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Edited by
Craig Newnes

Book Review Editor

Anne Cooke, Clinical Psychology Training Scheme, Salomons Centre, Broomhill Road, Southborough, Tunbridge Wells, Kent, TN3 0TG, UK. Please contact Anne if you wish to review books. Books for review should be sent directly to Anne.

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Craig
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Editorial

So, there I was minding my own business (as if), 33 years old, ensconced in the Peak District with a new baby and adjusting to life back in the NHS after two years in Boston. A brief phone call later I found myself editor of *Changes,* Journal of the Psychology and Psychotherapy Association. *Changes* represented a group of dissidents including Don Bannister, Miller Mair, Glenys Parry, Dave Pilgrim, Dorothy Rowe and David Smail who suspected that Emperor Psy, if not naked, was clothed in illusion and magic. I had only just taken on the editorship of *Clinical Psychology Forum* – two journals already and barely back in the UK six months.

My first issue of *Clinical Psychology Forum* had been a special on Community Psychology. Broadly supportive of a de-individualised Psy agenda it had been met with raised eye-brows by the Division of Clinical Psychology; surely he would temper things from now on? The PPA was a more welcoming environment, more difficult to antagonize. The challenge (Frank Zappa famously retained the right to offend *everyone*) was met with a specially commissioned first issue on 'The Harm that Services Do'. The cover featured a print of Benjamin Rush's 'Tranquillizer Chair' (1811). Co-signatory of the American Bill of Rights, Rush, an alienist, saw the mad as conspicuously less equal than their fellows. The deputy editor of *Changes* was Audrey Campbell, an ex-nun, holder of three doctorates who had been told – in *1976* – to give up her seat to a white woman on a New Orleans bus. Audrey had no problem aligning herself with that first issue; contributors included Thomas Szasz, Jeff Masson and Wolf Wolfensberger. Dorothy Rowe's 'A gene for depression. Who are we kidding?' nailed that canard and David Hill's 'Emil Kraepelin and the Invention of Schizophrenia' said it all simply by means of the word 'invention'. Several members of the editorial board are only with us now in spirit, memory or publication. This issue, twenty five years on, starts with a paper by another friend who lives on in the same way, Steve Baldwin.

And then, an issue conceived as an indulgent nod towards my sixtieth birthday became a memorial endeavour; an acknowledgement of still being around to edit at all. My friend Ron Cattrall didn't make it. His paper, reprinted

here, seems to capture some of his therapeutic anarchy. *Changes* was the first academic journal to regularly publish articles by Psy survivors (over fifty to date) – take a bow Betty Blaska, Jacqui Dillon, Peter Lehmann, Viv Lindow, Don Weitz; Uta Wehde and many more. Published first in house, Lawrence Erlbaum took over the year I was appointed editor – 1988. The baton passed to Wiley five years later; understandably, Wiley regarded profit as the only sensible route to take. They wanted papers telling counsellors what to do with distressed people and were aghast at special issues on literature, death and qualitative research. It was a relief to all concerned when PCCS took over. Their policy of allowing authors to retain copyright is but one example of the article of faith that keeps the journal going.

Since 1988, first *Changes,* then JCPCP has included over six hundred articles. Many have been in special issues co-edited by people willing to share the task. I am grateful to Erica Burman, Carolyn McQueen, John Marzillier, Jan Burns, Guy Holmes and many others for their help. I am honoured that so many contributors simply agreed to write commissioned papers with nary a blink and, for this issue, that everyone – again – said, 'Of course'. Better yet, a few 'Happy Birthdays' were thrown in. This one was for Ron until, just before we went to press, David Smail also died. Two drummers within three weeks of each other? The rhythm of life is haphazard.

Steve Baldwin & Yvonne Jones

ECT and Children*

This article examines the history of the use of electro-convulsive therapy in the context of shifting psychiatric practice and nomenclature. It argues that the use of ECT, particularly with those under 12 is not justified by systematic research.

Key words: Electro-convulsive therapy, children, informed consent, harmful effects

Few psychiatric techniques have produced as much controversy as electro-convulsive therapy (ECT). Since its first documented usage in the 1940s (Cerletti, 1956; Slater, 1951) there has been an ongoing debate about its harm and benefits. On occasions this debate has generated much heat, and insufficient light. Overall, the literature on ECT suggests, at the least, an emotive physical invasion with an unknown mechanism of action, with a domain of applicability diminished yearly by legislation, litigation and a wide range of alternatives.

In the 1950s ECT was viewed by many as relatively harm-free and available for a wide range of patients. It was believed to be helpful in the treatment of 'affect disorders', in particular with profound depression, for 'treating cases in which the clear-cut, dynamically understandable and approachable neurosis has been overlaid by a serious depressive affect' (Gallinek, 1952). In such cases, ECT was viewed by some as of decisive benefit, and as marking a turning point from therapeutic failure to success. Anorexia nervosa too was considered potentially resolvable by ECT. Similarly patient populations termed 'schizo-affective' or people with narcotic addictions and obsessional-compulsive behaviour were included in many early studies. Whilst literature reporting ECT

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At the time this article was first published Yvonne Jones was an occupational therapist in Edinburgh, Scotland. Steve Baldwin was Director of the Neighbourhood Networks Project, TACADE, Salford UK. Steve subsequently was Reader in Public Health at Aberdeen University, Associate Professor at Bunbury University, WA and Director of the Cactus Clinic in Middlesborough, UK.

with children was scant prior to the late 1960s, some clinics included intervention with children and young adults (Gallinek, 1952).

ECT research and practice in the 1960s was characterised by attempts to understand its modus operandi, and by further attempts to find the best people to use it on (Abrams & Fink, 1969; Mendels, 1967; Sargent & Slater, 1963). Whilst there was more interest in the establishment of experimental evaluations to examine the effectiveness of ECT, many of these were unsophisticated trials with poor methodologies, producing largely inconclusive results. Most work was based on modifications to existing clinical practice, rather than purpose-built experimental evaluations in field settings. Meanwhile the 'treatment' continued.

Task Force Report

In the 1970s, increasing concern about individual and civil rights in the field of mental health promoted a series of surveys and studies of ECT. This closer examination of ECT was associated with a narrowing of focus of its use. The Task Force Report on ECT in Massachusetts for example, reported that, 'most authoritative publications appear to be in agreement that symptoms associated with the depressed phase of manic-depressive illness (*sic*) or involutional melancholia are treated most effectively by ECT' (Frankel, 1973). Nonetheless, the Task Force Report noted continuing disagreement in the field with regard to the use of ECT in schizophrenia, its combined usage with psychotropic drugs, and in relation to unresolved questions about subsequent brain damage. The role of ECT use with children and adolescents similarly was viewed as an area for continued deliberation.

Analysis of responses to the Task Force Questionnaire (from which the Report was written) indicated that all respondents assigned some value to ECT in the relief of severe depression, especially with the potential of suicide; some stated that ECT would be considered when refractory to (i) prior use of medication; or (ii) unsuccessful psychotherapy; or (iii) when poor response to other therapies rendered the person 'non-functional'. With regard to contraindications for ECT, only 35 per cent of respondents stressed the inadvisability of administration to children or adolescents, or to persons with 'neurotic'/addictions problems (Frankel, 1973). As to harmful effects, the report focused in particular on memory loss following multiple administrations. Seventeen per cent of respondents indicated irrecoverable gaps in memory, intellectual deterioration or 'blunting' following multiple ECT administrations in individual clients. In contrast, other respondents claimed never to have seen adverse effects, despite extensive ECT usage.

With regard to legal and ethical considerations, there was widespread agreement about the need for informed consent, in addition to that of a relative or guardian; where the person was unable to grant consent, commitment laws would provide legal machinery for responsibility. The person (or next of kin) should sign a 'treatment request' which would describe the procedure and state that all the person's questions had been answered.

In the case of young persons, the Task Force was unanimous that: 'administration of ECT to children who have not yet reached puberty has no established usefulness and that therefore such treatment on a routine basis cannot be justified' (Frankel, 1973). If ECT was offered as a procedure for children prior to puberty then: (i) it must be explained to parents/guardians that effectiveness of ECT for problems in pre-adolescent children is not proven, and that such use is not generally accepted; (ii) that following a most rigorous investigation of the case, explicit indications for an experimental trial should be recorded *and that the quality of the study should ensure publishable results*; and that (iii) it would be prudent and wise before proceeding to have concurrence by a colleague from another hospital in clinical justification for the experimental use of ECT with a particular child. (One might ask how many clinicians have conducted 'publishable' trials of ECT with adults *or* children?) The problems posed by diagnosis and treatment of young persons aged 13 to 16 prompted unanimity that adequate consultation with a colleague be encouraged when ECT was contemplated. Many respondents were in favour of recommending *mandatory consultations with a colleague in another hospital* before administration to persons in that age group.

The Task Force also recommended the establishment of adequate and unbiased follow-up studies to permit the true evaluations of ECT, and that all persons who administered it should familiarise themselves with other approaches to allow long-term comparative studies. The Report concluded: 'We believe that the onus is now on those whose views differ markedly from the recommendations expressed here to report their findings' (Frankel, 1973).

ECT in the UK

In the UK ECT administration with children and adolescents was generally viewed as unusual, but not exceptional. It was readily available as an option to 'control an acute psychotic or depressive illness' (*sic*) and may be considered: 'if all drug treatments have failed after proper and prolonged use to control the illness' (Frommer, 1972). In some psychiatric clinics it was viewed as an option for adolescents who were persistently suicidal, and was given to inpatients prior to subsequent outpatient administration. ECT was recommended to continue as long as the child showed 'improvement'. Some physicians recommended that ECT should not be withheld on the grounds of age alone, but rather should be a pragmatic decision, as something available following non-response to drugs (Frommer, 1972).

This scenario was complicated however by disagreements and controversy about diagnosis (and treatment) of 'affect disorders' (i.e., 'manic' or 'depressive' behaviour) in children. Indeed the existence of some depressive 'disorders' was questioned (Warneke, 1974) then as they would be now. Confusion even extended to the use of the term 'children'; some clinicians recommended that this category be reserved for young persons who had not developed secondary sexual characteristics (e.g., Anthony & Scott, 1960). Diagnostic criteria for

recognition of manic-depressive disorders often were based on circular definitions (e.g., evidence of 'abnormal psychiatric state' or 'positive family history') verging on tautology (e.g., 'evidence of severe illnesses indicated by a need for inpatient treatment, heavy sedation and ECT') (Warneke, 1974). The presence of a hypothetical physical condition based on a histo-pathological model frequently based on the absence of anything obviously amiss in the child's family or social life. The supposed existence of illness/disease states thus *often hinged on the absence, not presence, of clinical data*.

By the 1970s some psychiatric texts included brief references to possible reasons for giving ECT to children. Such applications included consideration: 'when a severe handicapping affective disorder fails to respond to an adequate dose of antidepressants together with appropriate psychotherapeutic measures and environmental modification' (Rutter & Hersov, 1976). Such recommendations were modified by a caution that it should only be used if the 'affective disorder' showed the characteristics associated in adults with a good response to ECT; *failure to respond to treatment was not considered to be a sufficient indication on its own*.

A survey in New York hospitals in 1975/1976 also examined ECT use. With regard to using it on young persons, all physicians reported occasional use with adolescents; one physician from 30 interviewed reported ECT use with children under the age of 13 (Annis, Fink & Saferstein, 1978). Written consent was obtained for all voluntary persons: consent procedures were different for all persons who initially refused consent. The ability of a pre-teenage child to give informed consent is a matter for conjecture but not a consideration much explored in these academic accounts of ECT.

Unsurprisingly, the survey revealed that the training and experience of psychiatric staff affected the methods used. Where non-medical mental health workers held responsible clinical or administrative positions, interventions were social rather than physical. Alternatively, ECT was reserved for persons who failed to respond to other approaches. The study noted variations in consent procedures, minimal record-keeping, paucity of training courses for ECT administration; it concluded only that improved monitoring of the ECT process was necessary (Annis, Fink & Saferstein, 1978).

In Britain at the time, a review of ECT 40 years after its introduction suggested: 'plenty of testimonies to the value of ECT in all manner of psychological and behavioural troubles, but a dearth of scientific inquiries into efficacy' (Lancet, 1979). This review noted that the biological mechanism of action was still unclear, and that more information had been obtained about how ECT *did not work* rather than how it might. With regard to safety of ECT and its harmful effects, there was a powerful emergent lobby from civil rights activists. In particular, there was a popular view amongst mental health reformers that ECT was experimental, hazardous and irreversible, and that it should never be sued with compulsorily detained persons without the consent of an independent multidisciplinary review body (Gostin, 1975).

It is this issue of consent (and competency to give it) which had occupied other workers in the USA and Europe. In the most celebrated ruling, an Alabama State judge ruled that subsequently, before ECT administration even to a consenting person, the reasons for giving it required confirmation from four psychiatrists and one neurologist with monitoring by two attorneys. By the end of the 1970s in the UK, the prevailing ethos was for a second independent psychiatric opinion whenever ECT was considered for compulsorily detained persons, and a multidisciplinary review panel to reach a decision in such circumstances (Clare, 1978).

ECT in the 1980s

At the beginning of the 1980s, several reviews of ECT use were completed. Such reviews suggested a shift towards a consensus about use (and non-use) of ECT. It was advocated mainly for 'severe' depression and also for people with sleep disturbance, loss of appetite or weight, retardation, morbid guild and some 'delusional states' (Freeman, 1981). Despite the risks of ECT administration (e.g., death or injury via cardiac arrest from vagal inhibition; coronary thrombosis; cerebral haemorrhage; pulmonary thrombosis) no absolute contraindications for ECT were observed. Amnesia and memory loss following ECT were considered offset by advantages from its administration, and the 'win some, lose some' mentality of advocates of 'technological advance' from psychosurgery to diazepam. Other reviews published in 1981 suggested more restricted use of ECT with children and adolescents. A survey of 2,775 psychiatrists suggested that one per cent were wholly opposed to the use of ECT; 87 per cent regarded ECT as at least occasionally useful with some adult clients with some problems. Such problems related to 'depressive psychosis', 'melancholia' and 'endogenous' depression. In child psychiatry the use of ECT was 'even more restricted; it was rarely used and mostly, if not only, in post-pubertal children with adult-type psychotic illness'. 'A minority opposed its use in children under any circumstances' (Pippard & Ellam, 1981).

The survey indicated that the physician usually explained ECT and its indications with both the person and their relatives. Nurses were often, and social workers rarely, involved with this process; no written explanation of ECT was given in 87 per cent of cases. For persons unable to give valid consent, the decision to give ECT was viewed as the responsibility of the psychiatrist; whilst multidisciplinary workers were acceptable for consultation, final decision-making remained with the physician. Wide variation in the process of ECT administration was noted, with some clinics using special forms to record details, and others using only records in case notes. The survey produced many recommendations to improve administration of ECT in clinics, either via procedural reforms or from revision of codes of practice.

Another psychiatric review of the status of ECT in clinical practice confirmed many of these recommendations. In particular, it suggested that ECT could be effective for 'severe depression in adults' (Kendell, 1981) but warned that

evidence existed for acquired impairment of memory (or new learning) following ECT administration. The review noted an overall reduction in use of ECT following legislative restrictions and adverse publicity. The range of clients, problems and settings has become more limited, and increasingly limited to adults with severe 'endogenous' depression, a category open to considerable interpretation. Despite reports of its use with anorexia nervosa, obsessionality, organic confusional states and psychogenic pain, 'such use has neither theoretical justification nor empirical support and is therefore inappropriate' (Kendell, 1981).

The review confirmed the findings of previous studies which indicated that some people who have been given ECT claim never to have been given an adequate explanation (e.g., Freedman & Kendell, 1980; Hughes et al., 1981). Medical staff may fail to explain what the procedure involves when asking the person for their consent. The review concluded that, as a surgical not medical procedure, ECT would eventually be supplanted by some kind of pharmacotherapy.

The literature on use of ECT with children consists of reports of single-case reports and uncontrolled studies. Whilst some older texts had identified ECT as an option in 'childhood schizophrenia' (e.g., Freeman et al., 1972; Redlich & Freeman, 1966) others have been less positive (Kanner, 1966). Whilst some clinicians have been enthusiastic (Bender, 1974) other investigators have been less sanguine and have found the use of ECT with 'psychotic' children of little value (Clardy, 1951; Hift et al., 1960). Few condemn its use even though the literature on ECT with children offers no controlled studies, no reliably applied criteria and no valid assessment scales (Black, Wilcox & Stewart, 1985).

There are many good reasons against using ECT with minors (e.g., Baldwin & Jones, 1990; Barker & Baldwin, 1990). These include legal, ethical, moral, clinical and philosophical considerations.

