better… The weakness is its lack of validity’, and in a significant policy shift, ‘NIMH will be re-orienting its research away from DSM categories’. In response, Dr David Kupfer, chair of the DSM-5 committee, was forced to admit: ‘We’ve been telling patients for several decades that we are waiting for biomarkers. We’re still waiting.’ Allen Frances, using language as blunt as David Smail’s, albeit from a rather different conceptual position, admitted: ‘There is no definition of a mental disorder: I mean, you just can’t define it. It’s bullshit’ (Greenberg, 2012).

The furore has reached much more widely than this, to the extent that the whole future of psychiatry is regularly questioned. Mental Health Europe, a large umbrella organisation representing both professionals and service users, issued an article with the title ‘Western psychiatry is in crisis’ in which it decried ‘…the simplistic and imposed application of…reductionist science’ which can ‘encroach on basic human rights’ (Mental Health Europe, 2013). In the British Journal of Psychiatry, there has been a series of articles on the theme of ‘…whether the psychiatrist is an endangered species… Urgent action is required… to ensure the future of psychiatry as a profession’ (Oyebode & Humphrys, 2011).

The diagnosis debate is central to every other aspect of traditional psychiatric practice, since without a valid classification system, psychiatry would become ‘…something very hard to justify or defend – a medical specialty that does not treat medical illnesses’ (Breggin, 1993). And yet every month brings new articles, often by psychiatrists themselves, questioning the current nosology. ‘If it becomes apparent that the information obtained by testing disease theories is incoherent, we may eventually jettison particular disease constructs… The disease constructs in psychiatry may be approaching this point’ (Bebbington, 2015).

Meanwhile, there is disturbing evidence that the mainstay of psychiatric intervention, medication, may in the long-term create more disability than it cures (Whitaker, 2010). And those who do manage to leave psychiatry behind frequently date their recovery from the moment they decided to give up their diagnoses. Core themes in recovery have been described as finding a new sense of connectedness; hope and optimism about the future; identity (including overcoming stigma); meaning in life; and empowerment (Leamy et al., 2011). Ironically, these are exactly the opposite of the messages frequently imparted by a diagnosis (Johnstone, 2014). We have to ask whether people are mainly recovering from the original ‘illness’, or from the labels that were imposed on them.

It is legitimate to summarise this state of affairs as Dr Sami Timimi, critical psychiatrist, recently did in Clinical Psychology Forum: ‘It’s hard to imagine such a record of harms could be tolerated in any other branch of healthcare, and it is hard to imagine how an ethical perspective can tolerate our use of the failed medical model paradigm in mental health any longer. It’s time to reach beyond diagnostic dependence’ (Timimi, 2014, p.8).

This brings us to the main question: What are clinical psychologists doing about all this?

According to some, not much.

‘We work in service systems largely based on a theoretical model which is more or less completely incompatible with ours. Heaven knows, we have bent over backwards to disguise this fact, to fit in, to appease, not to give offence. We have extensively adopted the language of medicine… we have described people in terms of an extraordinary range of deficits… we have eagerly adopted models such as the biopsychosocial model or the stress-vulnerability model, which make it easy for genes and biology to remain privileged… We have used the DSM framework to organise textbooks and much of our research and practice… The medical model remains dominant; we are graciously allowed to continue research and practice, provided we don’t say or do anything too threatening… Why are we so timid in taking the lead?…Which are the truths we are still not speaking?’ (Boyle, 2006).
Other clinical psychologists have also urged the profession to take a broader view.

‘We see it as essential that psychologists... have a critical and questioning perspective on the values and practice that dominate mental health services and psychology... Whilst we believe that our profession can contribute to obscuring and individualising people’s experiences, we also believe it has much to offer in terms of explanations of human despair’ (Coles, Diamond & Keenan, 2009).

‘An overwhelming amount of evidence tells us that as clinical psychologists we cannot afford to ignore the context of social inequality and injustice in our work, for scientific as well as ethical reasons. This will inevitably also involve us in challenging, not colluding with, some of the core tenets of biomedical psychiatry. In this way we will be facing ethical dilemmas head on, wherever we work, and fulfilling our moral and professional responsibilities as clinical psychologists’ (Johnstone, 2011).

So, what stops us from doing this? Are we too comfortable in our position of high pay and high status, to risk speaking our minds? Do we challenge, compromise or avoid (Johnstone, 2011) in relation to dilemmas about the fundamental issues in mental health work – diagnosis, biomedical models, the use of medication, the role of social inequality and deprivation, and the application of what might be called ‘medical model psychology’ solutions to complex social problems? The IAPT programme is one example of the latter – which attracted David Smail’s memorable comment ‘...this kind of bureaucratised ‘science’ peddled by NICE is exactly the kind of thing a healthy and independent clinical psychology, in charge of its own soul, would criticise, not endorse’ (Smail, 2006).

