Agents of social control?

Stephen Joseph *takes a look at psychology, social injustice and mental health, from a community psychology perspective.*

WE would all agree that psychology can be applied to health and social care. But what is more controversial is *how* psychology is applied. There are many that would argue that the profession of psychology has lost its way, that it has unwittingly become an agent of social control. This article is an overview of the issues raised by critical psychologists who say that mainstream clinical practice overemphasises the psychological causes of mental health problems at the expense of social-environmental causes, thus perpetuating social injustice. As a result, it is argued that we need to consider three issues: first, that our conceptions of psychopathology are social constructions that inevitably reflect the wider social ideologies of the day; second, that as a result the practice of psychology is not politically neutral; and third, that explicit professional self-reflection on these issues and our role in society is required.

Social origins of distress

Research shows that both internal psychological factors and external social-environmental factors are involved in the development of mental health problems, but the view of critical psychologists is that mental health problems originate in the first instance through the social-environment. They argue that although there may be proximal correlates of distress at the biological or cognitive level, it is vital that intervention should be targeted at the distal social-environmental level. By leading people to believe that their problems reside in their biology or their way of thinking, psychologists are serving to divert people's attention from the real causes of their distress. For example, Gillian Proctor (2005), a clinical psychologist, has recently written of how:

> *…the psychologisation of distress firmly places the cause for psychological ill-health within the individual… Thus deprivation, abuse, oppression and the social and political context of distress can largely be ignored and the practice of clinical psychology can continue to try to mop up problems caused by a sick society.* (p.280)

Proctor (2005, p.280) goes on to say that in mopping up problems, clinical psychology preserves its 'status, power and the status quo of inequalities, which in turn perpetuates the creation of distressed people'.

Such views follow in the wake of other psychologists who have been critical of many of the traditional approaches to mental health (see, for example, Bentall, 2003; Martín-Baró, 1994; Pilgrim & Treacher, 1992; Smail, 1996; 2005; and articles by Oliver James and the Midlands Psychology Group in this issue). Writing in *American Psychologist* on the subject of how clinical psychology perpetuates the creation of distress, George Albee (2000) highlighted major political differences between a medical/organic/brain-deficit model to explain mental disorders and a social-learning, stress-related model. He argued that the former is supported by the ruling class because it does not require social change and major readjustments to the status quo. The social model, on the other hand, seeks to end or to reduce poverty with all its associated stresses, as well as discrimination, exploitation, and prejudices as other major sources of stress leading to emotional problems. Albee (2000, p.248) concludes that 'by aligning itself with the conservative view of causation, clinical psychology has joined the forces that perpetuate social injustice'.

These criticisms do not deny that clinical psychologists themselves are well meaning and believe that they are performing a helpful role in society. Nor do these critics claim that at the head of the profession there is an elite of people who wish the profession to function as an agent of social control. It is easy to feel personally accused when one reads these criticisms, but this is not their authors' intention, although sometimes the more polemic of the writing has perhaps served to alienate rather than engage with the wider profession.

Social construction and psychopathology

But is it possible that these accusations are true? The history of psychology testifies to how psychological practices are influenced by prevailing cultural conceptions (Jansz & van Drunen, 2004), and it would be naive to think that our current perspectives are not similarly influenced. In support of this view, in their discussion on the nature of psychopathology, Maddux *et al.* (2005) wrote:

> *…psychopathology and mental disorder…are social constructions –*

WEBLINKS

Social Power and Psychological Distress: *www.davidsmail.freeuk.com/introfra.htm*

The Tomas S. Szasz Cybercenter for Liberty and Responsibility: *www.szasz.com*

Legal, Ethical, and Professional Issues in Psychoanalysis and Psychotherapy: *www.academyprojects.org/alternatives.htm*

