Opinion Piece

Why Clinical Psychologists Should Read Philosophy: An Introduction

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Abstract: The aim of this paper is to argue for a deeper engagement between the fields of clinical psychology and philosophy. Clinical psychology has become divorced from its philosophical roots, in part due to its efforts to attain the status as a science. In this paper we argue for a clinical psychology that can recognise its philosophical roots in responding to contemporary challenges, thereby generating a meta-modern project that can open up new arenas for innovation.

Keywords: philosophy, values, social construction

For good ideas and true innovation, you need human interaction, conflict, argument, debate.

Margaret Heffernan

Introduction

One of the defining features of clinical psychology is its paradigmatic affiliation with science (Witmer, 1996) and its focus on the rigorous training and organisational monitoring of competence. These have held our profession in good stead, ensuring that we are best protected from the risks of charlatanism, accountable to both scientific evidence and professional bodies. Formulation also remains a defining characteristic. Evidence and accountability protect us as a field, formulation provides scope for our knowledge to be tailored to the needs of the individual; these together being the heart of evidence-based practice (Norcross, 2011; Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). This has helped guard us against the reductionism of diagnosis and supported the sophisticated integration of therapeutic modalities.
Despite these strengths, clinical psychology frequently risks being a conservative field, maintaining itself strictly within the bounds of positivism and post-positivism. Positivism, described in its most basic form, asserts that we must be guided by scientific knowledge, and that it is possible to make truth claims based on science. The aim of research is to look for general laws about human functioning through observation and measurement. Post-positivism, acknowledges the existence of objective realities, but accepts that we may only be able to see them imperfectly or probabilistically and that researchers inevitably influence phenomena that they are engaged in researching. Social constructionism, on the other hand, also acknowledges that objective reality exists, however argues that how humans access reality is through the language forms or discourses available to them within a social and cultural context. Central to this turn, is the position that there exists “no ‘versionless’ reality” (Wetherell & Potter, 1992, p. 62) and that human social realities are given meaning and constructed through language (Parker, 1992). Therefore any given reality or action may be multiply understood and philosopher Michel Foucault (1980) has highlighted that this privileging of certain versions of reality over others is an act of power.

Our profession of clinical psychology relies on the scientific discourse of objectivity in the construction of mental disorders and endorses particular therapies as valid, regardless of their external validity when implemented more broadly within the community. This confers power to those who (even inadvertently) use scientific discourse to speak about the true nature of the reality of the human condition in a way that is independent of language (Sampson, 1993).

Miles Little, renowned surgeon and ethicist, asserts that communities of practice are ‘discourse communities’, with unwritten rules about what can and can’t be said: “Commitment to a discourse community provides support, but demands a certain degree of conformity, if acceptance by the community is to be assured” (Little, Jordens, & Sayers, 2003, p.76). Many forms of knowledge remain marginalised in our field including interpretative qualitative research that privileges the voice and understandings of the experiencing person, narratives about therapists’ lives, reflective practice and, for the purposes of this paper, philosophical inquiry. The issue for clinical psychology is it privileges a certain form of philosophical enquiry restricted to positivist and post-positivist discourse. These discourses need not challenge our scientific integrity, but expand our capacity to humanise and heal.

**Looking Back: Physicians of the Soul**

Clinical psychology is both a science and an applied philosophy. The most prominent treatment modality, cognitive behaviour therapy (CBT), draws on the Greek and Roman Stoic tradition
Here, in the works of Marcus Aurelius, Epictetus, Cicero and others, lie the fundamental precepts of this treatment; “If thou are pained by any external thing it is not the thing that disturbs thee, but thine own judgment about it. And it is in thine power to wipe out that judgement” (Marcus Aurelius). The novelty of a cognitive-behavioural approach, according to Ellis is “the application of viewpoints to psychotherapy that were first propounded in radically different contexts” (Ellis, 1962, p.35).

The ‘third wave’ of CBT has also been influenced by the philosophical canon. Dialectical behaviour therapy (DBT) takes its name from Hegel’s dialectic, the concept of resolving ambivalence through the synthesis of opposing positions (Mueller, 1958), although it does not serve as a rigorous application of Hegel’s project. The synthesis in DBT is between the change-orientation of CBT and acceptance-orientation of Zen Buddhism. Acceptance and commitment therapy (ACT) is also based on Zen, but also draws on pragmatic contextualism, rooted in the work of Dewey and James (Baer, Wolf, & Risley, 1968). The idea informing pragmatic contextualism is that events cannot be separated out from the whole person or historical and situational contexts in which they exist. They aim to moderate the mechanistic metaphor of CBT (Arch & Craske, 2008), but of course, the evidence is still out.

Clinical psychology draws on philosophy to develop innovative treatment modalities, but reifying evidence-based practices as the only way to intervene therapeutically across diverse contexts can disembody them from their historical sources and socio-cultural contexts. Is anything lost in the process? Would philosophical literacy enhance efficacy? Are we doing ourselves a disservice? Our hypothesis is that philosophical literacy can ground a training therapist in the value-system associated with the model, deepening their understanding of the processes involved and raise pedagogy above the realm of competency-based learning. Philosophical literacy implies that psychologists are more familiar with the history of philosophical thought, at least in relation to those thinkers that have had a direct influence on our practices. However, it also implies that we engage more assertively in dialogue about ideas, both at an existential and sociological level.

