PSYCHOLOGISATION AND THE CONSTRUCTION OF THE POLITICAL SUBJECT AS VULNERABLE OBJECT

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Abstract

In this paper I wish to highlight some of the factors that have influenced the widespread adoption of a therapeutic sensibility within wider society, one marked by an increased sense of societal anxiety, vulnerability and estrangement from each other, traditional forms of authority and political institutions. One outcome of the myriad complex dynamics affecting contemporary subjectivity is that therapeutic categorisations and ways of thinking are no longer confined to the clinic or formal therapeutic encounter between analyst and analysand but have permeated popular culture, most notably in Western societies. I wish to consider the wider socio-political context that has influenced the widespread acceptance and adoption of a therapeutic consciousness focusing on the convergence of Left and Right political traditions around apocalyptic thinking, the institutionalisation of the concept of vulnerability and the move from macro to micropolitics. Some implications for individuals, society and politics are then highlighted. My main focus is on the United Kingdom, although I do make reference to developments in the United States of America (USA) as there has been a significant degree of mutual influence between both nations.

Introduction

The expansion of psychiatric and psychological theories and disciplinary techniques has been well documented and criticised from both within the disciplines (e.g. Szasz, 1961; Thomas, 1997; Parker et al. 1995), and also from many observers outwith the psy-disciplines (e.g. Reiff, 1966; Nolan, 1998; Furedi, 2004). Indeed, the influence of the psy-complex can be traced back to the late nineteenth and early twentieth centuries, with competing theories and critiques offered as to both the positive and negative consequences of such a way of understanding both the individual and collective psyche.

However, despite the often bitter disagreements between psychiatrists and psychologists it needs to be borne in mind that there is also considerable overlap between them. Many psychiatrists, whilst seeing 'mental illness' as primarily medical in nature will also acknowledge the importance of psychology and the environment, with the biopsychosocial model arguably the most common form of intervention today. Psychologists likewise will adhere to the medical model at times, not in a crude biological way but in the tendency towards diagnosis and prognosis. In this sense terms such as the medicalisation or psychologisation of life both imply a process whereby there is a tendency to categorise behaviour and intervene in evermore areas of people's lives. This colonisation of the life-world by psy experts is not the end of the psychologising process as it extends into our very subjectivity and hence how we perceive ourselves, others and the cause and solution for both individual and social problems.

The tendency to pathologise a range of 'problem' behaviours and to use broad indicators to allow more people to fall within such classifications is not a particularly novel development. The 'Child Guidance' movement, formed in Britain after the First World War to work with 'maladapted' children included such characteristics as 'shyness' and 'reserve' as aspects of maladaptation. In addition, it was held that vigilance was also required over ostensibly healthy children as they were considered as potentially being susceptible to mental illness. Other disciplines, such as social work, also embraced elements of psychological approaches, especially in relation to child development and psychiatric social work. Whilst the exact influence of psychoanalytic and other psychological theories within social work practice is disputed (Bree, 1970), they had enough influence for some to question whether such employees were primarily social workers or therapists (Irvine, 1978), and others to argue that social workers were being trained in a manner that precluded any political understanding of their work (Jordan and Parton, 1983).

Despite such criticism the 1980s and 1990s saw a continual expansion of therapeutic initiatives within the broader UK culture such that by the early 1990s counselling was firmly established in general medical practice (Pringle and Laverty, 1993) with half of surgeries employing one by the end of the decade (Eatock, 2000). The Mental Health

Foundation (MHF) published a report claiming that 20% of the UK's children were suffering from a mental health problem (MHF, 1999). Such a figure was an underestimate according to one psychiatrist giving evidence to a Parliamentary Committee who suggested that the true figure was around 40% (Marin, 1996). Neither were such problems confined to children, one media-friendly psychologist being of the opinion that one third of Britain's adult population exhibits signs of psychiatric morbidity (James, 1997).

However, the psychologisation process was not confined to the clinic, surgery or campaign group literature but began to filter through the mainstream media and popular discourse. For example, Furedi (2004) cites research on UK newspapers that charted the rise in usage of such terms as: self-esteem (no citations in 1980, three in 1986, 103 in 1990 to 3,328 in 2000); trauma (from under 500 citations in 1994 to over 5,000 in 2000); stress (from under 500 in 1993 to just under 24,000 in 2000); syndrome (from under 500 in 1993 to over 6,500 in 2000) and counselling (from under 500 in 1993 to over 7,000 in 2000).

