Clinical Psychology Training in Neoliberal Times

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SUMMARY: Neoliberal ideology has insidiously colonised almost every facet of Western society. How is doctoral training in clinical psychology affected and how can it resist collusion?

KEY WORDS: Neoliberalism, clinical psychology, training, individualism

As a newly qualified clinical psychologist I feel grateful for the privilege of being able to work in what I consider to be a worthwhile profession. I entered the profession at a time of great political turmoil both for the National Health Service (NHS) and the United Kingdom (UK) as a whole. As I have progressed through the clinical training programme I have become increasingly aware of how neoliberal politics have shaped mental health services and clinical psychology and the impact this has had on the people I have seen in services. In my view this has not been a change for the better. This article highlights the moral dilemma neoliberalism has posed for clinical psychology and more specifically, clinical training programmes.

What is Neoliberalism?

Harvey (2005) defines neoliberalism as 'a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade' (p2). Neoliberalism has been the dominant political ideology of most Western governments for the past thirty years and has led to a dramatic impact on the makeup

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of society and individual psychology. By fostering principles of individualism, self-reliance and self-governance (Pratt, 2006) communities have become effectively atomised leading to an ultra-competitive society of autonomous individuals forming a 'hierarchy of winners and losers' (Monbiot, 2016). The paradigm has an implicitly dehumanised technocratic world view encouraging quantification and commoditisation and a proliferation of bureaucracy and managerialism in approach to organisational structure. Furthermore, the ideology endeavours to purify economic decision making by relying on market forces and reducing state interference by curbing public spending through privatisation of public assets and services and enforcing austerity programmes to reduce welfare spending (O'Hara, 2015). These factors are particularly problematic for mental health services at organisational, professional and practice levels.

If you don't fit the bill, you are mentally ill

It is indisputable that neoliberalism has taken a profound toll on the health of the population, though the reasons for this are numerous and complex. Fundamentally, the atmosphere of individualism and competitiveness has led to a rise in diagnosis of depression, substance abuse, loneliness and fear (see James, 2008 for an overview). This is compounded by a medicalisation, responsibilisation and individualisation of normal human suffering. Those who do not fit the neoliberal agenda are diagnosed as 'mentally ill' and prescribed commodified treatments to suppress unwanted feelings and behaviours which detract from competitive or productive activity, whilst ignoring social context (Esposito & Perez, 2014). In the absence of cohesive communities and meaningful employment and with ubiquitous toxic media rhetoric labelling people who cannot cope as 'defective', 'skivers' or 'losers', those who suffer face an intense level of stigma and alienation from society, hampering their recovery (Wahl, 2004). Moreover, neoliberal policy has been at the heart of an unprecedented rise in income inequality (OECD, 2015) which has been associated with increased mental health problems, homelessness and other societal issues (Wilkinson & Pickett, 2010).

The marketisation of mental health services

Clearly the issues outlined can only truly be ameliorated by changes in government policy, social movements and media influence. Nevertheless on the frontline it is mental health services that are required to help individuals who are suffering, no matter if the root of the problem is environmental (Fisher, 2012). However, there has been a recent trend towards the commodification and quantification of the way services operate which has arguably limited their ability to respond to the rise

in personal difficulties (Ramon, 2008). The adoption of neoliberal economics has resulted in a significant push towards finding efficiencies through encouragement of competition within and between services (Pollock & Price, 2013), forcing professions to provide quantifiable evidence to prove their worth. At a time when the professions should be finding solutions to cooperate effectively, they find themselves in a fight for scarce funding opportunities (The Kings Fund, 2015).

The 'technical framework' of neoliberal ideology decontextualizes the person and evidences the outcome of technical aspects of measurable interventions for specific disorders (Bracken, 2007) to decide where funding is most efficiently placed. Esposito and Perez (2014) argue that biological psychiatry is well placed to function within this system as the medical model inherently decontextualizes and categorises the individual with specific treatments for specific conditions that are easily measured and monetised. It has, however, been suggested that the further mental health services collude with neoliberal ideology, the more blinded they may become to 'difficult to measure' human attributes such as relationships, compassion and empathy (Spandler & Stickley, 2011). I would argue that this is a huge problem for the profession of clinical psychology, given that studies are repeatedly showing that it is these attributes that are most pertinent to effective therapeutic work (Del Re, Flückiger, Harvoth, Symonds & Wampold, 2012; Wampold, 2015; Wampold & Imel, 2015).

