Teaching about the Individual and Society links on the Manchester Clinical Psychology Training Course

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In this article the authors want to discuss their experience of teaching about links between 'individual' and 'society' to clinical psychology trainees. The teaching has objectives of increasing knowledge about the influence of social inequalities on psychological disorder; understanding the relationship between individuals and their social context and considering the conceptual nature of this distinction; reflecting on existing clinical practice and considering alternatives; and considering clinical practice with marginalized people

The historical context

Clinical Psychology, like psychology more broadly, is often a site of tension between the recognition that people are above all social beings, and a set of concepts and methods that often seem to deny this, operating on individuals in isolation from the contexts that create and influence them. Within clinical psychology this tension is reflected, for example, in disagreement about the importance that should be attributed to social and economic causes of distress, and the appropriate methods for alleviating it. Psychology in general has often put social and economic factors beyond its disciplinary boundary, preferring instead to look to intra-psychic explanations (Danziger, 1994; Smail, 1993). A minority has always worked in other ways (e.g. Jahoda, 1936).

It might appear paradoxical that clinical psychology has so often ignored a societal perspective, given its location in and dependence on a socialized health and welfare system. However, the National Health Service, like the welfare state has always been a contradictory institution, concerned more with treating individual pathologies than creating and nurturing a healthy population. The last (Conservative) government promoted individual responsibilities for all aspects of health and ill-health, even hiding research that revealed the link between social and economic inequality and inequalities in health (e.g. The Black Report, Townsend et al 1988). For the first time in 20 years there is a Government that explicitly links health with poverty and other social and socio-economic factors, whatever may be thought about its practice.

Clinical Psychology training.

The authors both trained some 20 years ago. Then, there was little if any content that linked individual and societal factors, despite a context that included among other things the "crisis in social psychology" (Armistead, 1974), the then recent exposure of fraudulent research on heredity and IQ (Kamin, 1974), the beginnings of a critical psychology (Ingleby, 1970; Adlam et al.1977), and the emergence of the user/survivors movements. An exception may have been work with people who were learning disabled,

where even prior to the influence of normalization/ social role theory (see Gathercole, 2000) some elements of practice involved an explicit identification of extra-individual factors.

By November 1995, however, the British Psychological Society body that specifies the content and method of training in clinical psychology had caught up! Clinical Psychology training courses are governed by the Committee on Training in Clinical Psychology (CTCP), which is responsible to the Membership and Qualifications Board of the BPS. The CTCP issues Criteria for the Accreditation of Post Graduate Courses in Clinical Psychology, statements that specify the content and method of training. The most recent revision of these was in December 1995. One of the changes was the introduction of a new section 8.12 which stated,

> *Courses should ensure that the issues of gender, class, race and culture and the influences of society on the individual and their relevance to clinical practice are integrated into all aspects of teaching.*

Moreover, the introduction to the document stated that courses

> *.should enable trainees to understand the social, political and organisational context in which psychologists work and the effect that this has on service delivery.*

The clear indication is that training courses should include teaching on issues, which locate individuals in a societal context. It is unclear to what extent this happens. The authors` *impression* is that there is a widely varying picture across training courses and that in attending to section 8.12 there may be more emphasis on gender than on the other factors. This may be an accurate reflection of current academic research concerns and (without us wanting to minimise the importance of gender as a basis for social inequality), an implicit denial of the importance of class.

The content of the teaching in Manchester.

The introduction of a module of teaching that aimed to explicitly cover some of the issues identified at the beginning of this paper came about through a conjunction of interested parties, and a course that was willing to make changes in order to increase the breadth and quality of its training. The Course had existing teaching on race and cultural issues, as well as gender (amounting to 25 hours over 3 years), and care was taken to minimise overlap between these different modules.

The module was first taught to the first year of the 1997 intake and has now been completed, having been introduced to successive intakes.

The course content reflects the authors' interests in social and critical theory, its relation to psychology, and to a practical and action orientation. Concepts tend to be critical realist (there is a social reality, but experiencing and knowing it are socially constructed) rather than postmodernist, and social psychological rather than psychodynamic. Different teachers might handle the course differently.

The module consists of 8 hours of teaching across the 3 years of training and is composed of the following sessions:

Examples of references are included. More extensive lists of references for these sessions are available from the authors.

(1) Year 1, Term 1 (2 hours) *Social Inequalities and their links with Health and Mental Health*

Teaching focuses on importance of social inequalities in any serious consideration of health and mental health. Questions are asked concerning whether such links remain "hidden" and if so why. The role these factors play in assessment and formulation within clinical psychology models is reflected on. A model of psycho-social stress is examined.

Key references include: Brown and Harris (1978), Hutchings (1993), Smail (1993), Townsend, et al. (1988), and Wilkinson (1996).

