Paul Rhodes *Editor*

Beyond the Psychology Industry

How Else Might We Heal?

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Editor
Paul Rhodes
Clinical Psychology
University of Sydney
Sydney, NSW, Australia

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Chapter 1
A Drifters Handbook

Paul Rhodes

> You might do some good in your role as "psychologist" perhaps but treat that identity and the knowledge as a set of powerful and sometimes dangerous stories about people. Find inspiration and strength in the many other kinds of story from outside the discipline that are told about what human beings can do to reflect upon and remake themselves. (Ian Parker, 2014, p. 556)

I listened to a young clinical psychology student tell me a story recently of a placement they did in rural Australia, in an indigenous community far from our Eastern cities. This young student, trained at the top university in the country, felt ill-equipped. It was the story of a young boy, 14 years old, despairing and grieving the loss of a cousin to suicide, one of many such deaths he had experienced. He could not get up in the morning. He was harming himself. Contemplating death. One person caught in the epidemic of aboriginal suicide tied to colonization, intergenerational trauma, structural inequalities, and more. It was also the story of clinical psychology, a secular religion, with its missionaries and confessionals, focused on sin/pathology, rather than on social and emotional well-being (Dudgeon, 2017). Indigenous psychology is culturally safe, supporting the persons' strengths and their relationship with community, spirituality, and land. Contemporary therapy, on the other hand, is not safe in this context. It is a hyperrational approach to healing, built on individualism, the sole agent in a sealed room, cut off from culture and land. Thankfully this student, smart and progressive, sought the knowledge of aboriginal elders and health workers and soon learned to take her shoes off and sit in the circles.

The dominant method in clinical psychology is still cognitive and, like most models, serves as an evidence-based application of Western philosophical concepts. The original cognitive model is based on Greek and Roman stoicism (Robertson, 2018), transformed by the information processing of the 1980s into a formulation-driven metaphor for distress. Most contemporary models eventually become abbreviated in a similar fashion to support their promulgation: cognitive behavioral therapy (CBT), acceptance and commitment therapy (ACT), dialectic behavioral

P. Rhodes (✉)
Clinical Psychology, University of Sydney, Sydney, NSW, Australia
e-mail: p.rhodes@sydney.edu.au

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therapy (DBT). There is a new one called temperament-based therapy with supports (TBT-S). Each of these models emphasizes the intrapsychic over the interpersonal and decontextualized, with the focus on personal control or acceptance of subjective phenomenon.

I recently read an interesting paper by Waller (2009) on therapist drift, a beautiful example of Foucault's (2006) "technology of the self." Waller admonishes cognitive therapists for drifting from key principles, particularly from a focus on "doing" to "talking," lest we "behave in ways that reflect our own twisted thinking" (Waller, 2009, p. 122). This book serves as a manual for this kind of drifting.

As clinical psychologists, we are taught to keep our distance, to protect ourselves from distress and dysfunction, to objectify. This is achieved through language: the language of quantification, diagnosis, and the mental state exam. Here is an example of how we are taught to describe people in our research:

> Serial assessment of his mental state using MSES is shown in Figure 2, with a global score and sub-scale scores derived as percentages for mania and psychosis dimension scores, which were the most prominent symptom dimensions relevant to the patient. (Fernando & Carter, 2016, p. 78)

And how we might label a distressed person:

> Disruptive mood dysregulation disorder (DMDD) is a childhood condition of extreme irritability, anger, and frequent, intense temper outbursts. DMDD symptoms go beyond a being a "moody" child—children with DMDD experience severe impairment that requires clinical attention. DMDD is a fairly new diagnosis, appearing for the first time in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published in 2013. (American Psychiatric Association, 2013, p. 220)

And here is an example of what a mental state exam might read like:

> General appearance and behavior: Arnold is a 74 year-old man of average weight and height. At the time of examination, he was well groomed. On appearance, there were no signs of tremor or abnormal movements. Arnold was cooperative throughout the interview. He maintained eye contact, except when recounting his mothers' recent death. Then, he appeared depressed.

These forms of language seek to differentiate the clinician from the client, amplifying polarities. The clinician is the objective, the client is the object. The clinician is mentally healthy, the client mentally ill. We both become objects.