There are no simple answers to the challenge, compromise or avoid dilemma. It is impossible to be part of the mental health system without, at times, colluding with damaging practice. Equally, few of us can sustain whole careers at the sharp end of mental health work – we may need to have periods of ‘avoidance’ to preserve our family lives and sanity. We also need to be honest about the fact that there is often a high price to be paid for speaking out – whether in terms of opposition from colleagues, hostility on social media, or career progression.

At these times, it may be useful to bear in mind Gandhi’s saying: ‘First they ignore you, then they fight you, then you win.’ There is plenty of evidence of the middle stage of this process in relation to some of the bold steps the profession has recently taken. Here is a commendable example of speaking out – the DCP/BPS response to the DSM-5 proposals:

‘Clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation... The putative diagnoses presented in DSM-5 are clearly based largely on social norms, with ‘symptoms’ that all rely on subjective judgments, with few confirmatory physical ‘signs’ or evidence of biological causation. The criteria are not value-free, but rather reflect current normative social expectations.’ 1

There were strong reactions, both positive and negative, to the DCP Position Statement on Classification which called for the end of diagnosis and the ‘disease’ model of mental distress, including national coverage in The Observer on 12 May 2013. The same was true of the ground-breaking publication Understanding Psychosis and Schizophrenia (2014) which has as its central theme:

‘Hearing voices or feeling paranoid are common experiences which can often be a reaction to trauma, abuse or deprivation. Calling them symptoms of mental illness, psychosis or schizophrenia is only one way of thinking about them, with advantages and disadvantages’ (BPS, 2014, p.6).

Among the more bizarre accusations were that it ‘...exploits, disrespects, silences and marginalises service users... Understanding psychosis and schizophrenia should be seen as a cruel hoax perpetrated against more typical severely disturbed mental health service users, their family, and policymakers.’

It is hard to see how such a reasonable position, in a publication co-authored with service users, could have aroused such a degree of ire in some quarters, but clearly this is a sign of a nerve being hit. We can expect, and even welcome, this kind of response as a sign that we are finding our voice as a profession and are willing to ‘speak truth to power.’

Another hidden truth concerns the causal relationship between deprivation, inequality and all forms of mental distress. Clinical psychologists should remember that best practice principles of their core professional skill, psychological formulation, clearly require us to locate mental distress within its wider social contexts. The DCP Good Practice Guidelines quotes the WHO to the effect that ‘[l]evels of distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice’ (WHO, 2009.) One of the best practice criteria for a formulation is that it should ‘[h]ave a critical awareness of the wider societal context within which formulating takes place, even if this dimension is not explicitly included in every formulation’ (DCP, 2011, p.20).

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We also have reason to be proud of our role in researching, promoting and implementing alternative models of distress, and specifically the so-called ‘trauma-informed’ perspective. This explicitly recognises the causal role of trauma and adversity of all kinds in all human organisations and systems, and re-conceptualises psychiatric ‘symptoms’ as understandable, indeed adaptive, responses to threat which may have outlived their usefulness. A trauma-informed environment seeks to establish safety and avoid re-traumatising across all diagnostic presentations, setting the scene for trauma processing work and eventual re-connection with one’s life and community (www.asca.org.au).

A trauma-informed formulation ‘[c]onsiders the possible role of trauma and abuse’ and ‘[c]onsiders the possible role of services in compounding the difficulties’ (DCP, 2011, p.14). Trauma-informed formulations can help us to make sense of people’s distress, to bear witness to survivors’ stories, and to develop a shared framework for recovery. The meta-message of a best practice psychological formulation is: ‘You are experiencing a normal reaction to abnormal circumstances. Anyone else who had been through the same events might well have ended up reacting in the same way.’

As clinical psychologists, it is our duty and our privilege to support service users in this way. In the words of Judith Herman:

‘The knowledge of horrible events periodically intrudes into public awareness but is rarely retained for long... Clinicians know the privileged moment of insight when repressed ideas, feelings, and memories surface into consciousness... Victims who have been silenced begin to reveal their secrets... Survivors challenge us to reconnect fragments, to reconstruct history, to make meaning of their present symptoms in the light of past events’ (Herman, 1992, p.2).

And in the words of David Smail:

‘I’ve always thought that psychologists and people in the helping professions generally can be pretty chicken-hearted when it comes to political issues. I should re-phrase that probably, it’s not because they are cowards, or they are anything reprehensible... it’s because people who come into this kind of job are on the whole menders and compromisers or believers in being nice to people... and I think when you get down to political activities with a small p those aren’t the most useful characteristics. You’ve certainly got to be able to be diplomatic, you’ve got to be able to see where the lines of influence run, but you’ve got to be prepared to stick your neck out when it matters’ (Moloney, 2012).