In the 1990s ECT cannot be offered as a 'treatment of choice' for anyone. Neither should it be considered as a 'treatment of last resort', especially with children. In the context of a still-developing neurological system and a full range of psychological therapies, the use of ECT with children cannot be justified. That it has taken such a long and legalistic route to reach this position gives no credit to its early advocates, and no solace to its many victims.

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Policing Normality and Pathologising Protest: A critical view of the contribution of psychology to society*

Stephen Reicher

Institutionalised psychology remains part of the establishment, seen by most as part of the problem rather than the solution

Key words: inequality, racism, IQ testing, protest

For an increasing number of psychologists, the rationale for our discipline should be the alleviation of oppression and distress, the promotion of human welfare. Even the British Psychological Society pronounces the importance of such considerations and expresses (at least formally) its opposition to sexual and racial inequality. Yet, for those of us who would use psychology as part of the solution there is an immediate difficulty. Many of those whom we would see as beneficiaries of our enterprise see us as part of the problem.

A number of years ago I was involved in a series of seminars which brought together psychologists, sociologists and black activists in considering how best to advance our understanding of racial inequality. It rapidly became clear that, for the sociologists present, psychology was at best a technique for ignoring power inequalities and structural determinants of discrimination, at worst an overt legitimation of racism. For the black activists, even liberal psychologies of 'race' were exercises in victim blaming. In most of the sessions, we psychologists were left trying to justify our right to speak on the issue and little time was left to see if we had any positive contribution to make.

Similar stories could probably be told in relation to gender, to sexuality, to class and to a host of other contexts where our discipline has been seen as a tool of the powerful: to keep women in the home, to brand all but the heterosexual as an aberration, to investigate ways of extracting more labour from the worker.

* This paper was originally given as a talk to the conference on 'Psychology, racism and the third world: 500 years of resistance', held in Manchester, 4 July 1992. It was, and this is, expressed polemically and designed to provoke discussion. First published: *Changes: An International Journal of Psychology and Psychotherapy, 11*(2) 121–6. Reprinted by kind permission of Lawrence Erlbaum.

Stephen Reicher co-founded Psychology, Politics, Resistance and worked at the Department of Psychology, University of Exeter.

It may be objected, with some justification, that such accounts are one-sided. However, the point is that it becomes almost impossible to reconstruct a discipline upon the priorities and needs of certain social groups when those groups slam the door when they see us coming. It is not enough to stake a claim as a radical psychologist and expect to be accepted with open arms – we may know this dog doesn't bite, but we still look like a dog to others. Rather, full and open acknowledgement must be given to the oppressive consequences of psychological practice. Not only is such acknowledgement necessary in order to understand how to avoid past errors, in addition one cannot discard the past until one admits to having owned it. The aim of this paper is to provide a schematic overview of the ways in which psychology has facilitated the cause of injustice. My argument is that it does far more than simply reflect the existing social order, it also serves to help construct that order, enforce that order and to disqualify any challenges to it. The first two I have termed 'policing normality', the third, 'pathologisting protest'.

Policing normality

It is easy to think of many examples where social hierarchies are transformed into hierarchies of mind. Perhaps the most amusing example is Kohlberg's six-stage model or moral development, where the nearer you came to accepting the theorist's liberal morality the more cognitively advanced you were meant to be. Of course, at best you could only seek to sit at Kohlberg's feet since he latterly admitted that stage six was probably an ideal which had only been reached by himself and Rawls! With little doubt, the most pernicious example related to the intelligence industry.

A great deal has been written about the way in which the IQ score, that supposed index of ability, transforms a certain form of performance into a general measure of human worth. The content is inevitably culturally biased, the skills that are prioritised reflect social values, the very idea of a test and its competitive ethos are ideological products. What is more, the norms which underpin the calculation of IQ are not themselves based in some theory of human functioning. Rather, they derive from the functional needs of the social apparatus: schools, courts, factories and so on. Thus, in 1924, a Dr Laughlin was claiming to America's Johnson Commission on Immigration and Naturalization that 2,062,262 foreign-born white men, along with 4,287,573 other aliens were of grade D or E intelligence, described by the phrase: *cost of supervision greater than value of labour. Untrainable socially or economically.* I only wish to add one thing to this well-worn debate. The whole philosophy of IQ measurement, indeed of psychological measurement in general, depends on the assumption that it is getting at some internal quality of the individual. Yet, to take part in an IQ test is to be in a social interaction where the way in which one completes the exercise is an act of communication. What is more, this act has considerable social importance for it is meant to determine which doors shall be open and which shall be closed to the individual. By now, few people

are unaware of what the tests mean and how they are used. Those who have been most abused show an acute awareness of the politics of testing. Labov, for instance, recounts the anger of black youths at the white middle class psychologists who come with loaded instruments that will be used to justify oppression. Why should they play in a game that has been designed to make them lose? So, in making their responses, they do not seek so much to display their ability as to show the tester what they think of the test. Yet, as is so current in psychology, the researcher disappears from the picture and what is a communicational act is turned into a quality of the respondent.

The upshot of all this is that resistance is turned against the resister. When you are seated and the test is put in front of you, you cannot object to the nature of the test or to the logic of the items. All you can do is fail to respond, fail to try, or else to respond in terms different to those that are expected. Whichever your choice, you will lose marks, you will be stupid, you will be destined for the lower strata. The difficulty of resistance, or even of expressing difference, is not limited to the IQ test. All of us probably have the experience of being given some sort of attitude questionnaire and objecting to the ways in which questions are posed (I recall finding it impossible to answer a whole survey about the EEC because it was all framed in terms of the 'national interest') yet these objections never register as we are consigned to the realms of 'don't knows' or 'missing data'. In a slightly different context, some of the most well known studies in social psychology are Sherif's 'boy camp' studies of 1949 and 1954. In these studies the inter-group relation between two groups of adolescents is the focus of enquiry. Less well known is the study of 1953 where the boys saw that they were being set against each other by the experimenters and hence construed the situation as boys versus experimenters rather than as boys versus boys. The study was simply discarded. Once again, if you challenge the dominant definition of society, you are excluded from the story. In general terms, psychological practice does more than entrench the social order as part of the natural history of mind. It also ensures that resistance or difference lead either to failure or to disappearance.

Pathologising protest

Of course, outside of the rigid confines of psychological study people do resist. One of the major intellectual shifts of recent years is the realisation that people are not tightly bound into unequal social relations but rather they are continuously contesting the world as it is. The contest, however, does not take place on equal terms. Those with resources can articulate their interests through the manipulation of these resources. Those without can only rely on combination. That is why factory owners, speculators or stockbrokers rarely take to the streets. Riots, as Martin Luther King put it, are the voice of the oppressed.

When the exploited and the oppressed use collective action in order to voice their grievances and to challenge the social order they not only have to confront

the police, the army and the courts, psychology also has tools to deal with them. In fact, psychology tends to give all collective phenomena a bad press: groups distort your thinking, groups lead you into delinquency, groups make you smoke and take drugs, groups make you lazy, groups make you bigoted. In short, groups tend to cloud individual judgement which is the source of all rational action. Even if psychology may not quite concur with Margaret Thatcher's claim that there is no such thing as society, only individuals and their families, it would certainly agree with the spirit in which it was intended.

If the tone is generally disapproving when referring to ordinary groups, it becomes positively apoplectic when the topic turns to mass behaviour. Since the rise of industrialism and the formation of a modern working class, the masses have stood as a symbol of danger and degeneracy. They threaten a breakdown of 'civilised values', they threaten to destroy refined sensibility and to pollute all that is natural. John Carey, studying the mass as a literary figure, shows how it is repeatedly represented as dull of mind, swarming over the countryside, unnatural even in its strange preference for tinned over fresh food! However, if the mass is an imminent threat, the crowd is the mass in action – the point at which possibility of decline is turned into the actuality of overthrow. In literature, in psychology and in the media, the crowd member is an icon of irrationality and of savagery.

Crowd psychology was established as a coherent discipline in late 19th century France, where the fledgling Third Republic was buffeted by clericalist agitation, by populist movements but, most of all, by the seemingly inexorable rise of syndicalist and socialist agitation. For Gustave Le Bon, whose slim volume on the crowd, first published in 1895, has been described as the most widely-read psychology book of all time individuals, literally, lose their minds on becoming crowd members. They revert to a primitive racial unconscious and behave accordingly. The crowd member descends several rungs on the ladder of civilization, says Le Bon. Crowds, he claims, are only powerful for destruction. Le Bon may be long dead but his ideas are still used in the 1990s to explain crowd violence in Britain and elsewhere in the world. Even where not quoted, his understanding is revealed in headlines such as 'Bonfires of Insanity', which more than one paper used as a lead to coverage of the Los Angeles riot.

What is most striking about Le Bonian psychology is an absence. What caused Le Bon and his bourgeois colleagues so much concern were the class struggles of their time, where striker and demonstrator battled with the police and the army. Yet the latter never appeared in writings that focus exclusively on the crowd, as though it were acting in isolation. The results would be somewhat like taking a scene of a battle and shining a spotlight on one group alone. One would see the group suddenly advancing and equally suddenly falling back, flinging missiles and then falling passive, passing without pause from anger to joy. None of this would make sense, none of this could be related to a context that has been hidden. Just as psychological testing abstracts responses from their interpersonal context and uses them as a measure of the

individual psyche, so the crowd is abstracted from its intergroup setting and action is explained as resulting from the inherent characteristics of the collective psyche – irrationality and savagery.

This psychology has a number of important ideological effects. First, it leads to a denial of voice. If the crowd members are, by definition, intellectually vacant ('like a monstrous worm' according to one theorist) there is no point in listening to what they have to say.

First, crowd actions certainly cannot be seen as a reasonable expression of grievances. Second, crowd psychologies imply a denial of official responsibility. If crowd anger and conflict is an automatic consequence of aggregation, one does not need to look for reasons in the social background which lead people to take such actions. Nor need one look to the immediate actions of the authorities as a cause of violence. This is eminently useful since studies across a number of ages show that most crowd violence occurs around the intervention of police or army and the vast majority of casualties are inflicted by the police and army on the crowd rather than vice versa. Third, the Le Bonian tradition constitutes a legitimation of repression. If crowds are inherently dangerous then they must be treated harshly. Indeed, it is best not to allow them to come into being. Listening to a Chief Constable explaining, during the miners' strike of 1984–85, that Yorkshire miners had to be stopped by motorway road blocks from attending a demonstration in Nottinghamshire because they would inevitably riot once in a crowd was like hearing the spirit of Le Bon reborn.

By means of this triple bind, psychology manages to take the only means by which the powerless can challenge their oppression and use it to further intensify that oppression. On a political level it fits straight into a strategy whereby urban revolts are used to call for water cannons and CS gas rather than for the outlawing of discriminatory practices and police brutality. Protest is seen not as evidence of social injustice but rather as a sign of collective pathology.

Strategies for change

Putting both elements of the argument together, it is evident that they combine in a powerful way. The existing normative order is rendered inviolate. You are not allowed to express difference from it for that will be represented as inadequacy. You certainly are not allowed to challenge it for that will be represented as pathology. You play the master's game by the master's rules or you are not allowed to play at all. Lest all this seem a little over the top, consider the following extract from the first editorial of the prestigious *Journal of Abnormal and Social Psychology*. The most important aim of social psychology was defined as socialisation which is, 'the fitting of the behaviour of the individual to the social order'.An obvious retort is that such an argument inflates our influence beyond all proportion. To hold psychology responsible to class division, racial inequality and state use of repression is surely somewhat fanciful. Yet it does seem rather self-destructive to mount a defence on the basis of how useless we

are, especially when our continued survival depends on persuading various potential funders as to how useful we are. Nonetheless, the argument is useful in promoting a sense of proportion and in suggesting a practical level at which to pitch a strategy for radical psychology.

It is certainly true that classes would exist without psychology, that black people would be oppressed even if IQ tests had never existed and that Gustave Le Bon did not invent the baton charge. Yet ideas are important in justifying social practices, in recruiting support for them and making opposition seem perverse, and therefore in influencing their perpetuation or decline. If psychology did not create the injustices of our world, it is perhaps grandiose to believe that we can do much to remake the world through psychological argument. However, psychology has had an impact upon the lives of innumerable individuals. It has been and continues to be used to deny the experience of women who have been abused, consign individuals as educationally subnormal, to silence communities in revolt. We can, at the very least, fracture the consensus which allows such usage to pass as expertise. This would mean adopting a guerrilla strategy, lending ourselves to those who feel themselves abused by psychology, turning up in schools, in courts, in the media and challenging what our colleagues are saying. Of course, this is not likely to make us friends within the discipline. At a time when the British Psychological Society is professionalising itself as a means of increasing its power in relation to the state and other disciplines, it will not welcome anyone trying to dismantle its power over the oppressed and the exploited. Yet, if this is not a strategy for popularity, it does have another advantage. How can we expect a radical psychology to be taken seriously which analyses problems in the world but is not prepared to address problems within its own portals? Just as we once argued that my local Labour party was unlikely to be seen as the solution to sexual inequality when its clubs employed strippers for entertainment, so a psychology which fails to address its own practices is unlikely to get very far. Rather than seeking, say, to solve the problems of sexism we should start by analysing the ways in which psychology is sexist. Rather than purporting to overcome prejudice, we must investigate our own racist practices. Once we are seen to do this, both intellectually and in practice, then perhaps some closed doors may begin to open. If we begin to address the way in which psychology has historically formed part of the problem, then we may, in time, be allowed to become part of the solution.

Do Families Cause 'Schizophrenia'? Revisiting a taboo subject[1]

Lucy Johnstone

This paper explores the inconsistencies in Family Management approaches to schizophrenia and proposes a return to more honest attempts to explain distress.

Key words: schizophrenia[2], family dynamics, psychiatry in context

The issue of whether family dynamics play a causal role in the development of the conduct that is labelled 'schizophrenia' has for many years been one of the most controversial in the whole of psychiatry. In the 1960s Laing and his colleagues, among others, made the challenging claim that so-called 'symptoms' were in fact understandable responses to impossible dilemmas in family relationships (Laing & Esterson, 1964). Although Laing also emphasised that parents are partly the product of their own family backgrounds, and that all families exist within a less than ideal society which exerts its own pressures on them, the message that was picked up by more traditional psychiatrists, by the media and by the relatives themselves was that 'Families cause schizophrenia.' This misleading inference has been used to discredit such work ever since, with the current position being that such links are unproven and damaging, part of an outdated theory that caused much unnecessary distress to relatives. For example:

> You only have to live with someone who in fact is going mad to realise that it's not your narrow, pinched refusal to tolerate the discourse of the mad that's at fault, but actually that people are ill. I think that a great deal of harm was done to the families and to the ill themselves by the great sixties denial of mental illness (Miller, 1991).

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2. I have used the term 'schizophrenia' in inverted commas throughout, in order to indicate reservations about its validity as a concept.

Dr Lucy Johnstone is Consultant Clinical Psychologist at Cwm Taf Health Board, Wales, experienced conference speaker, lecturer and trainer, author of *Users and Abusers of Psychiatry* (2nd edition Routledge 2000) and co-editor of *Formulation in psychology and psychotherapy: making sense of people's problems* (Routledge, 2nd edition 2013). Her most recent book is *A Straight Talking Introduction to Psychiatric Diagnosis* (PCCS Books, 2014).

> Theories of family pathogenesis have in the past been widespread and are still held by some professionals. This has resulted in relatives being blamed and stigmatised for the patient's illness (Tarrier, 1991).
>
> Advances in the understanding of the biological basis of schizophrenia have left most of the philosophical objections to the medical view of it as an illness, the so-called 'anti-psychiatry' argument, looking distinctly old hat. (Appleby, 1992.)

Professional literature, voluntary organisations such as SANE (Schizophrenia: A National Emergency) and the National Schizophrenia Fellowship in this country, and in the USA, the National Alliance for the Mentally Ill, educational videos and media articles all maintain the same line. To challenge it is to arouse a storm of protest, to be accused of being ignorant of the research, callous to the relatives and impervious to the distress of the patients. It is consistent with this position that psychotherapy or family therapy with 'schizophrenia' is seen as at best irrelevant and at worst damaging (with the exception of the Family Management approach to be discussed below.) In the words of the distinguished American psychiatrist and analyst Michael Robbins: 'Schizophrenia is now generally believed to be an organic disease like diabetes or cancer … (Psychotherapeutic models) … are looked on as relics of antiquity, even of the age of magic and witchcraft.' (Robbins, 1993, p.3).