Prouty's Pre Therapy: *www.psychological-wellbeing.co.uk*

> *abstract ideas whose meanings are negotiated among the people and institutions of a culture and that reflect the values and power structure of that culture at a given time…it is time to acknowledge that science can no more determine the proper or correct conception of psychopathology and mental disorder than it can determine the proper and correct conception of other social constructions such as beauty, justice, race, and social class.* (p.16)

If we accept this position that our conceptions of psychopathology are social constructions, then we have to also accept that our research endeavours and approaches to practice are inevitably also bound up in our social constructions. Maddux *et al*. (2004) argue that how we conceive psychological illness and wellness has wide-ranging implications for individuals, mental health professionals, government agencies and society at large. because our conceptions determine what behaviours we consider it necessary to explain and the roles and functions of clinical psychologists. As the Midlands Psychology Group (2007) illustrate in this issue, reflection on our conception of unhappiness can lead to questions around the idea that unhappiness is necessarily undesirable and that our task should be to treat it as pathology.

Thus, the application of psychological science can never be a politically disinterested process no matter how much we might want it to be. Proctor (2005) goes as far as to say that all research questions are determined by political agendas (harmful or benign) and which research is publicised the most and becomes the accepted 'evidence' is similarly politically determined.

How we think we ought to offer help to each other in society is not a straightforward evidence-based question. What constitutes evidence, which evidence we value most, and what we do with the evidence that we choose to attend to, are all expressions of our values. For example, clinical psychology training and the mental health system emphasises the importance of specific treatment techniques for each of the so called psychiatric disorders. But there is also a wealth of empirical literature showing that the most important factor in therapeutic recovery is not so much what the therapist does but the quality of the relationship between the therapist and client (Bozarth, 2002; Bozarth & Motomasa, 2005). How would clinical psychology training and the mental health system be different if it instead emphasised the evidence-base on the therapeutic relationship? More interestingly, why doesn't it already? Is it, as Proctor (2005) suggests, because the profession of clinical psychology is actually more interested in its power and status than in the scientific evidence?

Psychology and politics

The practice of psychology is ultimately a political activity. A few years ago there was an exchange of letters in *The Psychologist*. In response to one letter, in which the author started that she did not want to belong to a professional body that became involved in politics, David Kidner (Letters, April 2001) wrote:

> *Whether we like it or not, psychology, like any discipline, contains an implicit political ideology; and silence or denial of our involvement is no less a political act than explicit political action… The choice we have to make, therefore, is not between involvement or non-involvement, but between awareness of our involvement or denial.*

Critical psychology looks to move away from the model of social control

Interestingly, similar concerns to those above are now also being voiced within the profession of social work – that it has been usurped by market forces, managerialism, and the domination of care-management approaches. As a result, social work has become defined by its function for the state as opposed to its value base, and worker–client relationships have become characterised by control and supervision as opposed to care. As a profession we also have to face up to these questions. If our discipline contains an implicit political ideology, or a collection of ideologies, we need to make it explicit.

But to engage with these issues is threatening to the status and power of our profession, and inevitably there are forces of professional self-interest operating against the adoption of critical psychology perspectives. There are those who will point to the limited financial resources and strict government directives within the National Health Service to excuse less than ideal practice and to argue in support of current practice regimes. On the one hand it could be argued that society needs various organisations which serve interests of social control, e.g. the police, prison, and there is no reason that the profession of psychology, or some aspects of it, should not sit alongside these other professions as serving a social-control function. But on the other, could it be argued that it would actually be better to see the marginalisation and dissolution of the profession of psychology rather than see it become a force for social control and oppression?

However, although arguments can become polarised in the way described above, the implication of critical psychology is not necessarily the dissolution of professional psychology For example, an alternative positive psychological vision for professional psychology is presented by Maddux *et al.* (2004) who argue that the practice of psychology has become entrenched within an illness ideology based on the medical model and that we should reject the categorisation and pathologisation of human experience, and the assumption that mental disorders exist in individuals rather than in their relationship to culture. They urge us to move towards understanding the facilitation of well-being not as a medical treatment but as the province of educational social and political intervention, not in hospitals and clinics but in community centres, schools and people's homes, and to give equal emphasis to mental health as we do to mental illness.