It matters.

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References
What then must we do?
Craig Newnes

The world is dominated by doing – from doing therapy to doing up shoe laces. This paper briefly examines some of what continues to be done by psychology experts. Doing less seems never an option and a systems theorist might suggest that doing anything will be met by opposing forces to maintain the homeostasis. A few tentative suggestions are made for a more cautious praxis within the psychology industry.

What, you might ask, qualified me to be the final speaker at a conference devoted to the inspiration, work and ideas of David Smail? It is certainly no shared presentational style. David was notoriously meticulous in his use of language and would read his presentations verbatim, asking only that the audience hold off questions until the end. This approach to interruptions was shared with Wolf Wolfensberger who would announce that questions should really wait on the basis that, by the end of any talk or seminar, they would have been answered.

My own style is far more haphazard – tangents are explored, questions welcomed and people are encouraged to keep their mobile phones switched on in case they want to phone a friend. A key difference between us, I think, is that I have no message, no coherent point I am trying to make. In any case, I firmly believe that people will take what they find rather than what I present. Like David, I believe in the all importance of context, and presentations are no different: what people learn will already be known and any minor points of interest are recalled dependent on what time of day the listener got up, what he or she has had to eat and if they have a train to catch or other appointment immediately after the talk. It’s similar to watching a TV documentary – entirely useless snippets of information are remembered by an audience with little use for them other than as part of conversations about what they have seen on television.

Therapy is, of course, no different. Despite an appeal to notions such as science or formulation, practitioners, just like their patients, are context-bound. Therefore, a therapist’s tolerance of certain utterances by a patient is dependent on random factors such as how busy the day’s diary looks, whether or not there are important things happening at home later that day, and the professional’s resting heart rate. What is revealed by the patient is based on factors such as shame, trust and cultural or other perceived similarities with the psychology practitioner. Both participants may have had too much coffee, be on prescribed medication or be nursing a hangover, all important physical variables rarely considered unless seen as a problem.

Unlike the presentation context, I have now been given the opportunity to approach matters in a more considered – and grammatically correct – manner, though writing post hoc still invokes the temptation to edit and bowdlerise the original. To begin then…

What then must we do?

Some people will, I know, find what I’m saying dispiriting, but I in no way feel it incumbent on me (nor do I expect anyone else) to offer solutions – indeed to do so would seem to me simply foolish. The world is in a bloody mess and even though I know, as do many others, what it would look like if it weren’t, I have no more viable idea than anyone else how to get there. I do believe, however, that an extremely important step on the way is to take really seriously the fact that we are a society, not a collection of individuals, and that we live in a real world that is as impervious to optimism as it is to wishfulness. (Smail, 2005)

The quote reveals one mutuality for David and I – the importance of others and the relevance of the material, physical world far in excess of the disguised magic presented by the psychology and counselling industry. Shared language and culture leave us in the position that being human can only be understood via that language and culture. I have written elsewhere that ‘we are each other’ (Newnes, 2014). Einstein preferred: ‘Individuality is an illusion created by skin’, a position diametrically opposed to the all-pervasive ubiquity of the individualistic discourse fundamental to all variants of capitalism, from selling cars to hair-styles to cures for human distress in all its myriad forms.

A kind of pseudo-Marxist romanticising of society was only one of our shared experiences. Like David, I have been a dad, brother, grandad. Like him, I am a musician though favouring guitar over percussion; 15 years ago we found ourselves swapping cassette tape recordings – Zappa for Shostakovitch. We were both clinical psychologists, chairs of the BPS Psychotherapy Section and directors of large NHS departments of psychological therapies. We shared the view that our elections as sectional Chair had been tokenistic for an organisation deeply embedded within the discourse of individualism and the mysteries of internal processes only available to study and correction by Psy experts.

Both researchers, we were also authors for PCCS Books. Indeed, David’s last publication – Power, Interest and Psychology was part of a critical psychology series commissioned by Guy Holmes and myself. By no means the least of our mutualities was that

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David had been the first editor of the *Psychology and Psychotherapy Association Newsletter* which I took over in its guise of *Changes*, long since re-titled the *Journal of Critical Psychology, Counselling and Psychotherapy*. Whether or not these identities qualified me to end the conference, it was an honour to be asked.