In examining these opposing views about family aetiology, I am starting from the basic assumption that theories about human nature do not simply arise in a vacuum. The social constructionists would argue that all scientific theories are structured by factors such as personal and political interests that need to be explored and acknowledged rather than hidden away under the guise of scientific objectivity and neutrality; science is seen as a form of knowledge that creates as well as describes the world. A powerful demonstration of how this happens in psychiatry can be found in Richard Warner's book, '*Recovery from Schizophrenia*', in which he demonstrates, with the help of a detailed analysis of recent and past studies from all over the world, that there is a close link between recovery rates from the condition and political economy. At times of labour shortage, the emphasis turns to rehabilitation and social causes of mental distress and the outlook for patients improves, whereas in economic downturns there is a swing towards biological theories and treatments, with correspondingly negative prognoses. His striking conclusion is that 'psychiatric ideology is influenced by changes in the economy…rather than psychiatric treatment having a big impact on schizophrenia, both the course of the illness and the development of psychiatry itself are governed by political economy' (Warner, 1994, p.139).

Starting from the premise that psychiatric theories represent something rather more complex than an impartial, objective search for the truth, we can understand the rejection of ideas about family aetiology at various levels. Patients, relatives and professionals may all find it easier to work with an account

that distances them from pain in relationships, and from blame, anger, guilt and responsibility. Non-medical hypotheses can be seen as a threat to medical dominance in psychiatry and to psychiatry's scientific status. There are powerful financial interests involved, such as those of the pharmaceutical industry, which has a major role in shaping research agendas by providing funding. And there has been a general shift away from social/psychological explanations and towards biomedical ones for reasons which are surely as much to do with politics as with science; for example, suggestions in the prestigious journal '*Science*' that there may be genes for unemployment, domestic and social violence, and homelessness (Lewontin, 1993). Thus, when the current orthodoxy is challenged, the responses consist not just of legitimate scientific arguments but also, I suggest, of anger and resistance as vested interests are challenged and personal dynamics touched upon.

Of course, the fact that there are vested interests in a particular theory does not necessarily mean that the theory is wrong. However, it may well mean that alternative views get a less than fair hearing, and that the currently accepted 'facts' give a less than complete picture of the evidence.

Before proceeding any further, I want to establish some points of logic which, although extremely obvious, can tend to get lost in a debate that is sometimes very heated.

If families do play a role in the emergence of 'schizophrenia' …

… does this imply that this is the *only* causal factor? The answer is obviously no. There is plenty of evidence for the relevance of factors such as socio-economic status, racism and external stresses. There also seems to be a role for individual vulnerability, although we are not yet clear exactly what it consists of. Almost certainly, like every other mental or physical state that human beings can experience, the causes will turn out to be complex and multi-factorial.

… would explanations that draw in part upon family dynamics necessarily apply to *all* cases where a diagnosis of 'schizophrenia' is made? This is highly unlikely. Because of the well-documented variations in diagnostic practice resulting from the lack of reliability and validity of the term (see Boyle, 1999) it would be very surprising if any factors emerged which applied to every individual so labelled.

… do such theories imply that families are in some way 'to blame?' No, they do not, for the obvious reason that parents are themselves at least partly the products of their own families of origin, and so on in an infinite regression. Moreover, families are themselves shaped by powerful pressures that are beyond their control. For instance, it is known that extended family structures may be able to bear the burdens of breakdown and promote recovery far better than nuclear ones (Warner,1994). This is not to deny a role for individual responsibility. However, psychotherapists working in the field find that the most useful position is one that assumes that relatives are doing the best they can in their own very difficult circumstances (Karen and Vandenbos, 1981).

… does this mean that identified patients are merely passive victims? No; systemic formulations would see them as contributing actively to the family dynamics, and there is evidence to support this (Scott, 1973b). Nevertheless, it is unarguable that the parents were there before the child, with the implication that with a different parenting style the condition might not have developed.

… would such theories mean that biological processes play no part at all? Of course, we are bodies as well as minds, and all human experience presumably has its biological correlates in brain chemistry changes and so on. The question is whether we see such processes as having a primary causal role, as in the diseases of general medicine, or whether they will turn out to be simply the correlates, or even the results, of psychosocial factors. No such biological factors have yet been identified in 'schizophrenia', but even if they were, there would be several logical hurdles to leap before we could be confident that they were *causal* in any way. The undoubted involvement of biological processes in some ways and at some levels does not in itself justify the use of the term 'illness' to describe this distressing condition.

Having spelt this out, we can briefly overview the evidence for theories of family aetiology. Here, we may note a curious paradox. Biological theories of 'schizophrenia' are frequently presented as established facts ('Schizophrenia … is caused by a biochemical abnormality in the brain', Haydn Smith, 1998), although one can occasionally find admissions in official sources that there is actually no evidence to support these confident assertions ('Although the concept of schizophrenia has been in existence for nearly a century … there has been no identification of any underlying causal pathology', Chua and McKenna, 1995). On the other hand, as we have seen, theories involving family dynamics are generally dismissed as completely unsubstantiated, although the evidence supporting them is arguably far stronger.

The literature on family aetiology is extensive; some key articles and overviews are listed at the end of this paper. To summarise the work very briefly, we can note that certain themes in family relationships have consistently emerged over several decades in work from a variety of therapeutic orientations – psychoanalytic, psychotherapeutic, existential, systemic, humanistic and cognitive-behavioural. These are:

- extreme difficulty in separating and achieving independence
- blurred boundaries in relationships
- fundamental confusions about identity
- confused and contradictory family communications
- emotional and physical/sexual intrusiveness
- difficulty in dealing with anger and sexuality
- severe marital disharmony
- social isolation

The model that emerges from this large body of research and therapy can perhaps be summarised as one in which parents, due to psychological difficulties that may date back several generations, are unable to facilitate their infant's very early development of boundaries and a sense of self. The child's identity becomes inextricably linked with parental identity, projections and defences. The consequences become apparent when the child's attempts to separate in adolescence or early adulthood are met with terror and resistance due to the crucial role that he or she plays in the parents' precarious psychological adjustment. The expression of anger and sexuality are particularly threatening because of their potential to disrupt the status quo. However, because these psychological difficulties are largely out of the parents' conscious awareness, and conflict with their (genuine) love and concern, they cannot be expressed directly but emerge in the form of confusing and contradictory communications. The child, torn between overt and covert messages, lacking a secure sense of self and isolated from healthier outside influences, is left with no room to manoeuvre. He or she may resort to expressing in metaphor what cannot be said or acknowledged openly. This carries the danger of being labelled as 'mad', with the false solution of locating family difficulties within an 'illness' suffered by one individual.

A particularly interesting example is provided by the Genain quadruplets, better known in the USA than in the UK. These four genetically identical girls, born in America in the 1930s, became the focus of possibly the most detailed investigation ever undertaken into one family when they were all diagnosed as 'schizophrenic' in their early twenties. They were admitted to NIMH (the National Institute of Mental Health) for a three-year period of intensive treatment involving numerous physical and psychological tests, while family, friends, neighbours, colleagues and teachers were all interviewed at length. The picture emerged of a highly disturbed family environment with a violent, jealous, unfaithful and sexually abusive father, and a mother who was unable to gainsay him or allow her daughters any independence of thought or feeling.

The researchers were initially anticipating confirmation of genetic influences; 'When one first learns that the quadruplets are both monozygotic and schizophrenic, one can hardly help but wonder what further proof of a genetic aetiology anyone would want to have' (Rosenthal, 1963). However, no such evidence was found, although Rosenthal, who summarised the mass of information, still favoured a model in which a non-specific hereditary factor such as an introverted and placid temperament made the quads more vulnerable to environmental influences. Instead, the results provided evidence for the causal influence of family dynamics in the emergence, timing, form, content and outcome of the quads' breakdowns. High levels of control, which included emotional over-involvement, excessive contact and intrusiveness, seemed to play a primary role in the *emergence* of the condition, while levels of parental hostility, which varied towards each quad, gave a perfect correlation with *outcome*. Thus the most favoured quad was eventually able to marry and have

children, while the least favoured of her genetically identical sisters spent most of her life on a locked ward. In addition, the characteristic pattern of 'symptoms' displayed by each quad seemed to reflect a different aspect of Mrs Genain's own intrapsychic life; for example one quad, who became aggressive and sexually active in her breakdowns, seemed to be acting out her mother's repressed sexuality and anger, while another, who was eventually able to marry and leave home, seemed to represent her mother's strivings for independence. 'The detailed history obtained from so many sources all tends to … indicate that the pattern of parental behaviour existed long before the girls became ill and in fact dated back to their infancy'(Rosenthal, 1963, p. 571).

Anticipating the response that this research has long since been contradicted by new findings, let us turn to some recent work from Finland. Tienari and his colleagues compared 155 adopted children whose biological mothers had been diagnosed as 'schizophrenic' with a control group of adopted children of mothers who had not been so diagnosed (Tienari et. al., 1994.) The percentage of 'schizophrenia' and other severe diagnoses was significantly higher in the index group. However, a clear difference between the two groups emerged *only in adoptive families which were themselves rated as disturbed.* All children – even those who were presumed to be carrying some genetic tendency to a 'schizophrenic' breakdown – did well in healthy adoptive families. Two conclusions may be drawn. One is that the quality of relationships within the family appears to be a crucial factor both in leading to, and protecting from, serious psychiatric breakdown. The other (in line with Rosenthal) is that any inherited component may, as the Finnish researchers suggested, consist of a non-specific predisposition such as general sensitivity to the environment rather than a gene or genes for a biologically-based illness. 'If this turns out to be the case, the diagnosis of schizophrenia as a distinct disease entity may also need revision' (Lehtonen, 1994).

The few longitudinal prospective studies on families with high levels of communication deviance (a measure closely related to high expressed emotion) also find that their offspring have a much increased chance of later being diagnosed with a range of severe psychiatric disorders (Goldstein, 1985; Doane et. al., 1981). It is important to note that neither these nor the Tienari studies tell us anything about 'schizophrenia' as such. If the concept is neither reliable nor valid, one would not expect to find precise links between pre-existing family disturbance and particular psychiatric labels. However, they do lend support to the common-sense but controversial notion that crazy families tend to produce crazy children.

It follows from this model that psychotherapy may, at least in some cases, be the most effective form of treatment for 'schizophrenia.' Some of the large and almost entirely neglected literature supporting this position is listed at the end of the chapter. A particularly important recent project comes, once again, from Scandinavia, and is based on a model which draws on the literature of the 1950s and 1960s but avoids a rigid division between the biological and the

psychological. Pre-existing disturbances in the parents are believed to lead to family relationships characterised by blurred boundaries, projections and symbiotic dependency, which play a crucial causal role in the child's subsequent breakdown. However, the condition is seen as multi-causal. Biological factors are also relevant, but not necessarily in the sense promoted by orthodox psychiatry. Interactionality with other people is part of human biology and inevitably has effects on cerebral development and functions (Alanen,1994).

Based on this model, a nation-wide project was set up in Finland offering 'need-adapted treatment' to all patients with a diagnosis of schizophrenia. In an initial meeting shortly after admission, all members of the family are helped to 'conceive of the situation rather as a consequence of the difficulties the patients and those close to them have encountered in their lives than a mysterious illness the patient has developed as an individual.' As they note, 'this is an important difference compared with the psycho-educational family therapy approaches, which usually regard schizophrenia as an organically determined illness' (Alanen et. al., 1991). A flexible and individually-designed treatment package, consisting of various combinations of individual, couple, family and group psychotherapy, is set up and re-assessed as it progresses. The package often starts with system-oriented family therapy to help the patient achieve a degree of separation, at which point he or she may be more able to make use of long-term individual therapy. Social needs, for example help in getting a job and developing social skills, are also addressed. Neuroleptic medication is used at the minimum levels and often discontinued entirely in the second year. Follow-up studies show a reduction in symptoms, inpatient days and disability pensions compared to a control group (Pylkkanen, 1997).

To summarise the argument so far

There is an accumulation of evidence over the years in support of the hypothesis that disturbed family relationships can have a causal influence on the emergence of 'schizophrenia', and that psychodynamic therapy can be an effective form of treatment. At the same time, there are powerful pressures on the psychiatric profession not to acknowledge this. This has resulted, as I now hope to show, in various unhappy compromises in current theory and practice.

The first type of compromise is found in the internationally known school of Family Management, which has been heralded as 'the most significant breakthrough in schizophrenia since the discovery of neuroleptic medication' (Kavanagh, 1992). It is based on a model of 'schizophrenia' as a biological illness, which may be triggered or made worse by environmental factors such as stress: the so-called 'vulnerability-stress' model. Researchers have found that a proportion of relatives score highly on a scale of Expressed Emotion which includes hostility, critical comments and over-involvement (e.g., excessive self-sacrifice, inability to lead separate lives and over-protectiveness), and that a patient living in such a family has a much greater chance of relapse. Intervention is aimed at reducing levels of Expressed Emotion, and hence the rate of relapse,

by problem-solving, improving family communication and encouraging patient and relatives to spend more time apart.

This list of family characteristics has a very familiar ring to anyone who has read the literature of the 1950s and 1960s, as do some of the clinical observations: 'Separation is always the key issue … for some families it was possible to work towards hostel placement, in others the intensity of closeness was so great that the focus had to be on small issues … Attempts to reduce contact were often met with fierce resistance and reflected the central problem of being unable to tolerate separation, so often seen in these families' (Berkowitz, 1984).

It is important to note that Family Management workers explicitly distance themselves from theories of family aetiology. Families are 'educated' that 'the symptoms of schizophrenia seem to be caused by a chemical imbalance, which is partially or fully corrected by the medication' (Falloon et. al., 1984), and that 'THERE IS NO EVIDENCE THAT FAMILIES CAUSE SCHIZOPHRENIA' (Smith and Birchwood 1985, their capitals). High Expressed Emotion is seen as relevant to relapse, but not to initial breakdown: 'We consider that families do not exert a *causal* influence, although they can modify the *course* of the illness' (Kuipers et. al., 1992b). This preserves the orthodox biomedical view of 'schizophrenia' in line with all the vested interests that were discussed at the start of the chapter, but at some cost, as I have argued elsewhere, to logic and conceptual clarity (Johnstone, 1993).

For example, Leff has admitted that over-protective parental attitudes seem to develop very early in life (Leff et. al., 1982). This makes the claim that High EE has a causal influence on relapse but not on the development of the condition in the first place, highly implausible. Nevertheless, the preferred explanation is that High EE is *caused by* the stress of having to live with the patient's disturbance. Even the strangest behaviour described by the researchers, such as a mother sharing her bed and all her leisure time with her adult daughter while father was banished to another room, have to be understood in this way. This leads us into further improbabilities; patients are apparently able to cause disturbance in relatives, but not vice versa (or at least, not until the first breakdown has occurred.)

It is consistent with the vulnerability-stress model that clinicians, in the words of one of them, 'do *not* view the family as being in need of treatment. Hence we avoid calling our interventions 'family therapy.' Our aim is to help the family to cope better with the sick member who is suffering from a defined disease' (Kuipers et. al., 1992a). However, the same book gives several examples of interventions that are borrowed from standard family therapy practice; thus, it is suggested that separation can be facilitated by changing seating arrangements, positive reframing and paradoxical injunction. The message to families can come across as 'There is nothing wrong with you' and, simultaneously, 'You need to change'. In other contexts this could be described as a double-bind. These confusions in practice spring directly from confusions

in the theory, in which 'Blame is avoided only at the expense of conceptual clarity – by declining to address the issues of aetiology altogether' (Terkelson, 1983).

Genuine growth and change may be another casualty of the apparent need to preserve an illness model of 'schizophrenia' at all costs. Most reviews report that overall gains are modest: 'Globally, patients appear better but not well … relatively few patients appear to achieve independent living and continued employment' (Hogarty et. al., 1991). Over-involvement, as rated on the EE scale, is particularly resistant to change. This is exactly what one would predict from a psychotherapeutic model which sees separation difficulties as a central causal factor, rather than the by-product of dealing with a relative's biological illness.

Family Management researchers thus find themselves in a very awkward position. While denigrating supporters of family aetiology for not having any evidence to support their theories, they themselves have inadvertently uncovered much of this evidence but cannot afford to acknowledge it.

The second type of compromise is found in the work of those who, while acknowledging the importance of exploring the meaning of so-called psychotic experiences and beliefs, still retain the medical term 'schizophrenia.' This is true of most of the recent work on cognitive therapy with psychosis (Haddock and Slade, 1995, Fowler et. al., 1995). It is also true of the Scandinavian groups and Robbins in the USA, who, although seeing family dynamics as having clear implications for aetiology, appear to find the concept of 'schizophrenia' unproblematic. In this way they are, I believe, avoiding the full implications of conceptualising the condition as a psychological or psychosocial phenomenon. Medical and psychotherapeutic models are based on incompatible assumptions. It is contradictory to imply that someone is suffering from a biological illness and, at the same time, having an understandable emotional response to their situation; that the cause is internal, individual and biological on the one hand but rooted in relationships on the other; to categorise experiences as symptoms while at the same time looking for meanings; to relate to someone simultaneously as a patient (whose role is to take expert advice) and as a client (who needs to take an equal role in exploring the meaning of their distress).

