***The “Trauma-Focused Turn” in Critical Psychology***

***By Laura K Kerr, PhD***

***A Review of:***

[**De-Medicalizing Misery II: Society, Politics and the Mental Health Industry**](http://www.amazon.com/gp/product/1137304650/ref%3Das_li_qf_sp_asin_il_tl?ie=UTF8&camp=1789&creative=9325&creativeASIN=1137304650&linkCode=as2&tag=lakkephtrsla-20&linkId=5QDYJAHUUX7SSLR6)

**Edited by Ewen Speed, Joanna Moncrieff and Mark Rapley**

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Critical psychology is known as much by its subject matter as its positioning on the perimeter of the fields of psychology and psychiatry. Here critical psychology takes a distinctly political stance as it employs methodologies from disciplines such as anthropology, history and sociology to deconstruct the knowledge claims of the “psychological complex,” or *psy-complex* — Nikolas Rose’s often-used phrase for “psychology, psychiatry, and their cognates” that comprise the mental health field (1996: 2). Critical psychologists’ analyses often have the effect of derailing claims to scientific objectivity, especially with regards to diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders* and the biomedical model of mental illness.

Thomas Szasz (1970) was one of the earliest and best-known advocates of this approach and leading voice of the anti-psychiatry movement in the 1960s and 1970s. A psychiatrist by training, Szasz was an ‘insider-outsider’ who chronicled the pseudoscience and ideological commitments that led to shoddy treatments as well as human rights abuses in psychiatry. By being part of the discipline yet positioning himself on the periphery, Szasz avoided digressions into intellectual arguments that can risk losing sight of the reality of human suffering.

Unlike the 1960s and 1970s, today people pursue their own diagnoses and mental health care more often than they are forced into treatment. Furthermore, in the 1960s and 1970s the focus of the anti-psychiatry movement was primarily on human rights abuses during an era when democratic freedoms were a primary concern. Yet today the center point of analyses is frequently how mental health care is influenced by neoliberal ideology, including the push for greater individualism and personal responsibility for one’s mental health. Direct-to-consumer advertising and self-diagnosing through online symptom checklists contribute to expectations that individuals will take responsibility for their own care. Furthermore, such resources rarely acknowledge the social conditions that contribute to misery.

Perhaps as a result, there is increased interest in the types of analyses critical psychology provides, since they contribute to ‘informed’ choice. Critiques of the psy-complex are now mainstream, showing up regularly in major news sources such as the *New York Times, Time Magazine* and *The Atlantic* (for example, see Schultz, 2004). Accounts of lawsuits against pharmaceutical companies and prominent psychiatric researchers are also lead stories. And popular websites such as [*Mad in America*](http://www.madinamerica.com/) are devoted to reproaching the biomedical model of mental illness.

Given that the psy-complex is regularly associated with misinformation, professional agendas, and skyrocketing profits in the pharmaceutical industry, critical psychology’s deconstruction of knowledge claims may well have become as central to the process of knowledge construction as controlled trials of psychotropic drugs.

Critical psychology, then, rather than oppositional ‘Other’, increasingly plays a more integral role. More than providing marginalized analyses of the field, critical psychology now also informs choice, identifying best practices along with revealing the emperor has no clothes.

In their edited collection, [*De-Medicalizing Misery II: Society, Politics and the Mental Health Industry*](http://www.amazon.com/gp/product/1137304650/ref%3Das_li_qf_sp_asin_il_tl?ie=UTF8&camp=1789&creative=9325&creativeASIN=1137304650&linkCode=as2&tag=lakkephtrsla-20&linkId=5QDYJAHUUX7SSLR6)(2014), Ewen Speed, Joanna Moncrieff, and Mark Rapley, show how these dual roles of critical psychology work together. Their collection includes the types of analyses expected from critical psychology, in which the historical, social and political influences on the psy-complex’s diagnostic system and biomedical model of mental illness are central concerns. Yet they also include contributors who identify trauma-focused care as a corrective to psy-complex’s failure to address the social origins of suffering. And there is repeated reference to neoliberal ideology and its implicit expectation that social origins of suffering will be ignored.

[*De-Medicalizing Misery II*](http://www.amazon.com/gp/product/1137304650/ref%3Das_li_qf_sp_asin_il_tl?ie=UTF8&camp=1789&creative=9325&creativeASIN=1137304650&linkCode=as2&tag=lakkephtrsla-20&linkId=5QDYJAHUUX7SSLR6) is the second part in a series that emerged from conferences on the medicalization of ordinary human experience. According to the editors, “The first volume of *De-medicalizing Misery* detailed how the neurochemical society we currently inhabit acts to banish suffering by representing it as a condition arising from bodily dysfunction that needs fixing, rather than a social problem that needs redressing” (2014: xiv). This second volume, they write, “… develops these themes by presenting a sociological and political analysis of the creeping expansion of the *psy* project” (xvi).

[*De-Medicalizing Misery II*](http://www.amazon.com/gp/product/1137304650/ref%3Das_li_qf_sp_asin_il_tl?ie=UTF8&camp=1789&creative=9325&creativeASIN=1137304650&linkCode=as2&tag=lakkephtrsla-20&linkId=5QDYJAHUUX7SSLR6) contains fourteen chapters, over a third of which were previously published in journals. The vast majority of the authors work in the UK, although their perspectives and subject matter are relevant to the medicalization of human experience occurring throughout the West, and increasingly, in the global south.