The title of the talk comes from a pamphlet by Tolstoy. Appalled at the position of the urban poor he asked the question in 1886. A role of clinical psychologists and other members of psychology is, in part, to offer answers to Tolstoy’s question based on praxis first designed to distinguish the undeserving from the deserving poor (Szasz, 1994). This praxis is not well recognised by professions though their use of interviews and psychometry reveals the agenda. In effect, the aim is to discover if someone is disabled or otherwise suffering through no fault of their own. This may entail a reading of the person’s intellectual ‘level’, the supposition of an internal biochemical problem ‘causing’ mental imbalance or an assumption that the person just needs to learn some psychological process – mindfulness, thought diaries, etc. – to ease their suffering. As Szasz has noted, it is actually suffering – of self or others – which becomes the entry point to the world of psychology. At that entry point, the psychology professional must discover if the person assessed deserves help. It is a version of the ‘mad’ or ‘bad’ dichotomy – the mad will be offered assistance, the bad punished (though the experience of many psychology recipients is actually punishment).

**Clinical psychology as science**

Having moved through scientific-practitioner and reflective-practitioner phases, the profession of clinical psychology now espouses psychological formulation. Practitioners are to ‘[c]arry out a psychological formulation as recommended by the Division of Clinical Psychology: … summarise the service user’s core problems; suggest how the service user’s difficulties may relate to one another by drawing on psychological theories and principles; aim to explain, on the basis of psychological theory, the development and maintenance of the service user’s difficulties, at this time and in these situations; indicate a plan of intervention open to revision and re-formulation’ (Johnstone & Dallos, 2006).

At first sight, this is simply another (re)positioning of clinical psychology as a market leader. Though other professions may claim to offer similar formulations, it is now a distinguishing feature of 21st century clinical psychology that formulation is its core business. As ever, the move is ahistorical, as if building upon the capitalist notion of progress there has been an incremental, sometimes paradigm-shifting development towards this new apogee. Scientist and reflective practitioners are now to be incorporated in praxis presented as unique to clinical psychology. Brief historical research might find that we have been here before. Almost a century before clinical psychology as a profession first arrived on the scene in the 1950s, descriptive psychopathology was one professional path of alienists (Berrios, 1996). It was recognised that concepts such as love, guilt or fear were just that – concepts. Thus, no attempt was made to link specific conduct to abnormalities in the brain, an organ considered too complex to understand. Causes of distress were thus sought in the environment of the sufferer and the roots of madness were to be identified in diet, employment, poverty and the veiled world of moral aberration. Accordingly, cures might involve a change in diet or sexual habits though, as now, professionals were usually unable to offer better employment (despite the claims of the IAPT programme) or money, notwithstanding the way that an assessment of undeserved poverty may lead to disability living allowance payments (Klein & Walker, 2015).

Demands for the profession of clinical psychology to be identified with psychological formulation are particularly problematic if Smail’s account of distal and proximal forces is taken seriously. (See, for example, Smail (2005), p.48.) If we are influenced by immediate (proximal) forces and more distant and hard to specify (distal) forces, then a typical meeting between a psychology professional and prospective patient might bear some scrutiny. The professional will be influenced by the usual variety of forces influencing mood. These could include what they have most recently eaten, any recent frustrations and a sense, perhaps, that today’s work context just doesn’t allow people the time to think. The professional will also be influenced by the sex, appearance, late-ness or otherwise, age and perceived cultural background of the patient. The psychological formulation outlined above is to take these factors into account when explicating the patient’s distress but does not consider them if accounting for why the professional sees these factors as worthy of examination. It is as if only the patient’s position merits scrutiny; the contextual factors for the professional’s creation of a particular formulation at a particular time are ignored.

The professional is here being asked to somehow rise above the influences on his or her own discourse and make what appears to be an objective assessment of the patient’s plight. Meanwhile, the patient is taking many of these factors into account when considering what to tell the clearly middle class, probably female and almost certainly young, white professional.

A further problem with the psychological formulation approach might be seen in terms of the qualifications of the clinical psychologist as a professional well-versed in scientism and associated methods and, frequently, a language of diagnosis and distress divorced from common parlance, i.e. the position of scientist-practitioner. Much of the power of clinical psychology is rooted in claims to change people through scientifically proven methods applied to scientifically justifiable theories. This seems something of a sticky wicket. Writing in the *Tractatus*, Wittgenstein was less than sanguine about the potential for science to answer some essential questions, most notably, how to live: ‘... even when all possible scien-
tific questions have been answered, the problems of life remain completely untouched” (Wittgenstein, 1924, 6.5–6.51). For psychology itself, Beloff was just as doubtful: ‘Psychology has yet to establish a single fact about human behaviour’ (Beloff, 1973).