This mixed and contradictory model also creates problems in practice which are bound to have adverse effects on psychotherapeutic interventions. Scott, in some classic papers from the 1970s, coined the term 'treatment barrier' to describe what happens when one member of a disturbed group is officially labelled as 'the sick one' by the process of applying a medical diagnosis. The drawing of a line that, in his words, 'rigidly divides the sick from the well' means that 'human relationships are then maintained in a severed and disconnected state.' This false solution to unbearably painful conflicts is, according to Scott, often reached at a crisis point in family life, when professionals are called in to verify what is essentially lay people's selection of one person in the group as 'mad' or 'ill.' Although this initially brings relief, the long-term effect is disastrous. 'The parents deny that forms of relationship

threatening to themselves are relationships; they are seen as forms of disturbance in the patient. Thus, symptomatology is maintained by the conventional approach while relationship issues are depersonalised and evaded' (Scott, 1973a). All clinicians will be familiar with the scenario in which relatives complain, 'He's been answering his mother back/ playing his music too loud/ not telling us where he's going – he must be getting ill again.' The use of a medical diagnostic label may well put families beyond our therapeutic reach even before our first meeting with them.

We also need to be aware of the devastating impact of the label on the identified patient, to which many service users have testified: 'I walked into (the psychiatrist's office) as Don O'Donoghue and walked out a schizophrenic … I remember feeling afraid, demoralised, evil' (O'Donoghue, 1997). 'The diagnosis becomes a burden … you are an outcast in society. It took me years to feel OK about myself again.' (Lindow, 1997). Barham and Hayward (1995) have vividly documented how a psychiatric diagnosis introduces people into a life of stigma, isolation and discrimination in which 'an impoverished conception of what they can reasonably do and hope for – of their significance and value – have been brought to merge in a painful experience of exclusion and worthlessness.'

The way forward

What is the way forward out of this impasse in theory and practice?

The central message of this overview, it seems to me, is that we need to return to the key tenet of Laing and others from the 1950s and 1960s: 'schizophrenia' is, in many cases, best understood as a meaningful response to psychological conflicts arising within damaged and damaging family relationships.

We also need to acknowledge the full implications of such a hypothesis. One is that rather than a *diagnosis,* we need a *formulation*; an understanding of the meaning of the individual's experience that links past and present, external and internal, conscious and unconscious. Here we can recall, in conjunction with more recent critiques, the contention by another key figure from the 1960s that since the mind cannot be 'sick' in any but a metaphorical sense, the term 'mental illness' should be abandoned. (Szasz, 1961).

Another implication is that the primary form of intervention should be psychotherapeutic rather than medical, with a range of individual, couple, group and family therapies on offer.

As well as forgetting many of the lessons from 40 years ago, we have also learned a great deal. As we have seen, large-scale studies such as those from Scandinavia lend some empirical support to theories of family aetiology, while giving valuable indications of how such ideas might be put into practice nationally. At a broader level, we also know much more about the complex effects of poverty, inequality and racism on mental health (Thomas, 1997; Gomm, 1996; Fernando, 1991.) With sophisticated analyses like that of Warner putting individuals and

families into a socio-economic context, and demonstrating how the pressures inherent in industrialised societies can impact upon recovery, we no longer have to fall back on a vague conviction that society drives people mad. Instead, we can develop (as Warner has) a detailed blueprint of social and political strategies to back up our psychotherapeutic interventions. We have the theoretical and practical knowledge to justify abandoning the medical model of 'schizophrenia', along with the term itself, and adopting a psychosocial one instead.

However, we cannot afford to be naïve about the forces arrayed against such a shift in our understanding of what has been called 'the prototypical psychiatric disease' (Boyle, 1990). Warner, as we have seen, has argued that promoting good outcomes for patients is actually secondary to psychiatry's main function of social control, and 'Ideological views which emerge counter to the mainstream of psychiatric thought make no headway in the face of a contrary political and social consensus' (Warner, p. 139). And commenting on the same phenomenon from a psychoanalytic perspective, Robbins (1993, p. 190) has said, 'Because the recognition and validation of certain elements of genuine thought and feeling within the schizophrenic and his disturbed family have the potential to disrupt family structure… and hence pose threats to the stability of society, society appears to enact and support the totalitarian forces within the family designed to suppress and deny them.'

If 'schizophrenia' is a dramatic manifestation of some of the central contradictions of our Western industrialised way of life, filtered through family dynamics, it is not surprising that the debate surrounding it has been so controversial, so heated and so inconclusive. Robbins has argued that current psychiatric theories are little more than pathological processes writ large, designed to suppress the individual in order to support 'the myth of the happy family and the myth of treatment' (p. 470). The question of how to intervene thus becomes not just a scientific but a moral one. Are we ready to admit our own collusion with the denial and repression that leads to breakdown? Do we have the courage to meet the person behind the label? Whose side are we on?

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Three Years of Antipsychiatric Practice at the Berlin Runaway-house*

Iris Hölling

This paper describes life in an anti-psychiatric institution, where people can live without psychiatric diagnoses or drugs and regain control over their lives.

Key words: user control, antipsychiatry, survivor movement, drug withdrawal

The Berlin Runaway-house 'Weglaufhaus' was finally opened on January 1 1996, after ten years of struggle for its realization. It is the first anti-psychiatric institution that managed to get official funding as a crisis centre for homeless survivors of psychiatry.[1] The Runaway-house is a place for people who want to get out of revolving-door psychiatry and have decided that they want to live without psychiatric diagnoses and psychiatric drugs. It opens up a space outside or beyond the (social) psychiatric net that keeps people dependent, a space in which the residents can try to regain control over their lives. Here they can recover, regain their strength, talk about their experiences and develop plans for the future without psychiatric views of illness blocking access to their feelings and their personal and social difficulties. Refusing any diagnoses opens new perspectives on people's lives which for years have been categorized and reduced to symptoms to be combatted or reduced. Responsibility returns to the residents themselves.

It took ten years of fighting

The Runaway-house originates from the survivor movement in Germany.[2] After being a project group within the Lunatics' Offensive (Irren-Offensive), a self-help group for survivors, the Association for Protection against Psychiatric Violence (Verein zum Schutz vor Psychiatrischer Gewalt e.V.) was founded in 1989 as a mixed group of survivors and other antipsychiatric activists. In 1990 a

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Iris Hölling was co-chair of the World Network of Users and Survivors of Psychiatry

private donor whose son killed himself in a psychiatric institution bought the villa which was turned into the Runaway-house. The house, being the only prerequisite for the Berlin Senate to assure the financing of its running, turned out to be no longer sufficient after political majorities had changed. It took another six years of intensive fighting with contradictory demands of the various authorities involved until finally a day rate remuneration for people's stay in the house was agreed upon according to §72 BSHG (Federal Social Welfare Law) 'Help in special social difficulties'. This also meant limiting the target group to clients who are homeless or in danger of losing their homes.

Being an openly antipsychiatric project the Runaway-house continues to challenge psychiatry and to be perceived as provocation for different social actors. The neighbours went into court in order to prevent the house from opening but did not succeed. However, they are still carefully observing the house, although so far nothing extraordinarily dangerous has happened. The Runaway-house also has a lot of political enemies, but we hope that the longer we prove that we are working successfully, the weaker their position gets.

Daily life in the Runaway-house

The concept consists of not having a concept. Instead of being a therapeutic institution, the Runaway-house focusses on everyday life. Up to thirteen residents share the old villa in a Northern part of Berlin and organize the household, i.e., cooking, cleaning, shopping, working in the garden or looking after the house by themselves. The workers have a different role and serve as facilitators or supporters and so holding the house together, ensuring its functioning.

The team consists of 10 part-time permanent workers and two who work on an honorary basis. More important than formal professional qualifications are qualities such as attentiveness, tolerance, sensitivity, openness, personal experience, the ability to deal with conflicts and a clear antipsychiatric attitude. This means considering the residents without prejudice, being direct, honest and upfront with them, not to think of them in terms of mental illness but to regard them as responsible human beings, who decide about their lives themselves. At least half of the team members are survivors of psychiatry. Having been an inmate of a psychiatric institution does not in itself qualify people for working in the Runaway-house, but having had the experience oneself and reflected upon it and gotten out of it and having found other ways to come to terms with extraordinary emotions, experiences, perceptions, madness[3] than psychiatry's violence against them is a particular knowledge that is part of the foundations of the Runaway-house. It is important to note that not every inmate of a psychiatric institution has been crazy. The less significant professional qualifications and identities of team members (of both, survivors and non-survivors) include social workers, pedagogues, philosophers, psychologists, mechanics. There are no medical professionals and especially no psychiatrists working in the house.

Who lives in the house?

The residents who can live in the Runaway-house for up to six months have all been inmates in psychiatric institutions and are homeless or threatened with losing their accommodation. 34% of the residents (statistics refer to 1996–98) came directly out of a psychiatric hospital, 20% were homeless and living in the streets, 23% came from other social (psychiatric) institutions or women's shelters, 13% came from their families, friends or acquaintances and 8% out of their own apartments where they could no longerer stay.

In the first three years 132 persons lived in the house, 63 women and 69 men, the average stay in the house was 62 days. In the first two years women stayed a lot longer than men, 98 compared to 38 days. In 1998 the average stay of women and men was almost identical. The majority of those who seek advice and support in the Runaway-house have long histories of psychiatric treatment, most have been institutionalized at various times, have been forcibly treated and heavily drugged. They have been labelled with all kinds of psychiatric diagnoses during their stays in psychiatric institutions. These diagnostic labels are completely irrelevant in the Runaway-house. If they are 33 years old which is the average age of the residents (although the scope is from 18–68 years of age) psychiatry has mostly determined their lives for more than ten years.

It is notable that hardly anybody gets referred to the Runaway-house by other institutions. We insist on people interested in staying in the house to contact us themselves. Residents can only be in the house voluntarily and they are free to leave at any time. In the introductory talk where we try to find out whether the Runaway-house is the right place for a person we only rely on the information given to us by the potential resident. We trust his or her self-description and do not demand any authority's opinion. In my eyes, this starting point of taking a person and his or her self-presentation seriously and trusting their own words makes an enormous difference to their former experience due to institutionalization, since almost all the residents have experienced stigmatization and prejudice because of their psychiatric labels.

One of the most important characteristics of the Runaway-house is that it offers a choice and a new perspective to those who are dissatisfied with psychiatric services' treatment. Thus, the explicit offer that people can withdraw from psychiatric drugs (neuroleptics, antidepressants, tranquillizers, lithium, carbamazepine etc.,) in the supported environment the Runaway-house provides makes it a unique place. Since there are no doctors in the house, the residents are consulting general practitioners or other supportive doctors outside the house that are not easy to find. We mostly advise those residents who have taken their decision to get off psychiatric drugs gradually, especially if they have taken them for a long time. We also talk about questions like: What helps you, if you get crazy? Which kind of support do you want or need? Which experiences do you have with withdrawal? Most residents are amazed when asked about their wishes and experiences because nobody has asked them such questions before. Often they do not know what they would want or need because

they have never had the possibility of experiencing it. We then try to find out about helpful strategies together.

What happens in the house?

There is no therapeutic concept behind the work in the Runaway-house. Residents get support in everything they want. They choose two team members as persons of confidence, i.e., workers who feel especially responsible for them, who keep an eye on the things to do or to sort out. The residents can and will discuss and do things with every team member available, but there are sympathies and you get on more easily with some people. This system of special attention or responsibilities also enables the residents to choose with whom they want to talk more intensively.

Besides the important possibility of living through crisis, madness or extreme situations in a supported environment without being numbed by psychiatric drugs, the support is directed mainly to daily life. Planning a future: how do the residents want to live after their time in the Runaway-house: by themselves in an apartment of their own? Together with others in a shared apartment? In some kind of sheltered or supported living? It is often difficult to find some kind of sheltered apartment where the residents' critical attitude towards psychiatry and psychiatric drugs is respected, since we are the only antipsychiatric institution in Berlin. But we sometimes negotiate and succeed in finding solutions.

Most of the residents do not have professional qualification or training, some have not even finished school. Here we talk about their ideas: do they want to go back to school? Are they interested in an apprenticeship or training? Which kind of professional future do they imagine for themselves? What are their talents? How could they realize their ideas on a long term basis? Dealing with the employment office and training centres, doing applications, filling in forms are practical aids in this field.

On a different level, spare time activities and interests are relevant. Depending on the interests of the residents, art or gardening activities might take place within the house. Excursions outside the house, swimming, going to parties, dancing, sport courses, going to the cinema, and generally trying new things are also engaged in. Workers or interns might make suggestions or bring in their own interests, but it is always the residents' choice which activities might happen or not.

Clarifying the financial situation of the residents is also a task. Most of the residents live on Social Welfare aid, some get pensions or unemployment benefits. To find out which benefits they are entitled to, which authorities are responsible and to make the claims correctly is also part of our effort. If residents have debts we advise them in making arrangements with creditors.

Moreover, the juridical situation of the residents can be an issue. Often the residents have guardians for specific tasks. If they want to change their guardian because they cannot trust him or her or feel patronized and not

supported, they are helped to change the guardian or to even get rid of him or her altogether. We also refer residents to competent lawyers for specific questions.

Another important means to protect yourself, if you end up in psychiatry again is the 'Psychiatric Will', i.e., advanced directives where you declare how you want to be treated and what you refuse, which drugs you might agree to take, who are persons of confidence to be consulted, what you need in crisis and other details. It is important to make such a Psychiatric Will in a state of 'undoubted normality', i.e., when outside a psychiatric institution. This has some juridical validity in Germany and it enables people to get out of hospitals sooner and also to sue psychiatrists if they do not respect their wills.[4]

Most of the residents are very isolated when they come to the Runaway-house; reflecting upon relationships with (former) friends and family members plays an important role. Sometimes this means trying to reactivate contacts or friendships, sometimes it also means ending destructive relationships. In the house the residents are confronted with a community of survivors who have had similar experiences. Encouraging the self-help potential in the residents is an important basis for the events in the house. Some residents get on well with each other, support each other and develop friendships or contacts that last after their stay in the house. But there are also a lot of conflicts among the residents. Sometimes residents think that others persecute them or want to harm them. If there are conflicts, we first encourage the residents to solve them on their own, but if they do not succeed, a worker would serve as mediator and be there as a third person. It sometimes takes a lot of work and ongoing discussion and confrontation to clarify that different perceptions of the same reality are equally valid. A feeling of persecution might be real, although the other person does not have any intention or interest in hurting the persecuted person. Finding a shared reality is an ongoing struggle.

Every resident has his or her own story. Most residents have not only experienced psychiatric violence, but also sexual, physical or psychic violence during their childhood. Talking about their lives and the traumatic experiences, and being believed in is an important part in the Runaway-house reality. Residents are empowered to shed a different light on their personal history that goes beyond the organic psychiatric view, to make sense of their experiences, to re-appropriate their past. This is a decisive aspect of the space the Runaway-house opens.

Structures

User-control is assured in the Runaway-house on various levels. In the *Association for Protection against Psychiatric Violence* the survivor members who currently hold the majority have a right to veto on all matters. In the team we have established a quota which assures that at least 50% of the workers are survivors of psychiatry. Half of the team members have to be women – in fact, there were always more women than men working in the house.

Decision making bodies are the weekly team meeting and the house meeting twice a week with all the residents and the two workers present. From time to time, especially when basic decisions are to be discussed, a 'general assembly' of the team and all residents takes place.

As transparency is a key issue for people who have experienced being decided upon without their knowledge or being denied access to their psychiatric files, all official documents and internal notes are written in co-operation with the residents and always accessible to them. They have the option of attending the team meeting when we talk about them. We also document what we have said about them and tell them afterwards. They always can comment on anything team members write on their behalf. Initially, we did not want to have any files or documentation, but this became indispensable as a condition because of receiving official funding through the Social Welfare authorities. However, we do not write anything about residents without their agreement and we try to communicate as few personal details as possible, in order to respect their privacy.

The house meeting is the highest authority in the house. Organisational and everyday life issues are discussed there, common activities are planned, conflicts among the residents can be thematized and all decisions concerning life in the house are made there. The meeting also includes votes on visitors, new residents' stays after a two weeks trial period and on future interns or workers after they have trial worked for a day. The final decision, however, lies with the Association. The team members only serve as facilitators at the house meetings.