Looking Forward? Critique

Coming out, as a science, but also as an applied philosophy, allows for a range of new conversations and practices. Ethics, for example, are both codified obligations and one of the central streams of philosophical thought. Our ethics codes focus on issues such as consent, competence, and boundaries. They fail, however, to recognise the ethics involved in our role as makers of meaning and the fact that we may be imposing our values and beliefs onto others. One of the dangers lies in determinism. Do we see our clinical approaches as useful lenses through which we access reality or as
representations of what is actually out there? If we are ‘married to our models’ (Cecchin, Lane & Ray, 1992) there is a danger that we might also colonise the cultures of our clients, resolving their symptoms but still damaging their own meaning systems, for example through the pathologisation of their suffering? How do we pay respect to our clients’ values and beliefs? How do we access and prioritise their own hidden and potentially liberating voices? How do we tailor our therapeutic approaches in ways that prioritise our clients’ values and voices rather than applying recipe book approaches that assume one size fits all and may be potentially dangerous (Sackett et al., 1996)?

One of the difficulties we have had in responding to these issues has been the schism between critical psychologists and clinical psychologists. Psychologists like Parker (1999) and Gergen (1985) question our supposed industrialisation, focus on pathology and reification of psychiatric diagnosis. They see us as part of the Psy-Complex (Ingelby, 1986), affiliated with psychiatry and ‘Big Pharma’, leaving us beyond redemption. In turn, there is a tendency within the pedagogy and practice of clinical psychology to position critical psychologists as radicals and conspiracy theorists. This polarisation leaves clinical psychology cut off again, not just from its philosophical roots, but from considering how different philosophical traditions can inform and potentially transform its practice and role in contemporary society. Any contemporary philosophical inquiry must consider the problem of our increasingly individualistic and commodified culture. We live in the ‘Century of Self’ (Curtis, 2002), where Thatcher’s neoliberalism has run rampant. We can afford, as clinical psychologists, to ask whether our understanding of human psychological distress as an intrapsychic phenomenon and responding with increasingly branded treatments serve to collude with these developments in society.

Metamodernism and Dialogue between Social Constructionism and Scientific Accountability

If clinical psychology is to engage more with philosophy we need a theory of knowledge that can cater for both values and evidence, for the more significant recognition of philosophical thought alongside the accountability of science. One candidate is Vermeulen and van den Akker’s (2010) metamodernism. They reject both the endless critique of society and the utopian progress of science. “We contend that the contemporary structure of feeling evokes a continuous oscillation between (i.e. meta-) seemingly modern strategies and ostensibly postmodern tactics, as well as a series of practices and sensibilities ultimately beyond (i.e. meta-) these worn out categories” (2010, paragraph 10). In other words, we need to leave room for a deeper engagement between both worldviews, in the hope of creating something new.

Seikkula’s (2002) innovative approach to early psychosis is an example of a meta-modern project in clinical psychology. Known as ‘open dialogue’, or network therapy, this intervention is
inspired by social constructionist practices in family therapy (Anderson & Goolishian, 1992), but has been put to the test using randomised control trials (Seikkula, et al., 2006). Reading the work of Seikkula and his colleagues can be disconcerting if you are used to traditional scientific papers. The preamble to randomised control trials includes references to the influence of philosophers such as Bakhtin and Lacan (Seikkula et al., 2006). Proponents both reject the hegemony of the medical model and the pathologising effects of diagnosis, while embracing the need for evidence-based practice. Open Dialogue responds to acute episodes of psychosis by developing a community of care around the young person in the home environment as an alternative to hospitalisation. Therapists bring together medical practitioners, parents, neighbours, friends, case managers and others in large community meetings to listen to the young person and each other as equal players in dialogue. Importantly, the voices of the young person are considered part of the polyphony, to be understood and interpreted as ‘pre-narrative’ contributors. The use of medication is minimised and diagnoses are only considered valid when actual symptoms are manifest. Two year outcomes include 75% of the sample showing no signs of psychosis and 80% returning to employment.

What Can We Do To Learn More About Philosophy?

Reading and discussing philosophy can be challenging for practitioners trained in the sciences. This has certainly been the case for ourselves (the authors) who have struggled with the complexity and sometimes arcane language that characterises the field. This has been one of the motivations for starting the Australian Clinical Psychology Association Philosophy Special Interest Group, with the aim of encouraging each other to take on challenging reading and dialogue together. A good place to start, however, can be to read some of the work of colleagues who have written about the impact that philosophical engagement can have on practice. Hall (2011), for example, has discussed how Kubler-Ross’ universal stages of grief can serve as a social construction which diminishes the diversity of responses that we find in clinical practice. Breen and Darlaston-Jones (2010) have written a wide ranging critique of the positivist hegemony in Australian psychology, calling for greater methodological diversity in our research endeavours.

Conclusion

As clinical psychologists we have inherited a long history of drawing on a wide range of inspirations, incorporating philosophical thought into our practices and putting them to the test. Our hope is that this introductory essay will remind us of our status, both as science and a form of applied philosophy, allowing for our continued engagement with a diversity of ideas.
References