Colonised clinical psychology

Clinical psychology has been under increasing pressure to conform to the neoliberal system to survive as a profession and maintain funding. Though historically a broad church balanced between the intuitive (e.g., psychodynamic) and the technical (e.g., behaviourist) approaches, the drive to be defined as 'evidence-based scientist-practitioners' has led to a hegemony of therapies which fit the modern agenda (Hall, Pilgrim & Turpin, 2015). Ferraro (2016) summarised the issue with these changes: 'contemporary psychotherapy is, overall, a cheaper, more quantitative, more standardized, and more coercive endeavour than that which existed before the neoliberal era … the new aim is to produce subjects who conform to the alienated individualism of austerity capitalism'.

Though the dominant 'evidence-based' models such as Cognitive Behavioural Therapy (CBT) take the brunt of the criticism from those who feel it is oversold, it seems more likely that it is the neoliberal colonisation of the profession that is the real source of hostility (Watts, 2015; Ferraro, 2016). By stripping therapies down to a manualised, time-limited series of techniques and quantifiable outcomes for 'psychiatric disorders' it has been argued practice is at risk of becoming 'a dehumanising, mechanical allocation of client to procedure in a technical manner'

(Milton & Corrie, 2002). These developments mirror neoliberal ideology and are actively encouraged by government; an example of this is the establishment of Improving Access to Psychological Therapies (IAPT). Though offering more therapy provision as opposed to psychiatric medication alone is arguably a step in the right direction, it is the systemic focus on efficiency and motivation to return people to productivity, rather than genuine intention to improve wellbeing that engenders cynicism (Marzillier & Hall, 2009; Wesson & Gould, 2010). The most recent example of this neoliberal colonisation is mindfulness. Jon Kabat-Zinn (2003) introduced the concept of mindfulness-based stress reduction as a well-meaning endeavour to bring the benefits of Eastern wisdom to the West. However, it has been suggested that this has since been hijacked by the neoliberal agenda, stripped of context and 'reoriented to the needs of the market' (Purser & Loy, 2013; Harding, 2016). This insidious reframing of therapeutic ideas has also been criticised by service user groups in regard to the recovery movement: 'we reject this new neo-liberal intrusion on the word 'recovery' that has been redefined, and taken over by marketisation, language, techniques and outcomes.' (Recovery in the Bin, 2016).

As a result of these developments clinical psychology finds itself in a moral dilemma, where due to neoliberal changes to the health care system such as the Health and Social Care Act (see Pownall, 2013 for a comprehensive discussion) it must adapt to survive in the 'marketplace' environment or perish through lack of investment. This has involved what some would consider compromising on principles by colluding with the medical model which structures the systems of government, research, law and the NICE guidelines; leading to a confusing, contradictory and lacklustre merging of paradigms (Mollon, 2011; Harding, 2012; Whittaker & Cosgrave, 2015). Whilst at the same time heavily investing in technical, 'scientific', 'evidence-based' therapies which are deemed cost-effective and therefore marketable. The evolution of these changes is traceable in the British Psychological Society (BPS) doctoral training programme accreditation criteria, which will in turn likely shape the future of the profession.

Clinical training

Due to the variance in styles and approaches in training programme syllabus and selection protocols, it is important to note that the critique written will not be applicable to all institutions. But, it seems the BPS are under increasing pressure to conform to the changes neoliberalism has introduced to the wider systems and training programmes must bend to its will, struggling to maintain their identity and values.

CBT: the neoliberal Trojan horse?