Other critics have been scathing about the psychometric agenda – for many commentators, one of the building blocks of the profession. David Stein suggests that ‘validity and reliability of psychological tests are low, almost worthless …’ (Stein, 2012). The language of clinical psychology, in its mimicry of psychiatry, is, for critics and linguistic philosophers alike, a further difficulty. For the majority of clinical psychologists, diagnosis and working within a diagnostically based system is normal practice. For academic psychologists, publishing as a means of gaining cultural capital and research grants is axiomatic. The majority of psychology journals require the use of diagnostic terminology. Indeed, the description of the Journal of Clinical Psychology explicitly positions it as a ‘medical’ journal. Stein, however, goes on to state that ‘…diagnoses have no predictive, internal, external or concurrent validity. They are about as accurate as a Ouija Board’ (Stein, 2012). This position is reflected in recent position papers from the Division of Clinical Psychology. The papers fail to suggest that clinical psychologists maintaining diagnostic praxis and language (as represented by their publication records) should be refused membership of the division; a move that would have a seismic effect on training course staff. (See Newnes, 2016.)

If, then, science has little to offer us concerning the question of how to live, psychology-as-science is fact free, psychometry is a fraud, and diagnosis is merely a way to gain cultural capital via publication, on what grounds would a clinical psychologist claim the authority to make pronouncements about human distress?

One aspect of that authority is the claim to expertise via the obscurantism of scientific methodology and medical terminology, i.e. diagnosis. One concern, however, with any form of categorisation is that a small, powerful elite invariably categorises the (usually poorer) many. This is one reason why we seldom see categories like: corporaphilia – the need to take care of others; Povertyphobia – the wish to earn more money than other people; or psychobabblia – the need to categorise people according to perceived deficits (Newnes, 1995). In this last case, the closest we might get is a proposed DSM category: pervasive labelling disorder (Levy, 2010).

The language of psychology changes. Notwithstanding the lack of validity of diagnosis in psychiatry, those same scientific terms are soon incorporated into the vernacular. Here they become both insults and signifiers of expertise for journalists wishing to sound authoritative. We have seen the rise and fall of terms such as moron, cretin, imbecile, retard, mongol, and handicapped. Now Spesh, as a diminutive of Special Needs Child is used as a play-ground insult. We are inscribed by teachers, GPs, psychologists, psychiatrists, counsellors, parents, other children, and ourselves. One opportunity for self-inscription is made available by the internet. Among the numerous tests for so-called psychiatric conditions, can be found questionnaires concerning Asperger’s, Autistic Spectrum, Depression, ADHD, Alzheimer’s and Schizophrenia. For all the DCP’s efforts to announce paradigm shifts relating to the diagnostic project, a quick glance at websites, questionnaires and Facebook communities based on diagnosis might suggest the horse has long since bolted and the stable door is off its hinges.

What then must we do?

Clinical psychologists – as people – have many ways to approach this question, a concern of artists and philosophers for millennia. They might, for example: ‘Change lives through art, maybe. Cherish your friends…’ (Nicholls, 2009); ‘Love the one you’re with’ (Stills, 1970); ‘…be allowed to decide what to do, not by themselves, each in his own corner, but in the company of others’ (Sartre, 1968); ‘…improve the quality of life for all in his or her community’ (Vonnegut, 1997); or even ‘Have babies and look after the place’ (Connolly, 2005). Those without children might offer to babysit for friends, colleagues or patients that do.

Tolstoy himself saw women, particularly mothers as some kind of salvation – ironic in a world many decades from universal suffrage. The year of the publication of What Then Must We Do? – 1886 – was also the last year of Czar Alexander III’s policy of Russification. The Czar had hoped to save Russia from anarchy, social disorders, and revolution by the three principles indigenous to Russia: Slavic nationalism, Eastern Orthodoxy, and autocracy. Alexander wanted a nation containing only one nationality, one language, one religion and one form of administration. It was hardly an auspicious climate in which to foster an ideal of women as agents of social change. None the less, Russia had long been referred to as ‘Mother’ Russia and the liberal agenda so feared by Alexander III had in fact been initiated by Catherine the Great in the previous century.

An – admittedly scanty – psychological formulation of Tolstoy’s hope might include the fact that he was raised by a beloved grandmother who jointly mourned with him the death of his mother (Tolstoy, 1857/1964). A tentative psychoanalytic view of his idealisation of women, however, would have to include the tempestuous relationship the author had with his wife, Sofia (known as Sonya) not only bore him 13 children but is often seen as the author of his death; following an argument he stormed from home in the middle of a Russian winter’s night and died of pneumonia at Astapovo train station the following day (Wilson, 1988).