Topics include sociological and historical analyses of diagnoses such as ADHD, bipolar disorder, depression and learning disabilities; critiques of the DSM and psychiatric knowledge (both its production and application); the neoliberal underpinnings of concepts like *recovery*; and scientific and clinical support for a trauma-focused model of care. The breadth of topics is a strength of this collection, which would have been aided by subdividing the chapters into themes, giving greater coherence to the project as a whole. Yet the quality of the chapters is consistently good, and in many cases outstanding.

[*De-Medicalizing Misery II*](http://www.amazon.com/gp/product/1137304650/ref%3Das_li_qf_sp_asin_il_tl?ie=UTF8&camp=1789&creative=9325&creativeASIN=1137304650&linkCode=as2&tag=lakkephtrsla-20&linkId=5QDYJAHUUX7SSLR6)would appeal to critical psychologists and other critics of the dominant biomedical model of mental illness, as well as practitioners within the psy-complex, especially individuals working in clinics that are grappling with creating trauma-informed services and transitioning away from a biomedical model of suffering. Graduate students in counseling psychology and social work would also benefit from *De-Medicalizing Misery II*as a text that familiarizes with critical psychology, reveals many of the influences on, and limits of, the biomedical model and contextualizes human misery in social conditions.

Examples of content in *De-Medicalizing Misery II*include Matthew Smiths’ historical analysis of the emergence of ADHD, “The Hyperactive State: ADHD in Historical Perspective.” Smith reconstructs how ADHD became a prominent diagnosis in the USA following nationwide fear of falling behind the USSR in the race for technological advancement, which led to restructuring the educational system. The shift from a liberal education, and ‘learning by doing’, to an education geared towards producing well-disciplined, science-focused minds, created the conditions in which traits associated with ADHD — fidgeting, lack of focus, short attention span — were readily identified and pathologized.

In “Uncovering Recovery: The Resistible Rise of Recovery and Resilience,” authors David Harper and Ewen Speed show how the concept of *recovery*, despite rhetoric of empowerment often associated with it, is influenced by neopolitical ideology, which champions individualism while ignoring obstacles, like lack of affordable housing and work opportunities, that can complicate the recovery process. They write, “Neoliberal policies invite people to see certain problems as the responsibility of the individual rather than, for example, the state” (2014: 45).

In “Time to Abandon the Bio-bio-bio Model of Psychosis: Exploring the Epigenetic and Psychological Mechanisms by which Adverse Life Events Lead to Psychotic Symptoms,” John Read, Richard P. Bentall and Roar Fosse use the science of epigenetics to explain the role of poverty, oppression, and childhood abuse in the development of psychotic symptoms. Their chapter marks a departure from purely constructivist analyses of the psy-complex found earlier in the book, such as David Healy’s “The Cardinals of Psychiatry” in which psychiatry’s deceptive scientific practices are outlined, or David Pilgrim’s “The Failure of Modern Psychiatry and Some Prospects of Scientific Progress Offered by Critical Realism,” in which psychiatry is shown to have failed as an applied science. In contrast, Read, Bentall & Fosse introduce an alternative to the biomedical model — *epigenetics* —in hopes of developing a truly integrated bio-psycho-social model of mental suffering.

Similarly, in “Trauma, Dissociation, Attachment and Neuroscience: A New Paradigm for Understanding Severe Mental Distress,” Jacqui Dillon, Lucy Johnstone and Eleanor Longden introduce the model of structural dissociation (van der Hart, Nijenhuis & Steele, 2006) to explain how many of the symptoms associated with a variety of diagnoses can be seen as outcomes of chronic childhood abuse, racism, bullying, poverty, and other forms of oppression and violence. They emphasize the adaptive role of dissociation for surviving chronically traumatizing conditions, and discuss the significance of attachment to a caregiver, and hence the social conditions of parenting, as a central determinant of mental well being. They also share a neuroscientific model of traumatic stress to explain the origins of human suffering, which although I believe is correct, seems to detour from the stated objective of the volume — to move beyond (potentially) medicalizing models of human misery.

Trauma-informed care may be a much-needed corrective to the anemic attention the psy-complex currently gives to social conditions that contribute to misery. Nevertheless, trauma-informed care is also situated within the psy-complex, and thus it too is influenced by the tendency to medicalize suffering that presently dominates the field (for further discussion, see van der Kolk, 2014).

Trauma-focused care also has its own historical, social and political influences. For instance, trauma often becomes the focus of treatment during periods of social upheaval, such as when veterans returned from the Vietnam War, and the first wave of feminism’s spotlighting of violence against women (and similar conditions currently are gaining attention), only to be largely ignored again. As trauma psychologist Judith Herman wrote, “Repression, dissociation, and denial are phenomena of social as well as individual consciousness” (1997: 9).

Like the biomedical model, trauma-informed care may not be capable of ending the psy-complex’s repeated history of erasing the social origins of human misery. Thus collections like [*De-Medicalizing Misery II*](http://www.amazon.com/gp/product/1137304650/ref%3Das_li_qf_sp_asin_il_tl?ie=UTF8&camp=1789&creative=9325&creativeASIN=1137304650&linkCode=as2&tag=lakkephtrsla-20&linkId=5QDYJAHUUX7SSLR6)*,* with their attention to both critiques and solutions, will continually be needed — and often on the margins — resolute in their commitment to revealing what is often ‘repressed, dissociated, and denied’ in the pursuit of a unified theory of human suffering.

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