Though BPS accreditation criteria (BPS, 2016a) maintain a stance on clinical psychologists being trained as 'multi-modal' therapists, over the past few years there has been a drive to enforce mandatory CBT competency in training. This may be a logical move to fulfil an overwhelming demand for CBT provision and supervision in the NHS, however there is a growing risk that CBT will become a monopoly; this has been shown to be disastrous in practice (Miller, 2012). A more cynical perspective would be that trainees are being groomed to become supervisors of less expensive IAPT workers to save money; a case of neoliberal 'cost of everything, value of nothing' thinking. Not to mention the ethical considerations of forcing trainees to find 'CBT clients' to practice with, many of whom may benefit more from alternative perspectives. The latest cohorts of trainees are now also required to complete a new set of rigid competency paperwork, which neatly dovetails into the costly British Association for Behavioural and Cognitive Psychotherapies (BABCP) accreditation process. This will make it easier for trainees to gain accreditation post-qualification, but in turn further strengthens the neoliberal grip over the profession.

I recognise that there is teaching and opportunity to practice in radically different models and that there is nothing inherently 'bad' or 'wrong' with CBT as a model (in fact research has shown models have little impact on therapeutic outcome [Wampold & Imel, 2015]). It is, however, this continued weighting towards 'scientific', pragmatic, technical approaches such as CBT that I fear will stifle diversity of perspective in training and edge future trainees towards Safran's (2015) observation: 'If anything, the trend is towards training therapists to become psycho-technicians, who deliver standardized *evidence based* treatments rather than responsible moral agents whose personal values, beliefs and biases have profound effects on the people they are trying to help.' We have already reached a point where our future trainees have to evidence 'having a sense of humour' as a 'CBT meta-competency' labelled 'judicious response to and use of humour'.

Be critical, but not a maverick

For me personally, being introduced to critical psychology was a vital part of the teaching process, offering validation to that niggling feeling that a lot of what I was being taught was built on sand. Criticism prior to this had been limited to scrutinising academic research, or sometimes, the validity of the medical model. In fact the BPS (2016a) encourages clinical psychologists to maintain a critical stance towards the evidence base. However, the lecturers that came to offer this perspective for a few sessions had a reputation in the profession as 'mavericks' or 'to be taken with pinch of salt'; an attitude I find unfair and damaging. Though considering many courses offer no critical psychology perspective at all (Newnes,

2004), I was grateful for the opportunity. The overarching message I gleaned from the training process seemed to be that as a qualified psychologist I should be skilled in critiquing limitations in research and practice, but not in questioning the political agenda or the status quo; those who do risk being, 'positioned as a radical or conspiracy theorist' (Rhodes & Conti, 2016). There seemed to be a process of nailing your colours to the mast of a certain model or approach in an almost tribal manner, but this distracts from considering the overall direction of the field and its social and political impact.

Critical psychology pulls no punches in scrutinising our profession's place in the political landscape, how whether we like or not we are always at risk of being complicit with the 'psy-complex' (Rose, 1985), a weapon in the neoliberal arsenal. It must be acknowledged that for people whose distress is largely rooted in the damage neoliberal austerity has caused, being 'treated' with psychological therapy will often iatrogenically locate the problem within them. If we do not expose trainees to this way of thinking, we risk continuing to sleepwalk into the neoliberal programme, losing our identity and failing to make a real difference for service users. Whilst the limits and contraintradications of therapy are often acknowledged during training, exposure to and discussion of relevant politics is often done in private. I believe courses would do society a great service by incorporating a combination of critical psychology and encouragement to join in positive action, for example the Psychologists against Austerity movement (Foster, 2015); helping future psychologists to dam the river of politically generated misery, rather than scoop it up in buckets at the end.

The great wall of academia

Though several courses have attempted to address this issue, it is a fact that the latest intake remains 82 per cent white and with 51 per cent in the top two socioeconomic quintiles (figures from Leeds Clearing House, 2015). The reasons for this issue with diversity are complex, though arguably the focus on academia over values and common factors may play a part. It is understandable that a certain level of academic ability is necessary to cope with the rigour of a doctoral qualification. However, the application process for many institutions is designed to filter out people who were not fortunate enough to achieve 2:1 or above. Even with a near impossible array of experience and postgraduate degrees these applicants still struggle to meet requirements. According to a report commissioned by the Institute for Fiscal Studies, those in this position are substantially more likely to be from a disadvantaged socioeconomic background (Crawford, 2014). This structure inevitably risks losing potentially excellent individuals to demotivation and perceived failure and stifles diversity. The barrier to those from disadvantaged socioeconomic backgrounds will only become more impenetrable should the

government change funding to a loan-based system (BPS, 2016b) and the trend toward voluntary assistant posts becomes the norm (Stevens, Whittington, Moulton-Perkins & Palachandran, 2015).