Finances

A stay in the Runaway-house is financed on grounds of §72 BSHG (Federal Social Welfare Law). With the day-rate-remuneration which is part of 'help in special life situations' guaranteed by the law only the very basic needs are covered. Coverage of costs has to be granted for each resident individually by one of the 23 different Social Welfare offices in Berlin. This leads to an enormous bureaucracy and distressing situations for the residents, since a lot of the responsible officers raise difficulties over the coverage of the costs, take a long time to decide, grant the aid only for a very short time or demand an enormous number of documents and justifications. To characterize this type of 'official madness', I invented the new diagnosis 'folia officialis' which describes the production of floods of papers, a denial of responsibility, a lack of accessibility etc.[5]

In times of scarce resources and cuts on budgets, some of the official representatives consider the Runaway-house with a day-rate of 200 DM per day as expensive, but this depends on the object of comparison. Compared to other institutions for homeless people that are not crisis centres but so-called 'lice pensions' of very low standards with very little support, the Runaway-house might seem relatively expensive, but compared to psychiatric wards (300-

700 DM per day) it is extraordinarily cheap. It is a short-sighted and very limited perspective to just consider your own restricted domain. This narrow perspective combined with the arrogant attitude towards the residents as an expensive burden instead of persons in need who claim their rights leads to very humiliating experiences for the residents and often causes fear and anger towards the authorities. In these situations, the support of the residents in the fight for their legitimate demands becomes vital. However, among the 23 different offices in Berlin we also encounter representatives that are very supportive and ready to help, and who are happy that a place for the doubly discriminated group of homeless survivors of psychiatry exists.

The financial situation of the Runaway-house remains precarious, although we have survived the first three years, but only by means of radical economies, temporary worsening of working conditions and a great deal of self-sacrifice of the workers.

The existence of the house is also still in danger. The actual financing agreement (which states the day-rate-remuneration the different Social Welfare authorities are supposed to pay for a resident's stay in the house) came to an end in December 1999. The change in the §93 BSHG (Federal Social Welfare Law) which sets the juridical grounds for the remuneration of social services now demands a new general agreement for Berlin. However, as negotiations could not be agreed, as planned for 1st January 1999, a transitory agreement was necessary. It took a lot of public and international support and intensive lobbying to finally persuade the Berlin Senator for Health and Social Services (who at first refused to continue the financial basis for the Runaway-house). Probably, the juridical impossibility of cancelling the agreement at that point was the major reason for her finally giving in. Negotiations between the Berlin Senate and the Welfare Associations are continuing for a permanent agreement after 2000. As we still have influential political enemies, we cannot be sure that once again purely political reasons and unfounded prejudice alongside ideologically motivated opposition might lead to arbitrary denial of funding. This is why the Runaway-house still needs moral and financial support.

Success

It is difficult to conclude success from statistics or to describe it in abstract terms. Moreover, only the residents themselves can evaluate the importance of their time in the Runaway-house.

20% of the residents moved into their own apartments (sometimes with an individual support worker for some hours a week). 25% moved into other institutions such as sheltered accommodation, supported living, or women's refuges. 17% went to stay with friends or their families. 13% went into a psychiatric or general hospital. As for this group it is important to note that, e.g., in 1998, four out of eight residents who went into psychiatry stayed only four days in the Runaway-house, the other four less than a month. 7% left for the street or shelters for homeless people and 5% are unknown to us. Statistically,

it is evident that the longer the stay in the Runaway-house the higher the number of those who move into their own apartment or into a considerably less intensive form of supported accommodation. The ideal of someone moving into her own flat, being socially integrated, having found a job, living an autonomous life free of psychiatric drugs and without ending up in psychiatry again is a very ambitious measure which only a small number of the residents come close to. However, quality lies in the details of small changes and success cannot be defined in absolute terms.

It is a success if vivid expressions return back to a face of a person who has suffered from the so-called Parkinsonian side-effects of neuroleptics, when she gradually withdraws from them during her stay in the house. 60% of the residents did not take psychiatric drugs before moving to the Runaway-house or immediately stopped taking them. All the others gradually withdrew from them supported by general practitioners outside the Runaway-house.

I consider it a big development to start to think about oneself in other than psychiatric categories of mental illness. This implies not to declare one's (crazy or extraordinary) experiences an illness, but to make sense of them (which I believe every individual can only do for him or herself) and to take responsibility for them. Assuming responsibility can be a heavy task after having been cared for by institutions for years, but it is also a challenge and can lead to completely new perspectives and to step by step realization of possibilities one has dreamed of for a long time. Going mad is, to a certain extent, possible in the Runaway-house, as long as there is some kind of contact with the others around. Contact does not necessarily mean straight verbal communication, but can have various forms. Our form of crisis support consists primarily of 'being with' as it was named in the Soteria Project in California.

Some women even managed to relive situations of extreme sexual violence they had suffered from as a baby or child. They became the child that was abused, they fought with their rapist. We were just there, prevented them from hurting themselves, talked to them, told them where they are, who we are, that no harm is done to them any more. They did not hear it, but at some point came back to their adult reality. Then it was very important to tell them in detail what had happened because they could not remember it. In psychiatry those women had been violently tied to a bed by several men and forcibly treated with neuroleptics which just meant a repetition of the original traumatic experience. Sexual violence as a child that very often leads to institutionalization in later life for women (but also for men) is an important topic in the Runaway-house. This connection is still widely ignored in psychiatry.

Not all forms of crisis or craziness can be supported in the Runaway-house: If contact or mutual agreements become completely impossible or if people several times break the house rules (no violence, mutual respect, no consumption of alcohol or illegal drugs in the house) and do not assume responsibility for it afterwards, or if people need the permanent presence of a worker for a long period of time, it gets difficult and residents might have to leave the house.

This is always very painful because there are hardly any alternatives. Sometimes, however, it helps the residents if we clearly point out our limits and their risk of having to leave the house.

Another aspect of success is found in the residents starting to develop and try out new strategies of how to deal with the voices they are hearing or to find alternatives to self harming. Finding different ways to come to terms with phenomena like fear, anger, aggression, persecution, using the sports and raving room, throwing things at the wall with someone else present, walking in the fields, writing, listening to music or playing it, working in the garden, etc. can be helpful actions. All these small steps can favour the residents' self-confidence that mostly has been severely disturbed due to institutionalization. It is not easy to regain trust in one's own perceptions, if one has been attributed a distorted view of reality or a mental illness for such a long time. The survivor members of the team are important partners for discourse on these issues as well as for the experiences of withdrawal from psychiatric drugs, as they have been in a similar situation. They somehow serve as role models, but the exchange with the other residents is at least as essential.

All in all, the three and a half years' practical experience of work in the Runaway-house have shown that psychic crises can be managed without psychoactive drugs and without means of coercion. It is also evident that more survivor-controlled spaces with less restrictions on access need to be created.[6]

Endnotes

1. The German term *Psychiatrie-Betroffene* (persons afflicted by or confronted with psychiatry) does not really translate into English. Since most of the members of the Association for Protection against Psychiatric Violence identify themselves as survivors rather than (ex-)users of psychiatry, I chose the term survivors of psychiatry, although it is more radical and critical than Psychiatrie-Betroffene. To my mind, however, *Psychiatrie-Betroffene* accentuates the violence of getting into psychiatry compared to the nowadays popular term of *Psychiatrie-Erfahrene* (persons who have experienced psychiatry) which is used by the German national association of (ex-)users and survivors of psychiatry Bundesverband Psychiatrie-Erfahrener.

2. Some of the basic ideas behind the Runaway-house in its early stages can be found in Uta Wehde's article 'The Runaway-house: Human Support Instead Of Inhuman Psychiatric Treatment' in *Changes, Vol. 10, No. 2,* June 1992.

3. The German word for mad or crazy 'verrückt' contains the notion of being distant from normality, if you take it literally. This means madness can be considered as a relationship rather than a quality or defect attributed to the crazy person. According to those connotations I consider madness or craziness as descriptive and not perjorative terms.

4. The German version of the Psychiatric Will is published in: Kempker, K. and Lehmann, P. (ed.) (1993) *Statt Psychiatrie*. Berlin: Peter Lehmann Antipsychiatrieverlag (pp. 253–98). The German version refers to Szasz, T. (1982) The psychiatric will – A new mechanism for protecting persons against 'psychosis' and psychiatry. *American*

Psychologist, Vol. 37, No. 78, 762–70. and Szasz, T. (1983) The psychiatric will: II. Whose will is it anyway? *American Psychologist, Vol. 38, No. 3,* 344–46. Cf. also: Kempker, K. and Lehmann, P. (1993) Unconventional approaches to Psychiatry. *Clinical Psychology Forum, 51,* 28–29

5. For further details on this topic cf. my article 'Ämterwahn' (pp. 149–58) in the book about the Runaway-house: Kempker, K. (ed.) (1998) *Flucht in die Wirklichkeit*. Berlin: Peter Lehmann Antipsychiatrieverlag. The book gives an excellent and colourful practical view of the life in the Runaway-house and includes articles by residents, workers, interns and members of the association.

6. The Runaway-house can be reached: Weglaufhaus 'Villa Stöckle', Postfach 280 427, 13444 Berlin, tel: 49-30-40632146, fax:49-30-40632147 or via the internet: http.\\www.weglaufhaus.berlinet.de.

Simon King-Spooner

Psychotherapy and the White Dodo*

The Dodo is now extinct, victim of an inability to adapt to an increasingly hostile environment. This article argues that psychotherapy needs to react to concerns about its efficacy, uniqueness and potential harm if it is to avoid a similar fate.

Key words: psychotherapy, research, efficacy

> There is … a great fowl of the bignesse of a Turkie, very fat, and so short-winged they cannot flie, being white, and in a manner tame; and so are all the other fowles, as having not been troubled or feared with shot (Tatton, 1625).

This, the White Dodo of the Indian Ocean island of Réunion, seems to have outlasted its better known Mauritian relative by a few decades – though why isn't clear; at least the regular dodo had a reasonable turn of speed, while the Whites, in the only other contemporary account, ' … were so fat they could scarcely walk, for when they walked their belly dragged along the ground' (van Hoorn, 1646). Pictorial evidence is no richer. A couple of crude but vigorous woodcuts by anonymous mariners and an aquarelle of around 1684 by one Pieter Withoos: the last having an improbable assortment of birds in a would-be naturalistic setting – the White Dodo peers out from behind a Siberian goose, with an expression of inane amiability that calls to mind early learning play materials, or the bombed out Arnold Ridley character in *Dad's Army*.

In fact the evidence is so scanty that dodologists disagree on whether the White Dodo and the Réunion Solitaire, which appears in the woodcuts as a scrawny creature with a distinctly evil look in its eye, were different species or – in parallel with the Mauritian Dodo, whose outline changed according to the state of moult and availability of food – were the same bird before and after lunch.

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Simon King-Spooner worked as a clinical psychologist in Edinburgh, Scotland. With Craig Newnes he co-edited *Spirituality and Psychotherapy.* PCCS Books, 2001.

Interestingly, by the way, they – the dodologists – feel obliged to take up one or other position on the matter, Hachisuka and Rothschild going for the two-species theory, Oudemans for dodo-solitaire identity (Hachisuka, 1953). Perhaps it is impossible to resist Gestalt closure, however meagre and deteriorated that data array; or maybe sciences take on the characteristics of their subject matter, like owners their dogs (witness the superhuman loopiness of theoretical physics, the fascinated rummaging of the sexologists): dodology, anyway, has definite dodoesque qualities, not least a kind of speculatory bloatedness that threatens to overwhelm its evidential skeleton.

But I digress. This is the story, more or less.

A few pigeons, lost or storm-blown or seized by an adventuring spirit, stray a thousand miles or so from their African home and land in paradise. There, endlessly gorging beneath the hawkless trees and through the catless, snakeless undergrowth, they have no need for flight or caution. Their wings shrivel down to neat little stumps, giving the bird a fussy, bourgeois appearance, like a dumpy matron with two handbags. Maybe the males engage in Sumo-like tussles; maybe the selective pressure is to out-eat your neighbour so you can better survive the resulting famine. Anyhow, they get fat.

Eight million years later a ship comes up.

It drops off a couple of pigs, whose descendants, it is hoped, will provision future voyages. The bosun is weary of the pregnant ship's cat – it winds round his legs all day, mangy with malnutrition from a diet of ship's biscuit, begging incessantly for food – but being too soft-hearted to lob it over the side, he leaves it on the beach, miaowing at the disappearing longboat. Half the ship's rats, sniffing the offshore breeze, exchange speculative glances and arrange their own landing.

With nothing to obscure the mathematics of exponential growth (the cats having easier prey) the semi-circular growing-edge of the rat colony rolls across the island. In a dozen generations it hits the opposite shore; in another dozen the backwash has percolated up into the remotest valleys. Some of the birds have enough of the old hard-winged predispositions left to keep an eye on their eggs and newly hatched squabs, and to lunge ponderously at any rats that get too near; they, if their waddling half-grown survive the cats, hold out just long enough to be hit by the pig explosion.

The moral? Don't avoid your enemies, unless you can avoid them forever. The White Dodo should have been looking down on the Siberian goose from a tree, elegantly preening its snowy primaries, clean-lined, swift-winged, alert – retaining the shape given it by its would-be destroyers, which in turn are shaped by their prey (what would a cheetah be, if gazelles were aardvarks?). Alas, its incomparably predator-ridden African homeland was lost to it; free of enemies, it was doomed.

Psychotherapy

Psychotherapy waddles, bloated with self-congratulation, through a benign undergrowth of conferences, workshops, consulting rooms, congenial journals, its strongest characteristic if not its defining expression one of inane amiability. Occasional Sumo-like struggles take place between competing schools, but conflict is generally dealt with by the antagonists flouncing off and having nothing more to do with each other; so islands and islands-within-islands proliferate, each careful that nothing disagreeable crosses the few interconnecting causeways of dialogue. The biggest island holds the marshes of eclecticism, cloaked in a warm fog, where all who have taken an oath of vegetarianism, and had their teeth surgically blunted, are free to wallow in the mud between the languid tussocks.

Safe, it seems. Far off, the eagle of rigour, the weasels of doubt. The owl of cynicism, hooting with disbelief. The logical hyena, whose jaws crush bones, cackling at every blithe non-sequitur. The creatures here are more congenial: the wombat of complacency, the lemming of hopeful enthusiasm. 'The figures fail to support the hypothesis that psychotherapy facilitates recovery from neurotic disorder' (Eysenck, 1952). 'The only wise course with respect to such a challenge is to ignore it' (Sanford, 1953).

Okay, okay, it hasn't been quite like that. Psychotherapy's best brains have been pitted, etc. An ever-growing accumulation of research data. Smith and Glass, 1977 and years thereafter. Psychotherapy works. In fact *all* the varieties of psychotherapy work … hey wow we chorus, non-competitiveness and pluralism vindicated: let's share some hugs, and then maybe a circle dance …

But not so fast, says the weasel. That 'Dodo bird verdict' (Luborsky et al., 1975) – felicitously so named – 'everyone has won and all must have prizes': isn't there a catch? Indeed, does the psychotherapeutic community's celebration of that result not show up an unnerving intellectual sogginess? Eysenck (inevitably; 1992) argues that, '… if different forms of treatment based on different theories have the same effect, then all these theories must be wrong', and only by the most energetic squirming can the craft avoid being impaled on his kindergarten logic. Three interconnected modes of escape offer themselves:

1. The amusing but implausibly remote possibility that the theories in question are all part-truths of identical validity, so taking equal-sized slices of the therapeutic variance (if that were the case, of course, any form of eclecticism ought to outshine any 'pure' therapy – an unlikely one-up for pluralism);
2. A more sophisticated version of the same – that given the crudity of our conceptual schema, and the (literally) unthinkable complexity of the interactive flux of which psychotherapy and all other human engagements are composed, it may be that the different schools of psychotherapy are in some, at present, ungraspable sense saying the

same thing, and the methods derived from them are doing the same thing;

3. A simplistic and reductionist derivation of (2) is that there might still be some single efficacious nugget or non-specific factor in all psychotherapies – Hanna and Puhakka's (1991) 'resolute perception' of repressed or otherwise warded-off material might be a plausible candidate.

Unless one or other of these somewhat ramshackle manoeuvres can be satisfactorily firmed up, the 'Dodo bird' ('everything works') scenario points very firmly towards a more familiar bunch of non-specific factors: sensitive listening, non-judgmental, encouragement, the ventilation of feeling, and so on. Fine by me, the exclamation resounds – what's so bad about all that?

This. 'Psychotherapy' – it rolls off the tongue; a term with rhetorical leverage, with a big fat claim in it. Of what? Of healing – of quasi-medical skill engendering quasi-medical benefit, of techniques that get results. It might not be unreasonable to propose that the survival of the enterprise, in its current breadth and vigour, and in both its mainstream and alternative branches, depends crucially on just that rhetorical leverage. 'What we do doesn't actually work, in the sense you might expect, but we're jolly good at sensitive listening, encouragement …': try it on BUPA, or a posse of fund-holding GPs in suits – or on some poor right-on scraping along on benefit in the alternative ghetto and making a do-or-die, once-and-for-all attempt to sort her/himself out. (Perhaps I should confess that, like most therapists, I have no doubt that important and uncommon things happen in psychotherapy, that are not explicable in terms of non-specifics or of cognitive-behavioural moves sifting in on the sly; though those 'effects', psychotherapy's real value, lie beyond the quasi-medical, consumerist rhetoric the enterprise has saddled itself with. It makes a difference but not that kind of difference.)

