So what do we need to do? A response to the Draft Manifesto

Anne Cooke and Friends

Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has. Margaret Mead

True to the Midland Psychology Group's philosophy, the invitation to contribute this response came not from one individual but from the group. It's been rather strange corresponding not with a particular person but with an anonymous – or collective – emailer called 'Admin'. Perhaps, come to think of it, that weirdness might be evidence of one of the group's contentions, namely that we are essentially social beings who organise our world in terms of other social beings - and like to know who we are interacting with…

Anyway, being a particularly social being myself, I think best in conversation with others. So when the email arrived from 'Admin', my first thought (apart from 'Holy Cow, when did you say the deadline was?') was that I wanted to discuss it with some of my critical (in the best senses of that word) friends. Many of the ideas in what follows are not mine but those of Angela Gilchrist, Louise Goodbody, Peter Kinderman, Laura Lea, Ian Marsh and John McGowan, or evolved in conversation between us. I'm tempted to call us the 'South East Psychology Group' but since some of us have never met, others aren't in the South East, and not all of us are psychologists, that might be stretching it a bit. Dave Harper also contributed to our conversations, indeed so substantially in response to my first draft of this piece that we decided to include his response as a separate piece, continuing the conversation (see next article).

The praise

I'll start with the praise. There was a lot. We all agreed that the Manifesto is a thoughtful, well-argued and persuasive document which invites the profession into a much needed conversation. Laura, who has experienced the mental health system as a service user as well as as a professional, wrote 'I love this piece! It's been therapeutic reading it, and a great antidote to the relentless pathologised individualised ambience that pervades, albeit very subtly, the world of therapy and, I'm sorry to say, clinical psychology'. Contrasting it with the largely values-based manifestos that have gone before, Louise called it 'the closest we've got to something approximating a philosophical coherence to underpin ideas critical of mainstream psychology.' Ian praised the clarity with which the twelve propositions challenge the traditional western 'psy' discourse privileging what goes on

inside people's heads, be that at a psychological or the biological level. Many of us found it refreshing to hear a group of psychologists acknowledging the importance of the 'bio' and the 'social' in 'biopsychosocial'. We welcomed the acknowledgement of the role played by our physical bodies despite the rejection of a medical or 'disease' narrative. We agreed that so-called 'mental health problems' are often more usefully seen as social problems. The twelve propositions position distress squarely as something that arises in relationship – to each other and to our specific life circumstances. Yes, distress is psychological but it arises in response to the social world. The idea of 'therapy' as primarily providing a social relationship rather than a technical fix, also made sense to us, as did the suggestion that the technical fix idea 'cheapens and oversells psychology itself'. Writing this I'm aware that other readers of CPF may have a different reaction, and indeed could rightly point out that our response is likely to be influenced by particular circumstances and interests. Together with most of my critical friends, I speak from the particular position of someone who works for a university. Our colleagues in the NHS have to negotiate more directly the 'commodified culture' in relation to the provision of psychological help that is described in the piece. Some might accuse us of political naiveté in challenging the narrative of technique-based psychological 'treatments', suggesting that it has driven expansion of the profession and has led to many more service users being offered the opportunity to talk rather than only medication. Speaking as a trainer, the manifesto will be great to use in teaching. Ian's comment about the twelve propositions was 'I don't think they are all true, but they are a great discussion starter'. Particularly at doctoral level, where critical thinking is the name of the game, and in an era where an individualised, technological discourse increasingly dominates in the services where they are on placement, these are the kinds of fundamental debates that our trainees should be engaging with. I'll certainly be asking our trainees to discuss their reactions to each of the propositions with each other and then with us. Speaking as a BPS/DCP member, it would also be great to see these ideas debated at Division and Faculty events, for example within the Managers' Faculty, as well as at wider BPS ones which include people who organise undergraduate teaching. I'll also be recommending it to my colleagues who are involved in the education of trainees from other disciplines.

The critiques/suggestions

The authors position the manifesto as a draft. Unsurprisingly my colleagues and I, not a bunch known for being backward in coming forward with our opinions, had some questions and reflections. We offer them in the spirit of continuing the important conversation that the Group have started.

Some welcomed the way the manifesto positions itself as a series of what might be called 'truth claims', articulating and evidencing an alternative to other such claims, for example medical or cognitivist explanations of distress, in an implicit dialogue with their proponents. Others wondered whether this runs the risk of creating or reinforcing 'camps' of those who agree more or less with the propositions, and whether it might be better just to open up conversations about how useful (when and to whom) certain ideas or practices are. Maybe - hopefully - these are just different stages, and over time the gauntlet that the group have thrown down will get us out of 'camps' and into useful and productive discussions. The positioning of the manifesto as a draft helpfully implies an invitation to such conversations.