Of course, this is not to say that current trainees have not worked very hard to get their places, whatever their background. But this perhaps unintended bias toward the academically gifted and socioeconomically privileged reflects neoliberal ideology; society is a meritocracy and if you cannot prove your worth in a way the system recognises, you are left behind. As a by-product this benefits institutions, as highly academically minded trainees are more likely to improve university research credentials. But as ever, neoliberalism leads to blindness toward human qualities. Unless they reach interview, potential trainees do not get an opportunity to demonstrate these qualities which are equally if not more important than technical or academic qualities for clinical work. Though naturally people from all backgrounds can possess the common factors and values for therapy, it is disadvantageous to have cohorts of trainees that are not representative of the diversity of the people accessing our mental health services.

Technique takes over

Milton and Corrie (2002) argue that clinical psychology is steadily tipping the balance toward technical knowledge over intuition. This has been a hallmark of almost every subject touched on throughout this article and characteristic of neoliberalism. The authors neatly suggest that it is 'implicit wisdom' – the difficult to define essence of the therapeutic relationship – that is necessary for technique to 'come alive'. Without this, you are left with the dry bones of manualised technical instruction and decontextualized scientific research. Iain McGilchrist (2009) meticulously analysed this phenomenon, concluding that the narrow focus of the rational mind is constantly censoring the broad attention of the intuitive; that society has become obsessed with 'knowledge of the parts' over 'wisdom of the whole'. The intuitive mind can never defend itself in a world of scientific evidence as it is by its very nature relational and intangible; the 'gut feeling' that is improvable. My own 'gut feeling' is that this is the direction training is heading in as it continues to select, teach and train trainees to fit an increasingly scientific, technical paradigm in line with neoliberal ideology. Given mental health problems so often require an extraordinary level of empathy, intuition and imagination to comprehend; rational, scientific thought alone will never suffice.

In response to this issue, Rhodes and Conti (2016) suggest trainee psychologists should be exposed to philosophical ideas such as existentialism, social constructionism and the works of Foucault during training as a counterpoint to scientific evidence. Milton and Corrie (2002) propose we should be 'encouraging therapists to maximise 'alternative' sources of personal growth through contact

with the natural world, literature, art, music, drama, dance and spirituality which can better equip therapists to access the curiosity and playfulness that is necessary for extra-ordinary therapeutic work.' Furthermore, though once thought to be fundamental component of training (Yalom, 2003), personal therapy has also dropped off the mandatory agenda of many institutions, preventing trainees from being exposed to in depth exploration of their own subjective world.

Conclusions

We live in a time of great uncertainty, but also great opportunity. There are signs neoliberal politics are beginning to erode for the first time since the 1980s (Roberts, 2016), but the direction the Western world takes remains to be seen. It is vital for the future of clinical psychology that trainees are well equipped to fight against iatrogenic practice and collusion with a continuation of this damaging ideology. Courses must pay close attention to the application process to ensure we recruit the right mix of intuitive and technical skill, to have such oppressive academic requirements shuts out a whole swathe of potential. Critical psychology must be incorporated into the curriculum and taken seriously, helping trainees to understand the bigger picture and consider that all of us are impacted by some form of oppression (Smail, 2005). Teaching should move away from pseudo-medical models of therapy, whilst it is important trainees understand the diagnostic system so that they can work alongside it, it is detrimental to the profession to collude with it. CBT should be taught and practised but not favoured and monopolised. Trainees should be encouraged to get involved in political action fighting for good mental health in addition to developing clinical and academic skills. We need to be turning out cohorts of 'responsible moral agents' whose mission is to encourage positive change on an individual and societal level and who are willing to stand up against toxic ideas. If we do not, we risk continuing to become 'psycho-technicians', components of capitalist machinery.

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