Uncomfortable as it might be, the strong suggestion that psychotherapy doesn't actually work, in the sense its practitioners' various paymasters might reasonably suppose it to, is not its only problem, maybe not even its biggest one.

For whatever doubts there might be about psychotherapy's capacity to do good there can be none about the damage done in its name, or through its exploitative misuse. Jeffrey Masson (1988), of course, goes further, arguing with remorseless documentation that the whole activity is *intrinsically* abusive. His case beats down one's resistance by the sheer cumulative weight of the horrors he recounts (despite, I think, some dodgy logic: for 'psychotherapy' read 'fire' – no catalogue of burns victims adds up to an argument that the stuff should be done away with). At what depth, and with what level of candour, is that case being answered? Is not a major and purgative collective examination of conscience called for, into the insidious way denigration and contempt seep up into therapeutic confrontation, into the way the warm hand of empathy, having

rested reassuringly a while on the young female client's shoulder, is so inclined to slip downward inch by inch? (And for every piece of honest wickedness there is surely a host of micro-abuses, of sneaky little encroachments and belittlings deftly camouflaged and folded into the therapeutic mix.) That examination of conscience doesn't seem to be happening; though of course there has been no lack of damage limitation, psychotherapy again distancing rather than engaging in the face of attack – the game-plan, it would appear, is cover your arse, and then call for more therapy (e.g., Sonne and Pope, 1991; Strean, 1993).

Staying on the themes of effectiveness and abuse, by the way, how is it (as Masson points out) that an enterprise whose *raison d'être* consists largely in helping people with their secrets should for so long have missed the biggest, dirties secret of all – the prevalence of child sexual abuse? More than missed it, actively connived in its suppression? And only have started to acknowledge it – and then, of course, to claim it as an area of special, profitable expertise – once the Women's Movement had rubbed it in our faces?

Other questions hover, buzzard-like. Few common threads run through all schools of psychotherapy – indeed the practices covered by the term are so diverse and so weakly related that one of the biggest question-marks hangs over the coherence of the concept itself; using a single term to cover those practices would have the consumer protection people running if you tried it with anything less abstruse. But one common thread is this: all schools assume, explicitly or implicitly, that at least in some circumstances – once our defences have been rolled back, say – we have direct access to what is going on in us, to our emotions, intentions, thoughts (I cite some chapter and verse elsewhere, see King-Spooner, 1990, p.19). It is difficult to imagine a form of therapy where that assumption was ruled out – in which the answers to 'How do you feel?', 'What are you thinking?', could *never* conceivably be given credence in the usual sense, so that not only did the notion of veracity lose its anchorage but so also did that of dissimulation in all its witting and unwitting modes.

But the notion of such introspective access is dauntingly problematic. There is overwhelming evidence that we are often blithely unaware of why we behave in certain ways – evidence that owes nothing to any theory of ego-defence, and a great deal to behaviouristic social psychology (Nisbett and Wilson, 1977). The debate over introspective access has tumbled through the pages of *Psychological Bulletin* and elsewhere for a good few years (e.g., Smith and Miller, 1978; White, 1980, 1988), while in philosophy our commonsense version of the idea has been pretty well cut to pieces (Lyons, 1986). And psychotherapy? How have we been handling the news that one of our foundational premises might turn out to be made of nought? Have whole issues of our journals been given over to the struggle, conferences anxiously convened? Or have we stepped over the whole tiresomely theoretical issue, either in naïve oblivion or with a self-admiring sneer, like a school refuser stepping over an algebra textbook? David Smail, who sees and raises Nisbett and Wilson (Smail, 1984, pp. 65–6) is, characteristically, an exception underlining the rule.

Soaring rather higher on the thermals, perhaps, but with a keen and baleful eye, there is a more recondite consideration. From a social constructionist standpoint, psychotherapy can look like an exercise in cultural vandalism: a blind, virus-like attack on a form of life – represented by the client, however uncomfortably, at the individual level – by an arrogant and deeply fraudulent cultural nihilism; or worse, perhaps, it can be seen as an expeditionary force in the relentless Californication of the world's cultures. Fanon (1967), according to Beveridge and Turnbull (1989, cited in Robertson, 1993) speaks of:

> processes in a relationship of national dependence which lead the native to doubt the worth and significance of inherited ways of life and embrace the styles and values of the coloniser … [It] is through the undermining of natives' self-belief and the disintegration of local identity that political control is secured – a process know as 'inferiorisation'.

One's automatic hand-wringing over the brutalities and inequities of rough working class life, for example; those characteristics are manifested within a (degenerating but still potent) matrix of conviviality and mutual interdependence utterly foreign to the yuppie nomads of the caring profession, whose missionary zeal sees no baby in the bathwater. (I don't claim that all missionary work is essentially malignant, that it gives people a chance the haul back from their cultural matrix is one of psychotherapy's virtues; but it is a virtue saturated with quiet violence, to be pursued cautiously and with sensitivity and regret.)

To repeat: the claim is that psychotherapy's characteristic response to these challenges is the dodoesque one of distancing rather than the more astringent but more foresighted one of engagement. To find support, and in the belief that *Changes* readers have a furtive longing for quantified evidence, I skimmed through all the copies of the *American Journal of Psychotherapy*, the *British Journal of Psychotherapy*, and *Psychotherapy: Theory, Research and Practice* from 1980, the year the second edition of Rachman and Wilson's *The Effects of Psychological Therapy* came out, to late 1993. A dullish penance, but not without its moments of amusement.

Here we go:

Total number of articles: 1857

Articles on outcome research and the question of effectiveness: 13 (0.7 per cent)

Articles discussing the issues of power and abuse: 14 (0.75 per cent)

Articles on the problematics of introspective self-knowledge: 0

Articles on therapeutic cultural vandalism: Ok, I'm joking.

Most of the 27 articles that look at the difficulties in question take, as anticipated, an essentially defensive line – the commonest technique, perhaps, being a cuttlefish-like generation of fog. The odd attempt is made (odd in every sense) to turn apparent difficulties to psychotherapy's advantage (Hynan, 1981). And while there are one or two tries at taking problems face-on they are exceptional, and anyway are limited in scope (Kisch and Kroll, 1980; Strasburger et al., 1992).

The review sections give the same picture. No review of Rachman and Wilson; none of Masson's *Against Therapy*. Five reviews of books which are downright 'anti' or ask seriously awkward questions (I'm afraid I didn't count the total, but it would probably be a hundred times that). The message is slightly ambivalent at one or two points, then, but on the whole we're talking dodo.

But so what, anyway? 'I can't believe that what I am doing isn't right, so I'll follow my intuition and let people who are into that kind of thing sort out the arguments – and if they don't too bad.' Hopeless. That shape on the horizon, it's getting bigger.

The White Dodo waddles back to her nest, crop bulging, eager to rejoin globular nestlings. But in their place there reclines a peculiar four-legged bird, preening its moth-eaten plumage and singing in a low vibratory monotone.

Picture it. One or two scandals, picked up by the tabloids, soul-searching in the *Guardian*. Investigative television: the producer tosses a coin, decides it's going to be an 'anti'. A few Tory rodents waving Masson or Rachman and Wilson in the House, 'cost-effectiveness, manifest superiority of other methods …'; Virginia Bottomley, the Surrey Puma: 'all Health Authorities are urged, pending a full inquiry …'. Psychotherapy could be scoured out of the NHS overnight.

Let us follow that one in. The Inquiry. Decidedly frosty climate; judge leading it an eagle-eyed gerontocrat, deep mistrust of anything beginning with 'psy', more than enough cortex left to laser through the outcome literature, leaving a smoking hole. Several 'sexual misconduct' victims, tears, the judge into fatherly mode: ' … just take your time m'dear …'; one doesn't make it, overdoses the night before, ' … our sympathies extended …' Then a Kleinian, giving a run-down on some background theory; a Jungian, a Reichian. Someone representing an eclectic-integrative-humanistic approach has to be helped from the stand after a tricky four hour cross-examination. A family therapist has difficulty in getting across the thinking behind her use of paradoxical injunction with a multi-problem family: ' … you mean you actually *told* them to … ?' And then the cognitive behavioural folk get a go, incisors gleaming.

The summing up. 'Evidence of damage … unproven value … money changing hands … climate of opinion … public needs to be protected … recommend legislation …'.

We end up operating like hedge priests, making stealthy visits to clients' homes in the guise of central heating mechanics, perhaps, or Liberal Democrat canvassers; estate agents in well-off, trendy areas start adding 'psychotherapist

hole' to the list of a property's attractions. *Changes* goes the way of *Pit Bull News*. Some exemplary sentencing, 'the rule of law … however well-intentioned …'; a new and guileful breed of tobacco baron emerges.

Love your enemies, you need them. The Spirit of the Age is a middle manager with an ulcer and a fraudulently bonhomious handshake. He – oh yes, it's *he* all right – is gradually, inexorably, working his way round all the departments, even the remotest. And when he arrives he'll be asking some pretty searching questions; and, as is the way when the SOA asks questions, the answers will need to be crisp and to the point.

'Can I bite some big pieces out of you please?' says the pig to the dodo, 'Because I'm feeling jolly hungry'.

'Hey, wow, have you got problems' says the dodo, 'hey, c'mon, let's talk about it'.

'Okay' says the pig, 'after dinner'.

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Ron
Cattrall

Live, Direct and Written*

Written accounts of clinical work seem polarized: from the scientific dust of formal journals to the way-out wackiness of New Age newsletters. This article tells it how it is.

Key words: psychotherapy, psycho-speak, National Service Framework, professionalization of experience, Tarot.

'Have you ever tasted your own semen?'

'Errr, no.'

'Why not?'

'Well … '

I was standing in the grounds of a big bin of a mental hospital, Che was towering over me and I am not a small person.

'So you've probably never had oral sex then!' Che pronounced with the conviction of someone who has thought about this kind of issue rather more deeply than a young naive nursing assistant. I pondered this and suddenly I could see what he meant and how he made his interpretation. It was something I just couldn't help but laugh about.

For some reason that I can't fully remember I was supposed to be preventing Che from leaving the hospital; he was fully intent on leaving, but for a while at least both of our intentions were put to one side as we engaged in our conversation. Our talking was live and direct, it was powerfully spoken language that engaged me in the immediacy of the relationship; without using a word of the 'techno-speak' of psychology or philosophy, it involved both.

After talking for half an hour or more, Che put it to me: 'So if I were to do a runner out that gate what would you do?'

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Ron Cattrall retired as a clinical psychologist from Shropshire's Department of Psychological Therapies in 2007.

'I've absolutely no idea,' I replied with complete honesty and a feeling that I didn't really have any desire to stop him if he wanted to go.

'O.K.' says Che, 'let's go,' as he walks us both off back to the ward. I had the feeling he was doing it to do me some kind of favour. I think it was Che who a day or so later took an ambulance and drove away up the motorway with all the lights flashing, and I sadly never saw him again. It would be nice to think he got clear away.

Che was one of many people I met in my year or so working as a nursing assistant, all of whom taught me an immense amount without me realizing it at the time. My wish for him to get away from the hospital was, in hindsight, my wish for him to avoid the horrors that the mental health system did and no doubt still does contain. My story of that year is perhaps typical. I was involved in forcibly holding down a young guy whilst he was injected with Paraldehyde (the stench of the drug still remains in my nostrils), the line of naked women waiting to be washed and talcum powdered, the guy who'd had a stroke and for some inexplicable reason was admitted onto a psychiatric acute admissions ward, the guy who emptied all the ash trays into his pocket so that he could make his own cigarettes from the flakes of unsmoked tobacco: but, like Che, it became time for me to leave. It had occurred to me to pursue a career in nursing, but I couldn't bring myself to be involved in the control and restraint and so, kidding myself that if I could become a clinical psychologist I could make some changes for people, I became one.

Some twenty odd years later some things have changed and I would like to think that I have played some small role in this. What I am still amazed at is the number of people I currently meet who arrive with a belief they are mentally ill, the significance of which usually means they are taking stupefying drugs and use the deadpan language of psychiatry and psychology to describe their experiences and life. It is not that some psychiatrists and psychologists haven't spoken out against or offered alternative understandings to mainstream organic psychiatry or psychology, but medical discourses still dominate mental health within the NHS. It is important that more voices are heard and I have to think why it is that more people do not speak out.

I have been meaning to write something about psychology and therapy for a long time. Indeed I have been involved in a couple of writing groups with the intention of using these to inspire me to write something. I have written pieces, but apart from one published in *Clinical Psychology Forum* (which was a bit of a cheat as it was a transcript of a talk I'd given) most of what I end up writing is in the form of story narrative and rapidly moves away from anything which might resemble acceptable 'article-type psychology'. It is not that I can't write, or indeed that I couldn't write something in the form of 'an acceptable article-type psychology paper', but the truth is that I find most of formal written psychology to be incredibly boring and I find myself facing a huge concrete block/rift valley/some sort of super ego.

When starting out as a psychologist I was much better at relating to people than after I'd been paid a lot more for being one several years later. The problem was I'd had a bit of training and, in addition, read about how successful other people were at doing therapy (which was still mainly referred to as treatment). I was feeling guilt at earning money and tried to alleviate this guilt by seeing more people and by trying to do more. I did still genuinely feel concerned about the way people were abused and manipulated by the psychiatric system and tried to some degree to challenge this, but backed off licking my wounds. I was devastated to see the new breed of manager taking over from administrators. The new managers were often nurses who would, for instance, support a psychiatrist who when faced with a challenge declared he had five degrees whilst thumping whatever table or desk he was sitting at with such force that cups, papers, etc., took flight into the air, over other people offering what I considered a human approach.

If I hadn't been so afraid of my own madness I might have carried on offering overt challenges to psychiatry and other professionally abusive practices, but I was afraid of the monolith of psychiatry, the British Psychological Society, and some vague phantom figure called The Public. In short I never had the courage to write about what was really happening. Let me give an example.

John came to see me on a hot summer day wearing a tweed suit complete with waistcoat and tie. Sitting down crossing his legs rather rigidly in the chair opposite me, his hands clasped tightly together slightly nearer his crotch than his lap, his opening words spoken through a fixed tight smile were, 'I'd like a woman'. Direct and to the point, and I immediately felt my jaw drop and my stomach sink. Still I carried on meeting with John and rapidly read as much as I could about social skills training whilst also talking about his reasons for 'wanting a woman' and gleaning something of his life. He was 32 years old, lived with his mother, had never left the town in which he was born, was fervently religious and found it difficult to talk about any of his feelings as he interpreted these as sinful. Ten sessions later he was still sitting in the chair, smiling the same smile, and saying not much more than he wanted a woman. I was stuck, young enough not to believe I would still be a psychologist when I was forty, felt I ought to follow my instinct, and I had no immediate idea what I was going to do. My office, in a prefabricated building, was about 8' by 10' and was crowded out with two chairs, a desk, a swivel chair and a bookcase. I breathed in as much space as I could and stood up. I started talking to John, I can't remember the exact words; they were something to do with what we'd spoken about for ten hours (yes, I still hadn't learnt that the standard therapeutic hour was actually fifty minutes, which if I'd followed this code of practice would have meant we'd have met for eight hours and twenty minutes). I kept talking, but I'm not sure that the words were important. I walked to the window and looked out before turning and stepping onto the swivel chair, a dangerous manoeuvre as it was old and wobbly. It was only a short step across and up to my desk upon which I could touch the ceiling with the back of my head. John

was watching me with just a smidgen more interest and just a touch less of a fixed smile, which may have been due to the way he had to turn his head upwards and to the side to keep eye contact. I paused for a moment before again following my instinct and stepping onto my bookcase, not an easy thing to do but, being much more nimble and physically balanced than I am now and by supporting myself with one hand on the ceiling, the transition was made. As most mountaineers know it is often not the ascent but the descent that is the hardest part and I remained on the bookcase for a good two or three minutes before negotiating my way back to my seat via the desk. I sat down, asked John if he would like to come next week, arranged an appointment and said goodbye. Next week John arrived dressed in an open neck shirt, rested his hands on his thighs, legs uncrossed and started off by saying 'I think it's time to talk'. Well he said a lot more than that, yet we never ever spoke about that day. (Okay, for those of you who like a happy ending about two years later I heard from the hospital chaplain that he was getting married).