This is a quite remarkable expansion in such a short period of time and provides compelling evidence that the language of therapy has now permeated broader culture. It is not that the problems facing us have changed significantly; people still live in poverty, suffer relationship problems and/or breakdown, worry over exam results, lose their jobs, have conflict in the workplace, suffer bereavements and existential angst. However, how we articulate these problems and how they are presented to us in contemporary discourse would appear to have undergone a remarkable transformation in the latter decades of the twentieth century.

Into the twenty-first century and the situation does not appear to have improved. In the US a psychiatrist claims that one in ten nursery children are mentally ill (McLaughlin, 2005), whilst in the UK mental health charities such as MIND routinely inform us that 25% of us are suffering or will suffer from a mental health problem. Therapeutic techniques are now firmly embedded in the education curriculum whether at nursery, primary or high school and are also evident within the university system (Ecclestone and Hayes, 2009).

So, when claims are made that contemporary culture is dominated by psychologisation, in which social and existential problems are increasingly viewed through a therapeutic prism, it could be argued that we are merely witnessing the continuation of a trend that was evident to some observers during the early twentieth century and to many during the latter decades of that millenium. It is certainly the case that there is no clean break between the past and the present, no precise date or event that in and of itself marks contemporary psychologisation from its earlier versions. Nevertheless, we can delineate some changes which in interaction with other dynamics mark the present period from the past.

In the remainder of the paper I consider some explanations for this therapeutic turn, examine the overlap of those from both ends of the left/right political divide, look at the way

the term 'vulnerability' has become institutionalised in law and also at the way Politics (with a capital P) has been replaced by a therapeutic politics (with a small p).

Big Pharma and the Psychology Industry

There have been various attempts to explain the therapeutic turn in contemporary society. For example, Dineen (1999) likens what she terms the 'psychology industry' to any other industry in a capitalist market economy. In order to survive it must expand and open up new markets. In this process new problems and 'disorders' are created that necessitate the intervention of the therapeutic professional. So contrary to what we are led to believe it is not the demand for therapy that creates the supply of therapists but the opposite process; the supply of therapists creates the demand for therapy. This is a similar argument to that used by those who implicate the pharmaceutical industry for the rise in prescription medication. Rather than psychiatric medication being developed to treat an existing illness, in many cases the development of the pill precedes the identification of that which it is then said to treat and/or cure; the use of SSRI's (selective serotonin reuptake inhibitors) for 'social anxiety disorder' or 'night eating syndrome' and Viagra for 'sexual dysfunction' being some recent examples of where the pill existed long before the discovery of the 'illness' for which it is now prescribed (Lane, 2007; Goldacre, 2009).

In similar vein there are many who blame psychiatric professionals for the exponential expansion of clinical diagnostic criteria. For example, between the first and fourth editions of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual(DSM)*, published in 1952 and 1994 respectively, the number of pages grew from 130 to 886 and the number of diagnostic categories more than tripled. This led some sceptics to suggest, tongue only slightly in cheek, that at such a rate of growth we can reasonably expect the fifth edition to contain some 1,256 pages and 1,800 diagnostic criteria (Blashfield and Fuller, 1996). With the fifth edition due to be published in 2012 we will have to wait before finding out the exact contents. However, early evidence suggests that the trend to categorise evermore behaviours within its pages will continue, with reports suggesting tortured discussions amongst those preparing *DSM-V* as to whether such things as overuse of the internet, 'excessive' sexual activity, compulsive shopping and apathy should be contained within the parameters of clinically diagnosable mental disorder in the next edition of the manual (Lane, 2009). And whilst there has been some debate in wider society about the validity and/or expansion of the concept of post-traumatic stress disorder

(PTSD), with a recent BBC *Panorama*[1] programme detailing the expansion of the concept from extreme experiences (for example, war situations) to the more mundane (for example, minor traffic accidents, work stress). At the end of that edition of *Panorama*, presenter Jeremy Vine said the APA was looking at tightening up the diagnostic criteria for PTSD in *DSM-V*. Time will tell if he is correct, but he is obviously unaware of post-traumatic embitterment disorder (PTED), an illness said to afflict those who remain bitter or aggrieved for too long about a past wrong, and which some psychiatric professionals wish to be included in the new manual (Linden, 2003). One can only imagine what would have happened if this diagnosis was around during the year long British miners' strike of 1984-85.