In writing of women, however, Tolstoy was clear: ‘Yes, women, mothers, in your hands more than in those of anyone else lies the salvation of the world’
(Tolstoy, 1886). The position was re-stated several times by David Smail who thought that women past child-bearing age and thus freed from the demands of capitalism and family could be a force to reckon with. David was, perhaps, unaware of the extraordinary demands placed on some grandmothers, the never-ending imperative of capitalism to purchase youth-imitating unguents and the exhaustion (frequently inscribed as depression) common to so many middle-aged women.

What seemed clear to Tolstoy was a qualitative difference in the plight of rural and municipal poor:

‘I had spent my life in the country, and when in 1881 I came to live in Moscow the sight of town poverty surprised me. I knew country poverty, but town poverty was new and incomprehensible to me. In Moscow one cannot pass a street without meeting beggars, and beggars who are not like those in the country. When you meet or pass them they generally only try to catch your eye; and according to your look they either ask or do not ask.’ (Tolstoy, 1886)

The example of urban poverty, austerity and the impact on wellbeing is explored by environmentally-minded and community psychologists. For example, The Birmingham Family Well-being Project analysed micro-neighbourhood referral patterns to find any common features of neighbourhoods more likely to have high proportions of those deemed ‘problem’ families. Allies included teachers, local residents, police, substance abuse workers, general practitioners and other health and social service workers. Community psychologist, Professor Bernardo Jiminez-Dominguez of the University of Guadalajara, demonstrated an arrangement of oppressive building design and lack of green areas for play, obvious to local residents but ignored by planners and health-care professionals. Subsequent plans for new housing have avoided this type of design, and referrals to specialist services have dropped significantly. (Newnes, 2014).

In similar – participatory rather than expert – vein there are a few non-professionalised facilities for service survivors that clinical psychologists might support, for example, the Wokingham crisis house, Soteria Bradford, Leeds survivor-led crisis service, the Edinburgh Crisis Centre and the Haven Project Colchester. The role may be one of researcher, advocate or publicist; queries of how to help out are rarely ignored. The difficulties regarding funding, support, overcoming resistance and the amount of energy to be vested in such projects can be illustrated by reference to the Berlin runaway house, a project that took some five years to get off the ground and now remains the only such resource in Germany. Opening in 1996, the Runaway House (Weglaufhaus) is specifically anti-psychiatric in ethos and caters for residents who can live there for up to six months. All have been inmates in psychiatric institutions and are homeless or threatened with losing their accommodation. It is small and staffed by volunteers (often themselves psychiatric survivors). House decisions are made by residents and it has helped numerous people re-enter society (Hölling, 1999).

Clinical psychologists hoping to answer the question of what to do will benefit from allies. As noted above, these will be found in non-health care professional groups as well as amongst service users and survivor groups. There are few better places to start than the website of the European Network of (ex) Users and Survivors of Psychiatry (see: http://www.enusp.org/). Practitioners of a more individualistic bent might consider guerrilla tactics (see Reicher, 1993). These might include: (1) developing shyness groups for people who are too assertive – bankers, chief executives, politicians, journalists, Psy professionals, etc.; (2) picketing leadership seminars on the grounds that anyone attending couldn’t possibly lead anything; and (3) following employer and British Psychological Society guidelines exactly. Employer protocols and professional guidelines are so inconsistent – and frequently contradictory – that actually finding time to practice as a clinical psychologist whilst reading all these policies will be impossible (though entirely ethical).

At a Dumfries conference on clinical psychology featuring David Smail and hosted by the late Miller Mair, I suggested that individual professionals should also:

1. Be less fucking polite – professionals can get away with speaking nonsense because others are too polite to stop or question them; an example of the disciplinary praxis of psychology turned inward (Foucault, 1963).
2. Don’t suggest others do what you can’t do yourself – they might need some back-up.
3. Know your stuff – reading limited to individualistic accounts of therapy just won’t do.
4. Defrock the medical and psychology models.
6. Use referent power; the strongest power to influence comes from perceived similarities between people (French & Raven, 1959). This is one reason for despairing of young, middle-class, white professionals having much impact on patients but they may provide a means to influence other professionals.
7. Don’t keep notes. This is an important way to avoid being part of the gaze but, of course, will bring the practitioner into conflict with employer and BPS guidelines (see, Newnes, 2016).
8. Learn how to write press releases so the public will know what you are doing (Newnes, 2004).
9. Encourage criticism.
11. Aim carefully – think small. (See Newnes, Holmes & Dunn, 1999.)
In retrospect, it now seems that the list is not comprehensive. It would, I suspect provide a career’s worth of challenges for any clinical psychologist. Nor does it mention friendship, something surely to treasure. As David Smail said in his address at Miller Mair’s memorial service, ‘I am stronger as well as richer for having had him as a friend.’ (Smail, 2011). The words can just as easily be used as my final tribute to David himself.