Something significant happened between John and me; for me to write about this event now is totally different from ever considering writing about such an event as a young psychologist. Some of the reasons are obviously connected to how I have personally changed, yet even now I feel cautious in relating this tale and I am tempted to just dismiss it as the antics of a naive psychologist. When I have spoken about this event I am met with a mixed reaction. I am more interested in what it was that stopped me from writing about such things until now. I think it was about being caught between two alternatives; there was the possibility of writing for an accredited journal or writing for something like the then newsletter of the Psychology and Psychotherapy Association. To write for the formal journals meant somehow distorting what happened, to write for the PPA was to place myself alongside such giants as Don Bannister and I really wasn't ready to do that. There seemed to be very little in between the formal mainstream and the radical perspectives of people like Don. I would have to choose between being seen as a radical and possibly labelled as, at the very least, weird, eccentric and possibly mad, or of turning my back on what I was really interested in and what I really did do and conforming to the establishment rhetoric of cognitive-behavioural science.

Whatever the nature of the process that created that divide between radical and conformist is still present today. As a psychologist I can accept that people hold very different views of the world and what life experiences are about, yet the official line is to view – if not judge – these different world views from one stand point. The National Service Framework (Department of Health, 1999) is an example of this. It advocates evidence based practice and talks of Types I-V evidence in a way that places the evidence in a hierarchy of acceptability. Needless to say Type I evidence is defined as 'at least one good systematic review, including at least one randomised controlled trial', and Type V evidence is 'expert opinion, including the opinion of service users and carers'. At the same time the document refers to promoting user views and engaging with

carers. This to me seems hypocritical; give people a say, but don't really listen to what they say; it is to take peoples' life experiences, reify them into Type I evidence then subject the subjects of the research to the reified interpretation; it is a professionalization of human experience. As such, it is all too easy for psychology to be devoid of humour, love, sensuality and a thousand and one other experiences, only to be replaced by violence, anxiety, mental illness, how long it takes a rat to wander (they seldom run) along a T-maze, and why the moon appears to be larger on the horizon than at mid heaven.

If psychology is written and spoken about in a boring, deadpan way then that is what it will prescribe for people in their lives. Many psychologists, counsellors, and psychiatrists describe what they do in terms of helping patients/clients to see their mistaken beliefs, their magical thinking, or accept their mental illness, and yet become totally engrossed themselves by a pack of Tarot cards. Tarot cards *are* more interesting than formalized psychology and psychiatry, and the task of formalized treatments is not to excite people but to tranquillize them. The language of a lot of therapy, psychology, and psychiatry does not capture the richness of human experience as it can be experienced.

As psychologists and therapists we are urged to write for formal journals and produce textbooks and not at all encouraged to write using the freedom of our native language. A wonderful piece of writing in *The Birmingham University Newsletter* was well written and persuasive, but it was advocating for people to write in a way acceptable for publication in formal journals. It was using good writing to get people to produce dead writing. There is already far too much deadness and boredom in writing. It is time we try to write more courageously.

There are a number of people who have helped me to write. If, by any chance, any of you are reading this, then thank you. For those of you who can still write, write more; for those of you who haven't yet, give it a go.

Reference

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John Cromby

Depression: Embodying social inequality*

A critical realist social constructionist account of depression that attempts to thoroughly take account of embodiment, materiality and power by drawing on sources including neuroscience.

Key words: critical psychology, disembodiment, materiality, psychopathology, social constructionism

Mainstream psychology is predominantly disembodied, the processes and models it offers as capable of being enabled by silicone and wire as by flesh and blood. Yet this aspect of the mainstream has received relatively little attention from critical psychology, perhaps because critical psychology too is a mostly disembodied affair. For example, social constructionist psychology downplays or ignores the body (Bayer and Shotter, 1998), as do many feminist approaches (Wendell, 1996). When embodiment is omitted materiality also tends to disappear since, phenomenologically, these are dual aspects of a unitary experience. But the omission of both materiality and embodiment makes it impossible to adequately address issues of power. Without some notion of embodied beings whose activities are both enabled and constrained by a material world where resources are both scarce and unevenly distributed, power tends to simply dissolve into the play of discourse (Cromby and Nightingale, 1999).

The omission of materiality and embodiment creates particular problems for critical accounts of psychopathology, which must then proceed as though their focus was simply a discursive form in the DSM, or an iatrogenic arrangement of administrative-bureaucratic-technical practices somehow aimed at 'symptoms' that were immaterial before those very practices created them. This creates a conceptual space where individualised biomedical explanations can thrive since their explanatory force, derived from characteristics of and treatments to the soma, can appear greater by contrast with accounts that

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John Cromby is at the Department of Human Sciences, Loughborough University, Loughborough, UK.

disregard the embodied character of distress. Whilst some especially valuable critical accounts *do* emphasise materiality and embodiment to successfully generate convincing alternatives to the ideology of organic individualism that pervades most psychiatric accounts (Smail, 1984; 1987; 1993), they nevertheless do not specify embodied pathways or mechanisms whereby material environments and subjective experience actually come together.

Attempting to counter these problems, this paper will develop a critical psychological account of depression that is neither disembodied nor immaterial. Depression, here, is understood as a form of distress characterised predominantly by profound and enduring unhappiness. However, discrete psychological diagnostic categories are not reinforced by this description, since there is no suggestion that such experiences are ontologically or experientially distinct from other forms or aspects of distress. The term 'depression' is used only as convenient shorthand for the general class of phenomena addressed; as the account progresses, its nominally psychiatric content is decomposed into a constellation of actual modes of lived subjectivity with societal origins. Two assertions legitimate the account but are not addressed within it. First, that depression and social inequality are associated, and that causation flows from the societal to the individual, from the direction of socio-cultural structures, organisations and practices to the so-called symptoms of individuals (e.g., Fan and Eaton, 2001; Ritsher, Warner, Johnson, and Dohrenwend, 2001; Williams, 1999). Second, that evidence for a causal organic basis for depression predicated upon particular dysfunctions or organic pathologies, is confused, uncertain, and on balance largely inconclusive (e.g., Davidson and Henriques, 2000).

There are two parts to the paper. In the first part a social and embodied notion of subjectivity is compiled using a series of resources framed by a critical realist version of social constructionism; in the second part, this notion of subjectivity is used to develop an alternative account of depression.

Theorising subjectivity

1. Critical realist social constructionism

Social constructionism is an umbrella term describing a variety of approaches that share 'family resemblances' (Burr, 1995) but also differ in significant respects, particularly with regard to their understanding of the relationship between language and other aspects of our world (see Parker, 1998) There are nevertheless some positions that it seems all constructionists, in some form, must share. Most importantly, all social constructionists argue that the world we experience and the people we find ourselves to be are first and foremost the product of social processes: neither God, nor individual consciousness, but society itself is the root of experience, the prime mover. It is primarily the societal reproduction and transformation of structures of meaning, morals and discursive practices that constitutes both relationships and subjectivity. This implies that language, both as the principal carrier of categories and meanings and as the medium that provides much of the raw material for our activity, is central. Language is

understood to be organised into discourses, systems of statements that constitute objects and so call realities into being, making our world into this kind of place rather than that. Discourses organise forms of relating and so produce ways of being human. They define the boundaries of what is legitimately sayable with respect to any given phenomena, and in that way they condition what is actionable between people. And by shaping both what can be said and what can be done, discourses condition what is likely to be *thought*.

In this way, critical realist social constructionism (hereafter, CRSC) posits that discourses are *co-constitutive* of subjectivity. By structuring social interaction, permeating the norms and morals that regulate what can legitimately be said and done by people, discourses come, through socialisation, to structure the subjectivities of individuals. But CRSC also acknowledges that discourses are always already the product of embodied beings in a material world, and so the activities that structure this world are not exclusively discursive. Our embodied practices run alongside our discursive practices, shaping and constraining them at the same time as they enable and facilitate them. On the one hand, then, discourses are constitutive and call realities into being; on the other hand, there are extra-discursive influences that both constrain and enable the discursive constructs we can viably deploy. These extra-discursive influences can be organised into three broad and related categories: embodiment, materiality and power.

2. Shotter's account of subjectivity

John Shotter's work has been central to social constructionist psychology. His is not a critical realist constructionism; Shotter rejects critical realism in favour of a morally contested ontology of embodied intransigences and empowerments. This ontological grounding is nevertheless relatively close to CRSC (Bhaskar, 1993) so that, with additional theoretical work around materiality and embodiment, Shotter's notion of subjectivity can be deployed within the CRSC perspective outlined above.

For Shotter, subjectivity is the outcome of two conjoined processes that dynamically interact and are analytically rather than actually separable. The first is primarily discursive. Shotter calls it 'joint action', and it characterises the ways in which we use discourse to jointly negotiate our moment-to-moment interactions with each other. Shotter emphasises the open-ended character of joint action, which often produces outcomes unforeseen by either participant, and highlights the transformative role of statements and their power to bring into being a changed state of affairs in the world. For example, saying, 'I love you' for the first time, in the appropriate context, radically changes the nature of the relationship within which it is said (Shotter, 1993).

The second process producing subjectivity is called by Shotter 'knowing of the third kind', an 'embodied form of practical-moral knowledge in terms of which people are able to influence each other in their being, rather than just in their intellects' (Shotter 1993, p. 41–2). Here, Shotter is highlighting the role of

feelings in guiding everyday conduct: the ways in which the sense of an interaction or relationship communicates itself, is shared by us in relation to another, not just discursively but also in the embodied feelings we simultaneously experience. Shotter further describes 'knowing of the third kind' as an 'affective attitude', a way of orienting to a person or situation that exemplifies the feelingful quality of that relationship. These feelings include, but are not restricted to, commonly-named emotions like love or fear; some (such as 'gut feelings') are named, but this aspect of subjectivity is rarely examined and we have few terms with which to differentiate its characteristics. It is common to hear people say such things as 'well I just *felt* something was wrong' – but rare to hear them specify the character of such feelings, to describe for example their nature, intensity or location.

So, subjectivity is our sense of who and what we are, constituted of feelings and thoughts that arise from and are embedded within shifting networks of social relationships. The discursive responses and embodied feelings of others (communicated by such means as gesture, posture, tone of voice and facial expression), together with our own discursive activity and embodied feelings, dynamically create the situations 'into which' we must act and through which our subjectivities are continuously dynamically formed and re-formed. To align this account of subjectivity with CRSC we must also theorise embodiment, materiality and power. Materiality and embodiment are addressed next; the influence of power emerges in the subsequent discussion of depression.

3. Accounting for materiality: German Critical Psychology

With respect to subjectivity, we can theorise materiality by borrowing from German Critical Psychology the concept of 'subjective possibility spaces'. German Critical Psychology shares with other theories (e.g., Kelly, 1963) the view that humans live in a fundamentally *anticipatory* relationship to their world: what pre-occupies us is, for the most part, what we think might happen next. In German Critical Psychology, as in constructionism, subjectivity is structured by relationships – it is always simultaneously intersubjectivity, our awareness of the others with whom we share our lives. But subjectivity is *also* structured by the material resources actually available to each individual according to their societal location. Material resources structure subjectivity by providing options that must be considered and assessed, so creating an 'epistemic distance' between subject and object, person and world (in German Critical Psychology this epistemic distance, the necessity of choice provided by a social organisation that liberates individuals from the immediate demands of survival, is an evolutionary precondition for subjectivity in our species). German Critical Psychology describes the range of options available to an individual, the sum total of things they can anticipate, as their *subjective possibility space*. But because material resources are unevenly distributed, there will be variation in the subjective possibility spaces of individuals:

> The life world of the mine owner is literally different to that of the miner … they perform different functions in the division of labour … they occupy different positions in society and thus experience different life situations. This is bound to have significant effects upon subjectivity … [the real, objective, quantitative differences] in their respective life situations are experienced subjectively as distinctly larger or smaller subjective possibility spaces. (Tolman, 1994, p. 113)

So subjectivity is structured by the distribution of material resources, whose character and availability reflect patterns of inequality. The two interacting processes described above, 'joint action' and 'knowing of the third kind', are thus enmeshed in ongoing chains of interpersonal relationships within which materiality is always a factor. To generate a thorough account of subjectivity compatible with CRSC we must now theorise how embodiment and subjectivity are related. Shotter's 'knowing of the third kind' describes the phenomena of subjective feeling with which we must engage: this can be theorised by drawing upon some current work in neuroscience.

4. Accounting for Embodiment: the somatic marker hypothesis

Damasio (1994) describes a neural system that facilitates decision-making in social settings by using acquired repertoires of feelings or somatic feedback. His hypothesis is derived from his work with people with injury to the ventro-medial sectors of the frontal lobes: he has now worked with 60 people with such damage (Damasio, 2002), who all display the same two consequences. First, their emotions are greatly diminished: they are described as lacking in feelings, emotionally unresponsive. Second, they are chronically unable to make decisions in social settings: even simple choices, such as making a doctor's appointment some months hence, are problematic.

Linking these deficits, Damasio suggests that the ventro-medial sector of the frontal lobe is vital to brain systems that bring feelings into consciousness. Feelings, here, are the raw material of bodily states (muscular tension, posture, arousal levels, visceral activity, etc.,) derived from information gathered by the brain to assist in the vital function of homeostasis. Injury to the ventro-medial frontal lobes removes such feelings from consciousness and also impairs the ability to make decisions, suggesting that 'rational' decision-making is already related to somatic feedback. Damasio proposes that through experience we learn to classify some stimuli as positive and others as negative, and this learning includes a somatic component. On future occasions where this learning might be pertinent, the brain calls out patterns of bodily activity consonant with previous experience. When this happens, physiological states previously associated with either positive or negative outcomes get reconstituted to inform decision making as feelings, *somatic markers* which stamp putative options with valences: 'When a negative somatic marker is juxtaposed to a particular future outcome the combination functions as an alarm bell. When a positive somatic marker is juxtaposed instead, it becomes a beacon of incentive' (Damasio 1994, p. 174).

Somatic markers are bodily states called out within streams of interaction and used to weigh alternatives and provide a guide to action. They *do not* make decisions for us, but they *do* accelerate and simplify decision-making by reducing the set of choices that must be considered. They use neural pathways that evolved to facilitate homeostasis and so have an intrinsic bias towards pleasurable bodily states, but their character, for each individual, is derived from that person's particular history of incentives and penalties. As Damasio puts it: 'Somatic markers are thus acquired by experience, under the control of an internal preference system and under the influence of an external set of circumstances which include not only entities and events with which the organism must interact, but also social conventions and ethical rules' (Damasio 1994, p. 179).

Somatic markers have two further relevant features. First, the body proper is sometimes bypassed in 'as-if-body loops', wherein the somatosensory cortex gets organised by the prefrontal cortices and the amygdala to replicate the activity pattern which would have ensued had the body itself been engaged. Such loops cannot exactly copy the bodily state which would have occurred had full-blown somatic markers been engaged, they are an economy of processing forged during enculturation: 'as we matured and repeated situations were categorised, the need to rely on somatic states for every instance of decision-making decreased . Decision-making strategies began depending in part on 'symbols' of somatic states' (Damasio 1994, p. 184). Second, somatic markers can also operate outside of consciousness: although not in principle inaccessible, they simply do not always enter the limited capacity of awareness. This might occur at any time, but may be more likely where faster, more subtle 'as-if body' loops are engaged, or in highly charged or complicated situations where the situated demands of interaction command the full capacity of consciousness. In this way, somatic markers may generate a 'patterned irrationality', responses disjunctive with the present but consistent with aspects of past experience.

It is important to emphasise that whilst the neural system Damasio proposes for utilising somatic feedback to guide activity is biologically endowed, its specific content is, for each person, the outcome of her or his particular personal-social history. Just as the brain's capacity to acquire and use language in no way determines the languages individuals acquire and learn, so the mere existence of the somatic marker system does not determine the patterns of feelings it generates. Experience, not biology, is the determinant here. Adding Damasio's hypothesis to the resources already deployed therefore allows us to theorise a thoroughly embodied subjectivity that is simultaneously both relational (located in and formed through ongoing relationships) and material (structured and informed by the material resources available to the person). Combining these various resources yields a hybrid view of subjectivity as simultaneously constituted by discursive, material and embodied process: these processes work together to *co-constitute* subjectivity. Such a notion of subjectivity can facilitate a thoroughly critical account of embodied experiences and their

relationship to material factors; in this way, then, the effects of power can be made apparent. To illustrate, this notion of subjectivity will now be integrated with a psychosocial transactional account of depression.