A more materialist analysis is given by Cloud (1998), who claims the rise of the therapeutic to be 'a political strategy of contemporary capitalism, by which dissent is contained within a discourse of individual or family responsibility' (p.xiii), although she also accused some Marxist and feminist thinkers and activists of colluding in this process by advocating a 'politics of self-expression', a 'revolution from within'.

The insights afforded us by a critical analysis of the role of 'Big Pharma', the psychology industry and the workings of those responsible for compiling the 'official' list of 'mental disorders' can be extremely helpful. However, there is a tendency to reify such players, attributing to them omniscient powers with which they beguile a passive populace. Neither individual psychologists, biomedical pill pushers nor an all powerful psychology or pharmaceutical industry can account for the above trends. They are certainly influential players, but people are not mere objects into which professional explanations and treatments can simply be poured.

It was this to which Szasz was referring when he argues that the classification of people into diagnostic categories requires three different types of persons: the classifier (doctor/therapist), classified (patient) and, importantly, 'a public called upon to accept or reject a particular classification' (Szasz, 1991, p.53). At various times we play all three roles; we classify people, we are classified and we are members of a society in which some classifications are viewed more positively than others. However, as Szasz points out we can accept or reject this process. The issue then is if such explanations are more accepted today than in the past then what is it about contemporary society that has allowed such ideas to gain such a strong foothold in society? These are the questions addressed in detail by Nolan (1998) in the USA and Furedi (2004) in the UK, both of whom argue, *inter alia*, that we are witnessing a redrawing of the relationship between the state and the individual,

[1] *Panorama* is a current affairs television programme broadcast in the United Kingdom by the British Broadcasting Corporation (BBC).

particularly as old sources of moral authority are increasingly seen as discredited or irrelevant to present day circumstances.

In addition, heightened anxiety in society at the loss of older sources of authority, particularly when new ones have yet to appear and/or gain widespread acceptance, can leave people more susceptible to individualistic, psychological interpretations of life's problems. To expand on this further I wish to look at the influence of some political developments in the cultivation of the psychologically vulnerable subject.

Left and Right; Unite and Fright

Growing up in Scotland during the 1970s it was not uncommon during any visit to a city or town to see men wearing boards and carrying placards proclaiming 'The End Is Nigh'. Considered rather eccentric at the time and people to be avoided, they would not be out of place in many contemporary political movements. Today, society is no longer primarily concerned with attaining something 'good' but with preventing the worst. This anticipation of something going wrong at a later date is what Beck (1992) calls the 'Not-Yet-Event as stimulus for action' (p.34) or what Sontag (1989) termed 'Apocalypse from now on'. The individual in such a society is viewed as more object than subject, increasingly powerless in the face of omniscient and omnipresent malevolent forces. This symptom of cultural and indeed political malaise in Western society was highlighted by Sontag (1989) in relation to the panic about AIDS in the late 1980s but which also has relevance to today's myriad scares. She perceptively noted 'the striking readiness of so many to envisage the most far-reaching of catastrophe' (p.4).

If the population is more anxious and susceptible to therapeutic explanations for the problems of life today then another factor to consider is the extent to which the politics of fear have played in the creation of such a situation. Indeed, it is remarkable how many opposing political traditions and social groupings share a common tactic of propagating fear and anxiety in the population. The neo-cons in London and Washington highlight the danger of fundamentalist terror and 'rogue' states, the remnants of the left and new environmentalist groups highlight the danger of such things as climate change, global warming and genetically modified crops. According to Clare Short, former cabinet minister in the Labour government and current MP, 'Very soon, human civilisation will collapse and human life become unliveable' (Short, 2009, p.65). Whilst few would consider Short on the radical wing of progressive politics, her claim resonates with the wider proclamations from those who do claim the radical mantle. Campaign groups of various hues warn us *inter alia* of the dangers of climate change, genetically modified food, embryo experiments, domestic violence, child abuse, predatory paedophiles, bird flu, swine flu, bullying,

AIDS and other sexually transmitted diseases, and numerous other threats to our well being from the food we eat, our sedentary or hectic lifestyles, to name but a few. Trade unions frequently warn us of the threats we face from 'bullying' or 'stress inducing' managers and colleagues. A walk around any university campus in the UK will find an array of posters warning students of the potential dangers facing them on and off campus. University life, once a time of engagement with ideas, of intellectual stimulation, the first step towards adult independence away from the parental gaze, of making mistakes but learning from them, could now be reasonably perceived by students as a place where if not their life, then certainly their health was at serious risk.