In our new hyper-economy, however, we are moving from objectification to "off-peopling". We are now decentering the therapeutic relationships in favor of augmentation through artificial intelligence. There are now hundreds of cybertherapy programs, including computerized cognitive behavioral therapy (cCBT), BRAVE-Online for anxiety (Spence et al., 2011), Catch It (Van Voorhees et al., 2009) for depression, and MoodGYM (Christensen and Griffiths, 2011). Gunter Anders (Muller, 2013), philosopher of technology, warns of the proliferation of machines, devoid of debate on societal repercussions. He writes of Promethean Shame, that which comes when humanity that has lost control of its technical devices, and seeks then to become objects themselves. We live in the era of horrific challenges: racism, the refugee crisis, climate change, and this is what we offer. The new frontier.

The cultural context for these developments is neoliberalism (Dudley, 2017). Psychotherapy is obviously helpful for some, but the commodification and industrialization of healing is a moral issue. This cultural dominance of clinical psychology, exercised though the labeling of individuals, the branding of treatments, and the quantification and the drive for technological efficiency all threaten the emancipatory potential of therapy. We are not easily distinguishable from our increasingly dehumanized technocratic world. We have become complicit in supporting individualism and the denial of communal life (Martinez & Garcia, 2000). I fear that as a profession, we have also become socioculturally blind. Feminism, for example, is lost on the majority of researchers and clinicians in anorexia nervosa, where body image supersedes embodiment (Malecki, Rhodes, & Ussher, 2018) and the gene code needs to be cracked (Pinheiro, Root, & Bulik, 2009). The social determinants of "mental health" such as poverty, dispossession, and employment insecurity are lost to the neurological turn (De Vos & Pluth, 2017). We focus on cultural competence, rather than critical consciousness, reinforcing racism because we fail to look at ourselves (Lee & Farrell, 2006).

So if psychology is not well, what is the treatment? Mignolo (2007) uses the term *epistemic disobedience* in the context of decoloniality. Aren't we similar to the priests of the Middle Ages, sole arbiters of man's relationship with the mind? We must wrestle back healing from the healers.

The aim of this book is to demonstrate clearly that healing is a human enterprise that must not be the sole property of the psychological industry. This is not to suggest that people should not go and see therapists, or that current models do not work for some people. It certainly is not a critique of the many caring therapists out there working hard. It is important to recognize, however, that we cannot always be trusted. Our models are simply maps rather than the territory (Korzybski, 1933). And they are colonial maps, used to annex meaning. So we must also turn to ourselves, to our interiority and to the people who we love or might, and to the many discursive resources in culture for these purposes. The healing that we require takes longer than 10 sessions.

This is a book written mostly by friends, each of whom, in their own way, is an activist-practitioner, critical academic, psychologist, and/or therapist. While we are part of one tribe, critical of mainstream psychology, there is much diversity in this group of authors. We are joined, however, in our desire to rescue healing from the psychologists.

Chapter 2 is a callback to the tradition of existentialism. Anxiety, for the existentialist, is a sign of sanity rather than pathology, a rational response to an absurd world. For Kierkegaard, anxiety was not pathology, but rather

> may be compared with dizziness. He whose eye happens to look down the yawning abyss becomes dizzy. But what is the reason for this? It is just as much in his own eye as in the abyss, for suppose he had not looked down. Hence, anxiety is the dizziness of freedom. (Kierkegaard, 1844/1980, p. 152)

The existential journey cannot be captured in manuals and scales, but rather begins at the dark wood, where Virgil calls Dante (Alighieri, 1265–1321/2013),

> It is a hard thing to speak of, how wild, harsh and impenetrable that wood was, so that thinking of it recreates the fear. It is scarcely less bitter than death: but, in order to tell of the good that I found there, I must tell of the other things I saw there. (Dante, The Divine Comedy, Inferno, Canto 1:1–60, The Dark Wood and the Hill)

Dante's journey would have been very different if he was met by a psychologist at the edge of that wood, providing psychoeducation, strategies, and weekly homework. For the existentialist, anxiety, depression, and suicidality are part of an authentic life, a search for meaning that cannot be sidelined by an exclusive focus on cognition on symptom reduction.

Ross and Rachel serve as masterful advocates for a return to an existential position in mainstream clinical psychology, particularly the recognition of the fear of death as a core transdiagnostic principle behind many "psychological disorders." They provide a rigorous scholarly argument for the failure of the field to respond effectively to human distress, largely due to the fact that we have lost touch with the philosophical origins of the discipline. They propose terror management theory as a paradigm that can help us understand cultural practices used in the face of dread and argue for a return to compassionate and community-based practices of restorative healing.