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Depression Pfizer and NHS Direct: http://www.nhs.uk/Tools/Pages/depression.aspx

Clinical Psychology Forum 297 – September 2017
Reflections on organising the power, interest and psychology conference

Midlands Psychology Group

And then there were six…

It was mostly with feelings of relief that members of the Midlands Psychology Group (MPG) reached the end of the two-day Power, Interest and Psychology Conference. As conference co-organisers, it seemed we had achieved the overall aims and that much time had been spent paying tribute, remembering and celebrating David Smail’s ideas. At the same time, individual members of the group, to varying degrees, experienced mixed feelings about the two days. We continue to think and talk together about these and about the continued influence of David’s ideas on the profession of clinical psychology.

Inspired by outsight and people outside of clinical psychology

A SOURCE OF CONSIDERABLE inspiration for us was the way that all speakers referred explicitly to David’s work, often quoting particular phrases and ideas which captured important meanings for them in their own work. This was perhaps one reason for what seemed like the overall success of the conference, with the focus on David’s work meaning that ideas from a diverse range of speakers were brought together in a thoughtful and coherent way. It was particularly heartening to hear of the continuing relevance of his ideas to so many different disciplines and struggles for justice on the part of local communities and their representatives. David would surely have been gratified to know this.

A uniting theme of the conference was the notion of ‘outsight’, the call again and again to look beyond the individual for the sources of, and also solutions to, distress in our societies. It therefore seemed particularly apt that this message was evident in the presentations of many of the speakers. In fact, where presentations had a particularly critical edge, they were often from people outside of psychology such as Richard Wilkinson, Mark Fisher, Lisa Mckenzie, Kate Morris and Brid Featherstone. This reminded us that David’s work spoke often to how the web of power and interest we are all ensnared within might constrain our abilities to voice more candid critiques of the profession.

Comfor ted and encouraged from being with like-minded people

One of the main reasons the Midlands Psychology Group (MPG) got together in the first place was due 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’ (MPG, 2006). Latterly it seems to us that these inhospitable circumstances may have evolved further towards expecting compliance without questions, let alone offering any kind of thoughtful critique. Many presentations emphasised the importance of friendship to psychological wellbeing both in our personal lives and in the workplace. Whilst we have developed that friendship with each other in the MPG, it was comforting to witness the sense of solidarity and support that can be achieved when we come together to share experiences of ideas and practices that are troubling. So for some of us, hearing that David’s ideas are continuing to reach and influence people, and leading to small pieces of action, helped to give a sense of the many possibilities that his work can inspire. Essentially, in our opinion, that experience of solidarity is important for us all in giving us the confidence, energy and encouragement to continue challenging dubious theories and practices within psychology – such as the use of psychology in the return to work agenda of the DWP. As we have said previously: ‘the group (and David’s work) has continually given us the comfort of having our clinical and intellectual realities acknowledged (making it less likely that we end up feeling deficient ourselves); the clarification that comes with finding more accurate explanations for the trials and tribulations we sometimes face; and the encouragement to struggle, in whatever small way, to address our concerns. In this, at least, we are no different to many of the people referred to us’ (MPG, 2015).

If most people left the conference feeling satisfied and comfortable, then in some ways this is surely a good thing. But does it truly reflect the more radical challenges of David’s work? Starting out as a thoughtful defender of psychological therapy, David gradually became one of the most trenchant critics of his own field. Far from developing the scientific theories and tools to explicate the truths that confronted it, clinical psychology had opted...
Instead of being part of MPG became increasingly important. As we said in the recent CPF tribute issue: within the mainstream of the psychology profession, focused upon social power as the key to distress and to wellbeing, he nevertheless warned against hubris. He doubted that troubled communities, any more than unhappy individuals, could be fixed to order by self-appointed experts, however well intentioned they might be (Smail, 2005).

Within the conference, it was this questioning spirit that occasionally seemed to be muted, or lacking. Perhaps people were not always challenged enough. As a group, our feelings were mixed when hearing about ideas and practices which seemed closely aligned with mainstream clinical psychology. We wondered about the possibility of introducing a greater degree of challenge and critique.

Demystified and mystified
A central aim of all our writing in the MPG is that of clarification and demystification, of highlighting why certain ideas and ways of thinking gain purchase, and in whose interests this is. We were therefore pleased to hear some powerful presentations exposing the toxic effects of inequality, of the privatisation of stress, of unreasoned capitalism and of the damaging effects on families of massive cuts in social security (welfare) and support services. Those services that remain are turning increasingly toward the punitive surveillance of the poor and the vulnerable (Clark & Heath, 2015; Lansley & Mack, 2015). In exposing realities like these, the speakers helped to clarify and demystify issues around work, housing, health including public health and child protection where, so often, the political is individualised and detached from the social and material world it operates within and through.