For these campaigners we are all assumed to be vulnerable due to our powerlessness and/or lack of awareness of the dangers we face. The expansion of the concept of vulnerability has been well documented (e.g. Furedi, 2004; Ecclestone and Hayes, 2009; McLaughlin, 2008) and can be further illustrated by looking at the way it has become institutionalised within social policy. In the process, evermore people have become officially vulnerable and in need of protection.

A preoccupation with psychological vulnerability is not the only area where there is convergence between erstwhile political opponents. The tendency to use psychological terminology is not confined to those of a conservative nature seeking simple explanations for the complexity of human subjectivity. On the contrary to criticise the therapeutic turn can lead to accusations of being a right winger unsympathetic to the psychological suffering of the distressed. Also, those who consider themselves left wing are not averse to using the language of psychology against their opponents; terms such as 'homophobia' and 'Islamophobia' are often used to describe those who harbour a dislike or prejudice towards homosexuals or those who follow the Islamic religion. The implication is that such an attitude is 'irrational' which can overlook the historical, ideological, political and social factors in which such attitudes developed. Indeed the tendency to portray your political opponents as mentally ill is not new. It is well known, and been roundly condemned, that the former Soviet Union classified opponents as suffering from mental disorder. In effect, dissent was pathologised; failure to follow the political orthodoxy ran the risk of psychiatric diagnosis and incarceration. However, such a move is not confined to erstwhile Stalinists. In similar vein, some environmental campaigners seek to label their opponents as mentally irrational, suggesting that climate change deniers or sceptics are suffering from a psychological illness. For example, in March 2009 the University of the West of England at Bristol held a conference on the psychology of climate change denial. The news release advertising the conference opens with the axiomatic statement: 'Man-made climate change poses an unprecedented threat to the global ecosystem', and that the conference will consider the possibility that those not subscribing to this view are suffering from an 'addiction to consumption' (UWE, 2009, online).

The reification of the vulnerable adult[2]

The past fifteen years has seen a remarkable expansion in the number of people, children and adults, who are now officially classed as vulnerable. According to the *Every Child Matters* (DCSF, 2003) policy document there are approximately eleven million children living in England, between 3-4 million of whom are considered to be 'vulnerable', although the term is not defined. I wrote to the Department of Children Schools and Families (DCSF) to ask how they had defined 'vulnerable' and on what basis they could make such a claim, and was informed in reply that they had used 'a broad definition of vulnerability including vulnerability through living below the official poverty line' (personal communication 31/3/09). At a stroke a significant proportion of the nation's children were now officially vulnerable. However, it is in relation to the perception of adults that the construction of vulnerability and its expansion is most instructive and can be illustrated by detailing the changes in legal definitions of what constitutes someone as a 'vulnerable adult'.

In 1995, the Law Commission proposed the following definition:

> … a "vulnerable person at risk" should mean any person of 16 or over who (1) is or may be in need of community care services by reason of mental or other disability, age or illness *and who* (2) is or may be unable to take care of himself or herself, or unable to protect himself or herself against *significant harm* or *serious exploitation*. (Law Commission, 1995, my emphasis)

It is clear from this definition that vulnerability to risk is not automatically assumed to flow from the specific categories mentioned. In addition, even being at risk of harm or exploitation is not sufficient for the label of vulnerable to be applied; the harm must be significant, the exploitation serious. No doubt such a high threshold was used to withhold services from people who needed it, but it also reflected a view that to be vulnerable was not considered the norm. This definition was adapted by the Lord Chancellor's Department in 1997 with 'vulnerable person' being replaced by 'vulnerable adult', and the word 'serious' was dropped to have a similar threshold for harm and exploitation, both being required to be 'significant'. This definition was adopted by most local authorities.