Big topic, but several of us wondered about the place of personal agency in the manifesto's vision of the world. Louise was struck by the absence of the Foucauldian perspective which sees individuality as a wild card in the pack of otherwise potentially deterministic power relations. Is there a place for agency? How do people change? Angela, originally from South Africa, doubted that Nelson Mandela would have agreed that 'whether or not we have the power to exercise our will depends on the availability of the necessary social and material resources'. This is obviously true to an extent: the better resourced we are, the more easily we may find our way out of distress. However, Angela suggested that someone like Mandela would have argued that it is through the exercise of discipline and determination that we ultimately create the potential to become better resourced. She concluded: 'If it were true that without resources the exercise of will would be impossible, no political struggle would ever have been won. There seems little point in replacing enslavement to the biological model of psychiatry and medication with enslavement to victim consciousness.' Thirdly, some of us felt that at points the manifesto risked throwing a few babies out with their proverbial bathwater. This was particularly the case with the apparently wholesale rejection of 'evidence bases' (section 10), of work on 'cognitions' (section 11) and in the assertion that technique is unimportant in therapy. I'm willing to accept that a self-serving bias might be at play here, and I don't disagree with the general thrust of the argument. But I have found some techniques, or at least certain guiding ideas, really useful – exposure might be one example, or the cognitive behavioural model of panic attacks. I do agree, however, that these ideas have been oversold. As the manifesto points out, this brings with it the danger that therapy disables the person and those around them by 'bolstering the belief that (distress) is a mysterious state amenable only to professional help'.

Fourthly, one question that the manifesto provoked for us is why it is needed at all. In other words, what processes and interests maintain the current situation where we all – psychologists and the public alike, but particularly psychologists – tend to focus on individual 'psychopathology' in looking for the causes of distress, and a 'social materialist psychology' is something new and unusual that needs explaining or justifying?

Finally, John - the editor of the Salomons blog 'Discursive of Tunbridge Wells' - suggested that the ideas need to be articulated more simply if they are to reach a wider audience: 'I don't want to simplify the points but the Midlands Psychology Group (terrific individuals though they are) sometimes sound as if they have swallowed a philosophy book.' The next step might be to write a piece which is accessible to service users and the public as well as psychologists.

So what do we need to do?

Quibbles aside, most of the ideas in the manifesto chimed with ours, and I suspect, with those of many readers of 'Clinical Psychology Forum'. We're grateful to the MPG for summarising and articulating them so brilliantly. The question that exercises many of us is, as Dave put it: 'What do we need to do now?' If we largely agree with this analysis, where should we be focusing our energies, as a profession and as individuals? Peter suggests 'we need an action plan for practical political change. Having articulated what we believe, we need to articulate how to implement what we know.'

At the moment it can be hard to give ourselves permission to ask such a question. Many of us are worrying about basic things like possible redundancy. Even those of us whose jobs are relatively secure work in a climate where we are increasingly - in the words of a builder I once overheard reprimanding one of his labourers - 'paid to do, not to think'. However, arguably current circumstances only illustrate the web of power and interest that we are all caught up in, remind us how much greater the effects of this 'time of austerity' are likely to be on those we are trying to help, and make the project all the more pressing.

As a starter for ten, here are some ideas we came up with for two things that we can do as individuals and as a profession to implement these ideas and bring about positive change.

Adopt a public health approach

Firstly, the obvious implication of this analysis is that the profession needs to go beyond our current focus on offering therapy to individuals. We need to adopt a public health model, focusing far more on prevention. As the saying in public health circles goes, there's no point mopping the floor and leaving the tap running (Laurance, 2013). Arguably we are working in a society that is creating distress faster than we can mop it up. Adopting a public health approach would mean widening our focus from what goes on in people's heads to issues of power and social justice: getting involved in politics.

A famous example of the huge difference that 'public health' measures can make is that of Dr William Duncan in nineteenth century Liverpool (Laxton, 2000). As with most doctors (and like many present-day clinical psychologists, if we are honest) Duncan came from a relatively privileged background. But after working as a GP in a working class area of Liverpool, he became interested in the links between poverty and ill-health and started researching the living conditions of his patients. He was shocked by the poverty he found, and in the clear link between housing conditions and the outbreak of diseases such as cholera, smallpox and typhus. He started a lifelong campaign for improved living conditions, particularly better housing, cleaner water and better drains. These have led to huge improvements in the health of many millions of people.

So what might be the mental health equivalent of clean water and better drains? What might a 'psychological public health' or perhaps a 'public wellbeing' approach look like? Looking at the evidence, two important things to focus on appear to be firstly, safety and secondly, equality.
As psychologists we know the importance of basic safety. Too many of the people we see have lived with fear that their basic needs might not be met because of poverty, neglect, abuse or trauma. Addressing these issues in whatever way we can should surely be a central concern for a profession whose raison d'etre is to reduce distress. However, we also know that even when these basic needs are met, in fact even for people who are secure and well off, being surrounded by inequality is a predictor of psychological distress (Wilkinson & Pickett, 2010). As psychologists our challenge is to articulate why that might be, but also perhaps to do something about it and work to reduce the inequality in our own society.

A public wellbeing approach means putting more effort into active promotion of health and wellbeing rather than focusing on 'treating' problems after they arise. We need to articulate why levels of distress might be higher in certain communities and then think what we can do about it. Rather than self-servingly promoting individual therapy, we can offer community based workshops

designed to help people to help themselves and others. We can promote self-help approaches in the media and on social media.

Make our voice/s heard

As a profession we have arguably specialised in keeping our heads down. We need to put our heads above the parapet and make our voices heard both individually and collectively, and to challenge vested interests such as 'Big Pharma' and perhaps even sometimes (and this is harder) our own self-interest as a 'psy' profession. We need to draw attention in the media to the social causes of many psychological problems, and to the role played by inequality. As a profession we need to be more active in influencing policy. The DCP can only do this with our support (join the DCP if you're not already a member, and volunteer for something…). As individuals we can use our platform as psychologists to influence vital debates via Twitter, blogs or the media (give your name to the BPS media office and say yes when a journalist phones you…).

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