Loneliness, of course, also lies at the heart of many psychological problems, particularly depression. There are many instances in my own practice, when I have diagnosed a patient with loneliness, rather than depression, to support a process of reaching out for connection rather than an exclusive focus on introspection. Diamond et al. (2016) attachment-based family therapy supports the notion that adolescent depression can be conceptualized interpersonally, not only intrapsychically, as a symptom of breached parental relationships, being burdened by the traumas of life with no one to turn to. The association between loneliness and depression is also supported by a host of empirical reviews (Erzen & Cikrikci, 2018; Wang et al., 2018). Perversely, in the field of social neuroscience, Cacioppo and Cacioppo (2015) are attempting to open up the possibility for a designer pill to assuage the feelings of loneliness in the brain, a phenomenon they hypothesize is related to "the impaired biosynthesis of Allopregnanolone (ALLO), a brain endogenous neurosteroid" (p. 1).

Chapter 3 by Jennifer Fitzgerald serves as a wonderful primer for the critical role of attachment in establishing stability and healing in our lives. She builds on the legacy of John Bowlby, taking us on a journey from the cradle to grave, from the bonds of childhood to romantic love, from the effects of trauma on relationships to the attachment relationships that many have with God. I am grateful for her inclusion of religion in this chapter, given it is arguably an important omission for a book that aims to explore healing outside of the psychology industry. This chapter also provides an introduction to emotion-focused couples therapy, a much-needed antidote to the sometimes-mechanized individual therapies of clinical psychology.

The arts are also represented in this book. Poetry, fine arts, and drama provided means for the interrogation of self in society long before the advent of psychology. While empirical psychology searches for generalizable rules, based on observation, the arts embrace uncertainty and liminality and focus on *unconcealment* (Ireton, 2012), on processes of becoming and moments of being in the world.

> There are openings in our lives of which we know nothing. Through them the belled herds travel at will, long-legged and thirsty, covered with foreign dust. (Hirshfield, 2001)

Art also allows us direct access to the cultural nature of interiority, not simple subjectivity. Unlike the decontextualized cybernetic metaphors of clinical psychology, art can tap into the affective atmosphere of place (Anderson, 2009), revealing symbols of collective subjectivity. I first met the next author, Jhilmil Breckenridge, through a project titled We Are Barometers of the City: Collected Poems of Psychologists (Rhodes et al., 2018). In this project, we demonstrated that poetry can help us embrace "the messy entanglement of body–object–space in our personal and professional lives" (p. 15). Chapter 4 by Jhilmil is both an auto-ethnography and a primer for the use of poetic healing. She draws on the seminal research of social psychologist Pennebaker who conducted clinical trials on the therapeutic effect of expressive writing. She describes her use of poetry to heal from relational trauma and her role as founder of the mental health charity, Bhor Foundation, whose mandate is to take poetry into psychiatric institutions and prisons in India. Her writing is lyrical and moving and we are left with a series of edicts about why poetry is good for us.

The next three chapters concern themselves with community, in particular forms of practice that go beyond the confines of the therapy room. Community psychology began in the 1960s North America, when psychologists resisted conservative mainstream practice. The development of this field, from the Swampscott conference of 1965 (Meritt, Greene, Jopp, & Kelly, 1999), mirrored the influence the civil rights and feminist movements had in this period (Swift, Bond, & Serrano-Garcia, 2000). Community psychologists centered the field on social justice and the direct participation of neighborhoods, on ecological analysis and intervention, empowerment, social activism, and the recognition of cultural diversity (Nelson & Prilleltensky, 2005; Rappaport's, 1977). Clinical psychology, on the other hand, largely remained oblivious to the political realities of the time, maintaining a commitment to the scientist-practitioner model at the expense of activist practice.

Chapter 5 concerns itself with "(The ART of) Social Prescribing," a burgeoning practice in "mental health" service provision. Katherine Boydell makes a strong case for models of practice that directly target the social determinants of health rather than the reductionist targeting of symptoms. If loneliness, poverty, and lack of housing contribute to the so-called mental health problems, then these factors must be directly targeted as alternatives to a more exclusive reliance on intrapsychic therapy and psychopharmacological intervention. Rebranding the effects of poverty and marginalization as personal pathology is a perversion, and social prescribing offers a practical form of resistance. Katherine's scholarship is exemplary as she reviews the empirical evidence for this new field, including future directions.