David Small’s work was not necessarily welcome within the mainstream of the psychology profession. As we said in the recent CPF tribute issue: ‘Being part of MPG became increasingly important to David in later years, as his ideas sometimes received a lukewarm reception and he was seemingly marginalised by the mainstream of the profession in the UK. In this context, he felt strongly that acting and writing collectively was one way of countering responses of cultivated professional deafness to his work.’ (MPG, 2015). Hence, what felt like the unanticipated hailing of David’s work from the establishment of clinical psychology was difficult to make sense of. We were to some degree surprised and mystified by the level of enthusiasm of the Division of Clinical Psychology (DCP), including a subsequent offer to produce a special issue of Clinical Psychology Forum to represent the event. We wondered whether this shows a genuine commitment to taking David’s criticisms of the profession seriously or a tendency by the mainstream to co-opt dissent through subsuming it within its borders. Has virtue signalling arrived in clinical psychology?

If David wasn’t always popular within the profession, there are obvious reasons for this. Bostock, Fatamilehin and Godsi (2015) describe how: ‘David’s remarkable legacy to those who knew and worked with him was both professional and personal. With a sharp intellectual rigour, he was uncompromisingly frank as well as gently compassionate in the way that he analysed how self-serving power and the market affect both the providers and users of services. That vision alerted us to fake doctrine and the self-delusion that clinical psychology could be a cure-all. It ensured we kept our professional claims modest and at the same time offered some comfort about our own limited personal and professional potency, and an insight into the impact of more benign environments’ (p.17).

Clearly, it is against the interests of many clinical psychologists to question the effectiveness of their wares. In health services now dominated by business models that have overtaken medical models, this is ever more important. Bostock, Fatamilehin and Godsi go on to discuss how David Smail pioneered community psychology but ultimately the market for psychological therapies has hugely overridden this; there are no recommendations for community psychology in the NICE guidelines. It does not fit with care clusters and payment by results and the exhortation to ‘recover’, assuming you take the view that you have something to recover from of course.

The MPG believes ‘that psychology – particularly but not only clinical psychology – has served ideologically to detach people from the world we live in, to make us individually responsible for our own misery and to discourage us from trying to change the world rather than just ‘understanding’ ourselves. What are too often seen as private predicaments are in fact best understood as arising out of the public structures of society’ (www.midpsy.org).

But this is not always a popular way of thinking. It challenges the presumed divisions between mind and body and self and world that have long been taken for granted within Western culture and in the field of psychotherapy, in particular (Cromby, 2015; Epstein, 2006; Throop, 2009). It exposes the hollowness of the UK government’s ideologically chosen programme of ‘economic austerity’, which conceals its destructive effects behind a specious nostalgia for bygone days of stoicism and self-sufficiency (Hatherley, 2016). This is of course the same neoliberal government that is intent upon destabilising, cutting and ultimately privatising the health and care services that employ many psychologists (see David & Tallis, 2013; Mendoza, 2015). In circumstances like these, especially, it is not surprising that many of us would rather not ask too many troubling questions about the scientific and political basis of our work. This is not simply because such questions seem to threaten our personal and professional interests. It is also because most of us want to fit in to our profession, few of us like to be wrong about ideas.
that are fundamental to how we earn our living, and perhaps sometimes simply because we have heard arguments like these before, are bored of hearing them because we feel we can’t do anything about them, and so don’t want to hear them again. Like all creatures we move away from sources of discomfort.

Resolved?
Throughout history, stories are told again and again, of things people would rather not know. The hope is that the stories will somehow stop whatever it is from happening, or from happening yet again. Yet happen they do. Many different and terrible things are happening to many people, right now – in Guantanamo Bay, in Syria, on the beaches of Kos, on the deprived estates of Britain – yet our knowing this does not necessarily lead to change. It is not so much that we don’t care. It is perhaps more that we are living comfortably ourselves and have no need to face problems which seem far away from us, problems which don’t directly or even indirectly affect our lives that much. And yet these distal powers continue to have very real embodied effects in peoples’ lives. To borrow from Pink Floyd, has the profession of clinical psychology become comfortably numb?

David Smail believed that clinical psychology, as an intellectually based discipline, should be critical to its core: constantly prepared to examine its own assumptions and whose interests they ultimately serve. Despite our lingering questions, we feel that this conference represented an important opportunity to pay tribute to the work of our friend and colleague. David has left us with an invaluable body of work and memories that will continue to provide us with the inspiration and courage to speak out against injustice both within our profession and in wider society.

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