A mere three years later, the policy guidance document *No Secrets* (DH, 2000), whilst keeping the 1997 definition elaborated on what constituted 'community care services' 'to include all care services in any setting or context' (para.2.4). However, the same year the

[2] This section is developed from material discussed in my article 'Control and Social Work: A reflection on some twenty-first century developments', *Practice*, vol.22, no.3, pp.143-154, 2010.

Care Standards Act 2000 expanded the definition to a quite considerable extent. A 'vulnerable adult' was now:

> (a) an adult to whom accommodation and nursing or personal care are provided in a care home;
> (b) an adult to whom personal care is provided in their own home under arrangements made by a domiciliary care agency; or
> (c) an adult to whom prescribed services are provided by an independent hospital, independent clinic, independent medical agency or National Health Service body.
> (Care Standards Act, 2000, part VII, 6)

Gone is the need to belong to a specific category of service user, as is the need to be at risk of any form of harm or exploitation, never mind of a significant degree. Simply to use one such service now automatically classifies you as a vulnerable adult. Whilst such a move was likely made with the best of intentions there is a sense that not only do they view such adults as lacking resilience they also view those charged with caring for them as a source of risk.

The trend to further expand the categories of the vulnerable continued, culminating in the Safeguarding Vulnerable Groups Act 2006 (section 59, subsection 1), which views a person to be a vulnerable adult if they have attained the age of 18 and he or she:

> (a) is in residential accommodation
> (b) is in sheltered housing
> (c) receives domiciliary care
> (d) receives any form of health care
> (e) is detained in lawful custody
> (f) is by virtue of an order of a court under supervision by a person exercising functions for the purposes of Part 1 of the Criminal Justice and Court Services Act 2000 (c.43)
> (g) receives a welfare service of a prescribed description
> (h) receives any service or participates in any activity provided specifically for persons who fall within subsection (9)
> (i) payments are made to him (or to another on his behalf) in pursuance of arrangements under section 57 of the Health and Social Care Act 2001 (c.15), or
> (j) requires assistance in the conduct of his affairs (s.59(1))

This is quite a remarkable expansion, especially when you consider that health care means receiving 'treatment, therapy or palliative care of *any* description' (s.59(5), my emphasis), whilst any provision of assistance by virtue of age, health or any disability also renders the recipient amongst the ranks of the vulnerable (s.59 (5)). As many disabled people require some form of assistance, to varying degrees and lengths of time, this legislation effectively equates disability with vulnerability. It is also worth noting the equating of being in

'lawful custody' with being a vulnerable adult, which amounts to a sort of therapeutic exposition of criminology. In addition, included under the category 'in lawful custody' is any;

> detained person (within the meaning of Part 8 of the Immigration and Asylum Act 1999 (c.33)) who is detained in a removal centre or short term holding facility (within the meaning of that Part) or in pursuance of escort arrangements made under section 156 of that Act. (s.59, s.7, d).

The terrain of the immigration debate has, in many respects, coalesced around vulnerability; the extent to which the asylum seeker has suffered physical or psychological harm having great bearing on whether their application to remain in the UK is successful or not. Whatever the outcome, the border authorities are presented as protectors of the vulnerable asylum seeker; either allowing them to stay in view of their trauma, or taking care of them during the removal process.

From Politics to politics

The changing debate around immigration is instructive in how Political issues (with a capital P) have been downgraded and replaced by a psychological approach, dominated by the micropolitical (politics with a small p). Those who wish to be granted rights of residence are obliged to adopt the role of traumatised victim. This presentation of the damaged self can be a pragmatically chosen identity by those seeking to remain in the country, as they seek to overcome the legalistic hurdles that prevent the free movement of people across national borders. However, as macropolitical issues are downgraded the subject of immigration is increasingly viewed as a non-political issue; the need for heavily restricted national borders becomes almost naturalised and the removal process becomes an instrumental one disconnected from issues of social justice.

This process of the de-politicisation of immigration policy and practice and its repositioning as a psychological issue casts those subject to immigration control and detention as vulnerable victims requiring protection and care whilst awaiting removal from the country. The asylum seeker is here constructed as automatically vulnerable with the border control agencies (who include psychologists and social workers) presented as their benefactors.