Chapter 6 focusing on community is a coproduction by academics, researchers, and peer workers Holly Kemp, Brett Bellingham, Katherine Gill, Andrea McCloughen, Cath Roper, Niels Buus, and Jo River. This is an epic paper, the first ever written to explore the integration of open dialogue and peer work. Open dialogue is a Scandinavian practice that offers an alternative to hospitalization for those experiencing psychosis. A network is developed in the person's home, consisting of

professionals, family, friends, and others who engage in a series of meetings focused on dialogue rather than action, attempting polyphony rather than medical monologue, and the toleration of uncertainty rather than psychiatric determinism (Olson, Seikkula, & Ziedonis, 2014). Peer support, on the other hand, involves the employment of people with lived experience of the mental health system, who serve as professional storytellers, counsellors, activists, and advocates within services. The authors provide a convincing argument for the potential of peer support to address some of the potential problems with open dialogue, particularly the assertion that flat hierarchies are achievable in network meetings and that polyphony can deal adequately with structural inequities in therapeutic discourse.

Chapter 7 focusing on community is led by Omar Said Yousef, a Syrian psychologist and community leader. He is supported by Abdulrahman Alhalabi, Zachary Steel, Sertan Saral, and Ruth Wells, and by the voices of many Jordanian and Syrian psychologists working in the field. They ask, what role might a psychologist play when working with those experiencing conflict and human rights abuses? How might psychologists respond to those experiencing cruelty, oppression, and displacement? Their answer is to transform psychological practice, placing justice in the front and center and supporting dignity and resilience in the face of existential suffering.

Of course, the primacy of justice is not a concept that the mainstream clinical psychology industry has embraced, focusing instead on private phenomenon. Justice, however, is a critical imperative for colonial countries, built on genocide, slavery, and marginalization of indigenous peoples. In our own Australian context, we have a shameful history of colonization, including widespread massacres, abuses in missions and reserves, and the forcible removal of children and more. It was not until 2016 that the Australian Psychological Society issued an apology to Aboriginal and Torres Strait Islander people, acknowledging our role in contributing to the erosion of culture. Meanwhile, the suicide rate amongst aboriginal young people continues to soar at five times the non-Aboriginal population (The Lancet Child & Adolescent Health, 2019).

The next two chapters concern themselves with this critical issue, one outlining a clear practical model of practice and the other a personal account. Leading Aboriginal scholars Rob Brockman and Pat Dudgeon present Chap. 8. This chapter serves as a reimagining of our field, outlining and conceptualizing a decolonized form of practice, where culture, kin, land, self-determination, and strengths are primary, providing healing in the face of intergenerational trauma and racism. These authors are not advocating for the wholesale rejection of Western evidence-based therapies, but rather their integration with Indigenous psychology under the mantle of cultural humility. Chapter 9 by Merle Conyer comes from the perspective of a Western ally developing her capacity to work with Aboriginal and Torres Strait Islander peoples. Her work is a moving auto-ethnographic account of this journey, exploring how she has grappled with Whiteness and privilege in order to transform herself into an activist-therapist. Merle's impressive capacity for personal/political language takes us on this journey in ways that both move us and hold us to account.

The last chapter is definitely what we call in cricket-loving Australia a "captain's pick," given that it focuses on running, a personal choice for healing in my own life. I recall first hearing about Merleau-Ponty's concept of embodiment (Gallagher, 2005) at a conference, where much of the program was dedicated to new materialism and qualitative research practice. New materialism (or post-humanism) is a reaction against the dissociative discourse analysis that has dominated progressive inquiry for decades, in favor of a return to flesh and bones and place, streets, and the air that we breathe. It can serve as a recast phenomenology, positioning the body in place and time and culture, and, of course, with the much more radical ideas of assemblage and rhizome (Deleuze & Guattari, 1987). Chapter 10 by Leanne Hall serves as an exposition of the concept of embodiment, applying it to the plight of injured ultramarathoners. It serves to reimagine what healing from injury might involve if a physiological paradigm was resisted, in favor of one that responded to the mindbody as being. She takes us on a journey into the world of extreme running, a response to our disconnected neoliberal culture, to understand the challenges of suffering well, while staying within the bounds of our flesh.

Of course, there are many other chapters that might have been possible, in terms of representing the multiplicity of healing practices beyond the therapy room. Each individual has a wealth of cultural resources for this purpose, resources that have been coined folk psychology by the great narrative therapist Michael White (2001)—animals, travel, nature, creative writing, sex, ecological activism; but these are stories for another day. I hope you enjoy reading this book, and that it prompts you to reflect on these resources that you hold within yourself, between your loved ones, and the cultures that you hold dear.

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