(2) Year 1, Term 2 *Conceptualising the individual and society*. (2 hours

This draws on social theory especially Bhaskar (1979), and on Leonard's (1984) attempt to build a theory of the societal construction of the individual. The unit follows the adult mental health placement, and Leonard's approach is used to attempt a "societal case formulation" that considers the person as constructed through their social relations, past and present. Other texts include Burton and Kagan (1994), Danziger, (1994), Luria (1976) and Williams (1976).

(3) Year 2, Term 4 *An alternative*: *Community Psychology: what it is and what it isn't* (2 hours)

Community psychology (e.g. Sarason, 1974) that takes the community rather than the individual as its unit of analysis, is presented as a counter to individualistic models of psychological thinking and practice. Descriptions and developments in the field are presented, together with British and overseas examples of theory and practice (Holland, 1992; Orford, 1992, 1998; Rappaport, 1977; Smail, 1994; Thomas and Veno, 1992; Prilleltensky and Nelson, 1997).

(4) Year 3, Term 8 *Working with marginalised people*. (3 hours)

This session draws on the experience of social marginalisation, and how it can be understood both in terms of social determinants and psychological responses. Work by Freire (e.g. 1974) and liberation psychologists (e.g. Martín-Baró, 1994) is used as a framework.

How has the teaching been received?

All teaching for the Manchester Course is reviewed in two ways. First, each trainee is requested to complete a feedback form on every teaching session. These forms, currently under review, are sent to the relevant teaching module organiser who gives feedback to the teacher concerned. Second, there is a review meeting at the end of each term where all trainees in a particular year discuss the term's teaching with the Curriculum Co-ordinator and the Programme Director.

The feedback about this teaching has been variable.

Leaving aside inevitable criticisms of a new course under development, we have been struck by an apparent contradiction. Students have welcomed the existence of input on the real social issues such as poverty, powerlessness, or discrimination that they see in the lives of those they meet in practical work. Yet they often seem to want short cuts*; "what techniques should we use with marginalized people?"* For students studying at a doctoral level we find this surprising, as we find the question*" will we get examined on these references?"*! Our view is that issues such as social marginalisation have to be understood, both theoretically and through lived experience where those who are marginalised are also teachers. Interventions have to be generated through application of the craft of psychology with this understanding, in active interaction. That is not so different from some models of so-called clinical practice, yet the confidence to work in this way may be lacking.

Other problems are that *" The teaching is not psychological enough".* Here we are confronted with a dominant definition of what psychology is, a definition that is highly individualistic. Students who have striven hard to be accepted and socialised as clinical psychologists may be reluctant to break out of the boundaries and roles that they have adopted.

"The teaching is too conceptual". This was a problem with session 2 in particular, and to some extent has been met through the "societal case formulation" exercise. Time is a problem, where theoretical concepts (e.g. ideological *interpellation* (Therborn, 1978; Leonard, 1984) have to be introduced that may not be familiar. Sometimes the gaps are more surprising, for example a lack of familiarity with concepts of action research. This can mean students have few familiar landmarks when they encounter our teaching.

Nevertheless, the sessions do seem to address a need. As we develop the teaching we are getting better at engaging with students' experience of social issues, and offering some tools for understanding and acting on this neglected dimension.

From our perspective these comments have been very important. While recognising that attention needs to be paid to teaching style etc., we think that other issues may underlie some of the problematic reception of this teaching.

(1) The content may not fit with some trainees experience / identity.

(2) There may be a lack of fit with placement experience.

(3) Are the links to practice made explicit?

(4) Is there a tension within the doctoral qualification between on the one hand, gaining knowledge and practical skills and on the other, developing reflective abilities and thinking in different ways

How effective has the teaching been? This is difficult to answer. It may be even more difficult to assess directly in the short term and evidence of a broad approach to conceptualisation of human distress and resulting actions may not be visible until later as individuals develop their own theoretical and therapeutic practice.

The Manchester course requires trainees to submit 5 written reports describing clinical activity. One of the 10 assessment criteria for these is the

presence and integration into the report of social context. It is hoped that the teaching aids in the development of a social analysis of psychological distress described and helps trainees to report their activity in a way that meets this particular criterion.

Discussion

We would welcome a discussion about any of the points contained in this article. The teaching described here is one possibility; we recognise there are others. In particular we note that although exercises, the use of case material, explorations and dialogue are employed, much of the teaching described is *didactic* in mode, and that other methods are likely to be better.

It is immediately obvious that the teaching of these issues as a separate module may act against the *integration* of the content into the teaching content as a whole. This issue may also be relevant to the more extensive teaching on the Course about *`Race`, Culture and Gender* issues, although in this case explicit attempts have been made to develop teaching throughout the Course that includes consideration of these issues to complement the specific teaching. One consideration could be to integrate more that module with the one discussed in this paper.

Moreover, we would welcome discussion about the nature of this project of introducing societal thinking into clinical psychology training, theory, and practice: is it possible to do this, or is the discipline so irrevocably rooted in an individualistic ideology that this is a waste of time?

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