For Žižek (2009) the Included v Excluded distinction (in this case 'British citizens' and 'asylum seekers') is the universal political issue of the age, and one which necessitates the political efforts of anyone who considers themselves progressive today. He notes how walls are being built both literally and metaphorically around whole sections of society,

for example gated communities for the rich, slums for the poor. The issue of immigration control clearly separates the included from the excluded, and even those granted permission to stay can find themselves still excluded, viewed as a contaminant which society has to absorb. The process of psychologisation in interaction with wider political change can lead to 'the universal political issue of the age' being reconfigured as one of individual distress.

This insight into the implications of the downgrading of Politics (with a capital P) to a psychological culture that focuses on the micropolitical or interpersonal realm can help explain the cultural currency with which such a discourse has permeated contemporary society. The argument for free movement across national borders is rarely heard today, not least due to the collapse of left wing politics, certainly within the UK. The defeat of working class organisations can also help explain the rise of the sick worker as 'collective action' is increasingly replaced by 'individual inaction' such as going off sick or receiving counselling (Patmore, 2006; Wainwright and Calnan, 2002). Indeed, in terms of the way that macro-political problems are more likely to be recast as micro-psychological issues, and collective solutions to give way to individual solutions the role of the trade union movement in the UK is instructive.

Wainwright and Calnan (2002), in a detailed account of the rise of the phenomenon of 'work stress' regard the defeat of the miners' strike of 1984-85 as a pivotal moment, a defeat which effectively marked the end of the working class as a major collective political force in the UK. They note how the signs, slogans and representations changed during the course of the dispute:

> At the beginning of the dispute the miners were confident of winning: placards and badges made assertive militant demands: 'Coal not Dole', Victory to the miners'. But by the time of their eventual defeat the mood and the slogans had changed: 'Dig deep for the miners', 'Don't let them starve'. Rather than the image of the self-confident, politically conscious rank and file militant, the striking miners had become victims and charity cases (p.140).

This is not to criticise the miners, who throughout the dispute faced the full force of the capitalist state (police brutality; media bias; withholding of benefits etc) with tremendous courage and resistance. However, for many reasons it soon became clear that the prospect of success seemed remote. In the process a once strong and collective body was recast as vulnerable victims in need of individual protection.

In the wake of this defeat there was a refocusing by trade unions on how they articulated workplace conflict, increasingly representing the individual rather than the collective worker, with a focus on issues of health and safety at work. However, this came at a price; the adoption of a therapeutic discourse in which workplace conflict was recast as a health issue, and the rise of the discourse of 'stress' was a key outcome of this. In the process the

individual worker was reduced to a passive object at the mercy of a toxic environment that was hazardous to his or her health, often due to 'bullying' by management or colleagues (McLaughlin, 2008).

The rise of the term bullying, once almost exclusively confined to the school playground is indicative of the psychologisation of the workplace and the vulnerability with which employees are held. 'Workplace bullying' is now seen as a major threat to the health of Britain's workforce. Whether it is peer bullying or bullying by management towards staff, there is a growing consensus that there's a significant problem in the workplace. The Trades Union Council declared 7 November 2007 as 'National Ban Bullying at Work Day'. It also established a 'Commission on Vulnerable Employment' that defined 'workers in vulnerable employment' as those experiencing poverty and injustice resulting from 'an imbalance of power in the employer-worker relationship' (TUC, 2008, p.3). The Universities and College Union (UCU) have distributed posters which are displayed around campus informing us that 'Bullies Are a Workplace Hazard'. Staff common rooms have posters warning that there is 'No Entry For Bullies' (McLaughlin, 2009). No doubt such posters are displayed with the best of intentions. However, by equating problems in the school playground with those in the workplace the trade unions infantilise the workforce and view its vulnerability as axiomatic. Similarly, Nashra Mansuri of the British Association of Social Workers equates adult bullying with child abuse, which explicitly treats all of us as overgrown schoolchildren (McLaughlin, 2009). Indeed, some argue – without a hint of embarrassment – that workplace bullying is 'the second greatest social evil after child abuse' (Field, 1996, p.1).