Professional self-reflection

To achieve a new vision, what is important is to first of all define the type of profession we are and not to pretend to ourselves we are one type of profession when we are another. This is the main

implication of the critical psychology literature – to be honest with ourselves as to what it is we are doing, and who we are doing it for. What critical psychologists say is that we are deceiving ourselves, engaging in one type of work while telling ourselves it is another. This is a call for greater professional self-reflection .

As we begin to reflect, we embark on a process of change. I hope that as a profession we would want to move away from the social-control function, and the illness ideology. I hope that the training curriculum would begin to change to accommodate critical-psychology values, and positive-psychology perspectives, and ultimately the nature of applied psychology would change.

We have to accept that many of the employment roles we currently fill might disappear, or be reconfigured. Although this is threatening to the profession as it stands, it is the challenge that critical psychology presents from which a more ethically based profession would potentially emerge. There are many ways in which the future of mental health services can change and alternative ways in which psychologists can be employed (see Newnes *et al*., 1999).

Let us be honest with our patients and clients. If people's problems are not medical conditions, let us not pretend that they are (see Bentall, 2003; Boyle, 1999; Maddux *et al.*, 2004; Sanders, 2005). Where the current DSM-based language of psychopathology is an unhelpful medical metaphor, let us just stop using it. What it implies is that psychological problems are like medical conditions, requiring expert diagnosis and formulation in order in order to target specific treatment. Is this true? Maybe for some problems it is, but let's not just assume that it is for all. If instead problems in living do arise through disempowerment, let us work to empower people, not to diagnose and treat them for metaphorical disorders. If we inappropriately medicalise problems we not only divert their attention from the real causes, we further disempower that person.

Instead, we can see the role of psychology as a force to empower and free people to think for themselves. For example, in contrast to therapeutic approaches grounded in the illness ideology, person-centred therapies are founded on the idea that therapy should be to help people to evaluate experiences openly and honestly for themselves. Carl Rogers (1978) talked of a quiet revolution, recognising the possibility that personal transformation leads to social change. Therapeutic work at the individual level need not condone the medicalisation of human experience, nor ignore the influence of the distal social environment. For example, Proctor (2005) describes the conflict she experiences in her role as a clinical psychologist between her personal values and the values of the National Health Service, and how she manages to negotiate this conflict using the ideas of person-centred therapy.

As a more ethically based profession of psychology evolves it should strive to influence the wider world. Certainly, we can't change the world overnight, but there is no reason that psychology should not help to change the world. Part of our role as individuals within the organisations we work, and as a profession within society, is to influence the world around us. We already do. For example, a recent issue of *The Psychologist* (April, 2006) published a letter by John Sloboda and others expressing concern about the financial and human resources committed by the UK and US psychological communities to Iraq, in response to the psychological suffering of the people there. In 2005 the BPS condemned the use of psychological knowledge and techniques in the design and enactment of torture. As the profession of psychology increasingly realises that it cannot escape the fact that it has a political agenda whether it likes it or not, there is little choice but to engage as best we can in these and other social issues.

What critical psychology suggests is the possibility that as a profession we are currently failing in our responsibility to society. Certainly there are economic and political constraints on the profession of psychology, but it is more ethical to refuse to bend our intellectual integrity and values to fit these constraints. To engage with these issues is threatening to our profession and of course to our livelihoods as individuals, and we should not expect change to come about overnight. But if we begin to take seriously these ideas, to introduce them into the curriculum, to engage in discussion over our role in society, ultimately as a profession we will be the better for it.

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DISCUSS AND DEBATE

Should the role of clinical psychology be to mop up the problems of a sick society?

Does the practice of psychology contain an implicit political agenda?

When should we compromise our intellectual integrity and values?

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