The employer-worker power imbalance is not a new development. What is relatively recent is the way the workforce is considered weak, at risk and in need of help. Increasingly, as Ecclestone and Hayes (2009) argue, 'The workplace is no longer seen as the battleground between "capital" and "labour": indeed, it is more accurate to say that the class war has become the "couch war" with both sides [employers and trade unions] trying to help employees onto the therapy couch' (p.105). The suggestion of then government minister Norman Tebbitt in 1981 to the unemployed that they get on their bikes and look for work was criticised at the time for individualising a structural problem.[3] Today, it would be more likely to be seen as insensitive due to an assumption that such individuals

[3] Tebbitt actually said, in response to a question asking if the inner city riots of the time were not linked to rising unemployment, 'I grew up in the '30s with an unemployed father. He didn't riot. He got on his bike and looked for work, and he kept looking 'til he found it'. The common interpretation of this was that he was telling the unemployed to get on their bikes also.

could do so unaided by professional expertise. The equivalent injunction to the unemployed today would be to 'get on the couch and be helped to look for work'.[4]

Conclusion

The consequences of the continual expansion of psychologisation are severe, both from an individual and wider political perspective. For the individual he or she can be portrayed as a vulnerable subject in need of expert professional help, creating dependency on an external authority. It can also resign them to coping with rather than transcending their difficulties. The turn to 'experts' can also undermine the more informal resources of support available within communities and lead to a passive relationship to state authorities (Nolan, 1998). It also has consequences for the democratic process. The more we are portrayed as vulnerable, sick and irrational the more the process of democracy is undermined. The concept of democracy rests on the assumption that we, as rational agents, elect and hold parliament to account. If, on the contrary, we are classed as irrational, as suffering from myriad mental disorders that limit our capacity and responsibility, then the basis of democratic accountability is seriously compromised. Instead of 'we, the people' holding the state to account, the state takes on the role of doctor caring for a vulnerable and irrational electorate.

Of course, the idea that Western parliamentary democracy is truly democratic does not stand strong scrutiny. Many would agree with Chomsky's (1999) observation that 'it is only when the threat of popular participation is overcome that democratic forms can be safely contemplated' (p.69). This common view of the more radical Left, that parliamentary democracy pacifies the masses was expressed by Trotsky and has been articulated more recently by Žižek (2009) who points out that in a democracy we are all kings,

> … but a king in a constitutional democracy, a monarch who decides only formally, whose function is merely to sign off on measures proposed by an executive administration. This is why the problem with democratic rituals is homologous to the great problem of constitutional monarchy: how to protect the dignity of the king? How to

[4] It is worth noting that behind such public rhetoric it was actually that Conservative government that introduced the offer of counselling for workers facing redundancy. Widely criticised at the time it is something that is increasingly utilised by both employers and employees.

> maintain the appearance that the king effectively makes decisions when we all know this not to be true? (p.134).

However, at the present time the way the problem of democracy is often articulated is not that it is illusory, but rather that the populace are not rational enough to make the appropriate choices in terms of voting or political and personal action. Those who vote for the right-wing British National Party (BNP) are frequently presented as lacking the intelligence to vote the correct way, being mere dupes of BNP propaganda. In relation to lifestyle an oligarchy of health, therapeutic and scientific 'experts' purport to inform us of the error of our ways, whether in the wrong choice of food, wrong or inappropriate ways of thinking or feeling, or failure to grasp the global consequences of our 'addiction to consumerism'. For example, referring to the latter leading British environmentalist George Monbiot favours government repression via totalitarianism as the answer to the problems of capitalist consumption (Monbiot, 2008). As Heartfield (2009) points out such 'radicalism' is against, not with, the masses, and that 'what Monbiot means by "the problem of capitalism" is not the limits it puts on working-class living standards, but rather the growth in those living standards' (p.46).

The process of psychologisation shows no sign of abating at the present juncture. Therefore, there is certainly a need for a critical challenge from within the disciplines of the psy-complex. Such a critique of the many problematic aspects of contemporary clinical theory and practice can highlight areas of concern without negating those aspects of practice that can be beneficial to those experiencing mental distress and who could benefit from professional intervention. However, that on its own is insufficient, and in many respects secondary to the need to challenge the colonisation of the wider social body by a therapeutic culture. If, as I have argued in this paper, the main driver for the acceptance of the therapeutic ethos lies in wider social and political change, then it is there that the main battle needs to be waged.

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