Theorising depression

Wiener and Marcus (1994) examine discursively structured variation in social practices within Western culture. They identify transactional patterns with potentially harmful consequences, and suggest that such patterns might account for contradictions in the diagnostic criteria for depression. They describe three social transactional scripts (Helpless-Helpful, Powerless-Powerful and Worthy-Worthless) that, if they predominate during socialisation, might generate three distinctive ways of being in the world that psychiatrists would categorise uniformly as depression. These scripts characterise patterns of 'concurrent, interdependent, mutual activities' (Wiener and Marcus, 1994, p. 217). They are called transactions, rather than interactions, to emphasise their focus upon people acting collaboratively, not sequentially or independently. The Helpless-Helpful script characterises experiences wherein individuals gain recognition and reward for positioning or describing themselves as inferior and incapable. The Powerless-Powerful script characterises experiences where individuals are rewarded for placating others and ingratiating themselves, and the Worthy-Worthless script characterises experiences where individuals gain rewards for apologising and deploying self-deprecating discourses. Individuals socialised within families or settings where any one of these three scripts predominated might agree with statements such as 'I can't make decisions at all any more' (Beck, 1967), but for each individual *the meaning of their agreement would differ*. Persons socialised within the Helpless-Helpful script would mean something like 'I don't know how to manage responsibility'; those from the Powerless-Powerful script 'I am not permitted to make meaningful decisions'; and those from the Worthy-Worthless script 'I am not good enough to make decisions' (see Wiener and Marcus, 1994, p. 223).

By integrating these scripts with the notion of embodied subjectivity developed earlier, we can develop an account of depression that recognises its societal origins at the same time as it accounts for its embodiment within individuals. Over successive social interactions, discourses seen to have legitimacy and utility will get taken up by individuals to order and understand their own experiences. In settings characterised by the transactional scripts Weiner and Marcus describe, legitimated discourses will consistently invite persons to understand themselves as helpless, worthless or powerless, and consistently make germane dimensions of efficacy, power and self-worth. Alongside these discourses, and reinforcing devalued subject positions within them, will be affective flows or repertoires of feelings. In Damasio's terms, transactions discursively structured by these scripts will generate corresponding patterns of somatic markers. These somatic markers may influence subsequent activity by attaching negative or low values to options sensitively intertwined

with self-image, or by making choices which would affirm personal worth, power or efficacy *feel* impossible. Self-constructions derived from experience of such transactions will gain salience because of these associated somatic markers, which will typically be called out in social settings where discourses of power, efficacy or self-worth are deployed. Somatic markers will condition the positions individuals 'unthinkingly' occupy *within* these discourses, whilst simultaneously re-emphasising the continued relevance of the discourses themselves. Their (sometimes covert) operation helps explain the relative intransigence of unhappiness and shows how the experience of powerlessness, for example, is much more than just a discursive construction. Alongside its discursive aspect, powerlessness acquires an embodied, feelingful character composed of facial expression, posture, gaze direction and duration, breathing, head inclination, muscle tone, and less visible characteristics such as visceral and blood vessel activity.

The acquisition of such somatic markers could potentiate further trajectories of social transaction wherein power becomes salient. People who construct and display themselves as powerless (however unwittingly) may invite responses from others that accord with their self-construction. Such responses will increase for them, through rehearsal and reflection, the salience of the 'powerless' mode of relating and being. Additionally, because of the hyper-relevance power might thereby acquire, such individuals may sometimes perceive abuses of power where no abuse was intended. All these trajectories could further embody 'powerlessness' as a mode of being, each successive transaction wherein it is conspicuous increasing the probability of future salience. A vicious spiral may ensue: transactional scripts and social practices generate somatic markers and discursive repertoires, which in turn make further disempowering transactions and self-perceptions more likely.

Wiener and Marcus relate these transactional scripts to contradictions in the diagnostic criteria for depression, suggesting that each produces subtly different patterns of 'depressive symptomatology' that the unitary diagnostic category must contain:

> an individual who reports depressed mood … manifests psychomotor retardation, reports low energy, hypersomnia and weight gain, is diagnosed with major depressive syndrome, as is an individual with psychomotor agitation … insomnia, weight loss, feelings of worthlessness and indecisiveness. Although these people do not share a single action in common, and in many respects appear to be behavioural opposites, both are identified as belonging to the same diagnostic category. (Wiener and Marcus, 1994, p. 219)

Psychiatry sometimes acknowledges such variation (e.g., Tyrer, 2001) but does not routinely theorise its occurrence, implicitly ascribing it to variations in underlying biomedical pathology. In contrast, by combining these transactional scripts with the constructionist notion of embodied subjectivity outlined above, we can generate a psychological account that recognises this variation, locates

its origin in modes of socialisation, and systematically associates it with distinctive patterns of 'depressive symptomatology'

For example, for individuals whose maturation was typified by the Helpless-Helpful script, most possibilities could *feel* unavailable because of somatic markers that evaluate the person as globally incapable in relation to them. Apathy and listlessness could ensue, accompanied by excessive sleeping and weight gain due to decreased activity. Conversely, if it *feels* that all possibilities threaten further invalidation or denigration, because of somatic markers acquired in settings where power or self-worth were consistently at stake, then agitation and defensiveness might be more likely, alongside insomnia, restlessness and consequent weight loss. Difficulty concentrating or deciding is a prominent feature in many people's experience of profound unhappiness. This could be the product of somatic markers that evaluate *all* options as similarly negative, unavailable, dangerous or difficult, markers that position the person as powerless, worthless or helpless in relation to all thinkable possibilities. Such persons would be attempting to decide without effective somatic guidance: consequently, rational consideration would be laborious, time-consuming and difficult, and the acts of choosing *feel* either impossible or irrelevant. Somatic markers that position individuals as worthless, helpless or powerless within relevant discourses might also underpin other features of depression listed in DSM-IV and ICD-10, including: a perceptual bias toward negative events; negative views of world, self and future; excessive guilt; inability to experience pleasure; irritable mood; anxiety and apprehension.

The focus on depression might make this sound like a deterministic process, but it has to be emphasised that society is an open system, and that meanings are negotiated through these transactional scripts rather than determined by them. The open-ended character of the social interactions mediated by these conjoined discursive and neural processes inevitably creates contingency and variation, so that embodied subjectivity is always open to tangent or change. The intrinsic indeterminacy of social interaction, emphasised by Shotter, means that alternate trajectories can always emerge. Consequently, the vicious spiral into unhappiness does not occur for everyone who experiences adverse life events or unhelpful transactional scripts, because the causal associations between societal forces, situated transactions and modes of subjectivity are *necessarily* probabilistic rather than deterministic.

However, it must also be emphasised that all social transactions necessarily take place between embodied people in specific material settings. Re-introducing the material dimension makes it apparent that whilst societal causation is necessarily probabilistic, social forces are no less causal or influential for that. Interpersonal transactions are always informed by social divisions, for example of gender, class and ethnicity, which also condition the material resources, the choices and possibilities, actually available to participants. Not only do fewer choices impact directly upon subjectivity through the creation of smaller subjective possibility spaces, they may also make it more difficult to avoid

situations where harmful or humiliating scripts are played out. Moreover, there are reasons why scripts that position individuals as relatively helpless, powerless or worthless may be more prevalent and legitimate in material settings of relative deprivation. First, the visible contrast between opulence and poverty, between 'conspicuous consumption' for the few and bare survival for the many, may itself provide affordances that give denigrating discourses and practices greater apparent legitimacy. Second, the daily grind of coping with limited material resources may leave deprived individuals with less time and energy to sensitively negotiate the intricacies of their relationships, leading some to favour instead a more controlling discursive style – especially, perhaps, with their children. And third, such scripts may gain material force and legitimacy because of their prevalence in commonly encountered institutional and administrative settings – for example, through their deployment in and around the deliberately humiliating and difficult process of claiming benefits. In short, even though the idealised examples presented here don't make this explicit, the interpersonal is always already societal. Scripts such as those Weiner and Marcus identify always get played out within a broader arena of social divisions and associated material resources that can both structure and reinforce their effects: in this way, we can understand the influence of power upon subjectivity.

Conclusion

This account of depression has numerous advantages over psychiatric accounts. First, it clearly relates depression to social inequality, specifying social and neural processes whereby the two might be related. Second, it provides a coherent explanation for variation in patterns of depressive symptomatology, relating them to variation in the transactional patterns prevalent in the lives of individuals. And third, in recognising that society is an open-ended system, and so the social interactions that mediate the effects of inequality are therefore somewhat indeterminate, it explains why the effects of social inequality do not impact uniformly upon individuals.

This account also has advantages over critical psychological accounts of depression that, typically, do not thoroughly engage with materiality and embodiment. First, jointly including these influences helps to explain the intransigence of depression, since the modes of subjectivity we call depression are not caused and maintained just by faulty cognitions, nor even by ways of talking and relating. They also derive both from material circumstances, and from a socially-conditioned neural system that is itself extra-discursive, producing embodied feelings that run alongside discursive activity but are not reducible to it. Second, theorising the influence of embodiment through acquired somatic markers as a distinct neural pathway whereby depression is created and maintained might help explain the inconsistent efficacy of the various kinds of psychological therapy. This echoes the view that successful therapy is essentially a matter of feelings, and is also consonant with the observation that even though interventions can be helpful, their efficacy is not a matter of

cognitive re-programming: experiences such as depression might be alleviated, but can never be 'unlived'. And third, by including in the account a neural mechanism whereby societal influences can become part of individual subjectivity, it potentially mounts a stronger challenge to prevalent biomedical accounts. For example, it allows for the fact that anti-depressant medication might sometimes 'work' (by operating at the neural level to modify the *feelings* that help to maintain depressive states), whilst clearly demonstrating that that this modification is in no sense the 'cure' for an 'illness'.

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Dave Harper

Psychology and the 'War on Terror'*

Psychological knowledge has been used increasingly in wartime in recent years. This article reviews the evidence for its use in interrogation, surveillance, statistical modelling of suspects and psychological operations and outlines some suggestions for action which might be taken by critical psychologists and others.

Key words: interrogation, fear-generating techniques, psychology and torture

The military uses of psychology

> all knowledge is political and the refusal of politics is a political act (Wilden, 1972, p. xxii).

Some years ago I published a short article on how psychologists had been co-opted into many war efforts (Harper, 1995). I quoted some studies carried out during the Vietnam war – Bourne's (1969) study of stress in US combat troops and Cotter's (1967; 1970) use of ECT without muscle relaxants in a bizarrely horrific reinforcement experiment in a Vietnamese mental hospital. Helen Spandler's recent article highlighted a number of important aspects of the Gulf war: the impact on psychiatric patients in Iraq; the damage done to soldiers and civilians both emotionally and through chemical poisoning; as well as the insufficiency of a narrowly psychiatric response to such issues (Spandler, 2003). In this article I want to update what is known about the use of psychological techniques in interrogation and the uses to which psychological knowledge is put but I want to extend this by looking at how psychology may be used in euphemistically entitled 'psychological operations' not only on the battlefield but also at home in the media. Warfare has, no doubt, always used propaganda to great effect and this is especially so in cultures dominated by modern

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Dave Harper is a Reader in Clinical Psychology and Programme Director (Academic) on the Professional Doctyorate in Clinical Psychology at the University of East London..

communications technology. The attacks in New York on 11 September 2001 were an example of the propaganda potential of military operations as Rampton and Stauber (2003) have argued. In this article though, I will not be focusing on the use made of psychological knowledge by networks like Al-Qaeda. Rather I will be focusing on the use of that knowledge by Western, especially British, governments and organisations. I want to argue that there is a continuum of psychological knowledge used in the current War on Terror: from the extreme of interrogation techniques and battlefield psychological warfare through to more indirect uses in Public Relations campaigns and the use of the media to spread disinformation which has the effect of preparing the public for the ratcheting up of the security state and to gain support for, and undermine opposition to, military campaigns.

Psychology, torture and interrogation

As a result of the War on Terror we have been repeatedly informed that 'the gloves are now off' and this has particular implications for the use of interrogation techniques. At the time of writing there are approximately 660 detainees (including teenagers) held at the US base at Guantanamo Bay in Cuba. They are not considered to be Prisoners of War, but rather as 'unlawful combatants' by the US and the main reason for their being held in Cuba seems to be that their detention on the US mainland would be illegal. At Guantanamo they are regularly interrogated. There are also many detainees held in other countries (e.g., in Pakistan and the Middle East) in similarly unclear legal conditions – the UK currently has a number of detained foreign nationals. There are also detainees held by coalition forces at Bagram airbase in Afghanistan and in many other countries where US and UK intelligence officials are involved in interrogations but with few legal safeguards.

Shallice (1972) has argued that psychologists have a special responsibility for some British interrogation techniques which appear to have been produced by the 'conscious use of available scientific knowledge' (1972, p. 387). These techniques provoked a public outcry when used following a mass arrest by Ulster security forces in 1971. Twelve of 342 arrested men were subjected to several techniques which appeared to serve as pre-interrogation procedures. This included placing a black bag over their heads ('hooding'); being made to stand against a wall with their hands held high above their heads and legs apart for up to 16 hours at a stretch and being deprived of sleep for the first two or three days. In addition, the rooms where the men were left had recorded 'white noise' played in them and the men were made to wear boiler suits (perhaps to reduce tactile stimulation). It was also alleged that the men's diets were severely restricted to occasional administrations of dry bread and cups of water (British Medical Association, 1986, pp. 15–16; Shallice, 1972, p. 388). The British Army termed this 'interrogation in depth' and the methods used (hooding, noise bombardment, food deprivation, sleep deprivation and forced standing positions) were known collectively as the 'five techniques' (Hogg,

2003). At the time, the UK government stated that these procedures were necessary in order to 'provide security for detainees and guards', an 'atmosphere of discipline' and to prevent inter-prisoner communication (BMA, 1986, pp. 15–16). These are exactly the same explanations given by Guantanamo staff. Defence Minister Lord Carrington said the only people subjected to these techniques were 'thugs and murderers' (Hogg, 2003) – echoes of the current situation again: US President George Bush has said that the Guantanamo detainees are 'bad men'. Commenting on the Northern Irish interrogations, Anthony Storr, however, wrote:

> the hooding and the continuous noise were designed not to isolate the men from each other but as a deliberate method of producing mental disorientation and confusion. (BMA, 1986, p. 16)

Despite the fact that both a government and a privy counsellors' majority report recommended the continued use of these techniques, Prime Minister Edward Heath accepted Lord Gardiner's minority report (in which he noted that the 'five techniques' were originally used by the KGB in the 1930s) damning them (BMA, 1986, p.18). This may have been related to the fact that the Irish government was in the process of taking the British government to the European Commission of Human Rights (Hogg, 2003).

The BMA (1986), Shallice (1972; 1984) and Watson (1978) all note that these techniques appeared to have been designed in the early 1960s in the midst of burgeoning sensory deprivation research. Both Watson and Shallice make a direct link between this research and the interrogation techniques. Shallice observes that 'not surprisingly, psychologists, by investigating the nature of brainwashing have improved it' (1972, p. 387). Watson notes that the earliest researchers on sensory deprivation included Donald Hebb of McGill University who was carrying out (classified) work for the Canadian Defense Board (1978, p. 267). Both Watson (1978) and Greenfield (1977) have documented military funding of psychology research not only into sensory deprivation but also into the phenomenon of 'brainwashing' which appeared not to be benign but a way of providing the US military with more effective interrogation techniques. In fact, Greenfield (1977) has illustrated how the Human Ecology Fund was set up and backed financially by the CIA in the late 1950s. Originally organised to finance research into 'brainwashing' at Cornell Medical School, it developed its remit and by 1957 Carl Rogers was on the board of the organisation receiving some grants for his work on psychotherapy. He has commented:

> It's impossible … to realize what it was like in the 1950s. It seemed as though Russia was a very potential enemy and as though the United States was very wise to get whatever information it could about things that the Russians might try to do, such as brainwashing people. (Greenfield, 1977, p. 10)

Others in receipt of Human Ecology Fund grants induded Edgar Schein, Edward Hall, Martin Orne and sociologist Jay Schulman (who was one of only two of Greenfield's interviewees to have received CIA funds unwittingly). Shallice (1984) also includes Erving Goffman in this list. Is this all ancient history? – there seems to be relatively little sensory deprivation or brainwashing research going on today. The links between psychology and the Intelligence Community continue today – the CIA even advertises for social and clinical psychologist posts on its website – but, instead, the techniques studied are of a more high-tech nature. I'll draw on three main examples to suggest that the links between psychology and the military-intelligence-industrial complex remain as strong today: surveillance; statistical prediction of behaviour; and, especially, the development of psychological operations.

Surveillance technologies

Sherrard (1991) investigated why there was so much psychological research done on face recognition and concluded that this was because it was applicable to electronic surveillance techniques. In particular it is directly applicable to Closed Circuit Television surveillance – the UK has the highest density of CCTV cameras in the world. London's Newham Borough Council was one of the first authorities to employ a sophisticated CCTV system called Mandrake, whereby the 140 CCTV cameras are linked to software which can identify faces and compare it to a database of individuals considered to be 'of interest'. Face recognition and 'man-machine interface' (sic) were surpassed by no other research areas in the probability of an individual project receiving funding (80 per cent) according to Sherrard's research based on the 1987 edition of Current Research in Britain/Social Sciences. In addition, the US military are extremely interested in visual cognition, having spent 32 per cent of the 1980s 'Star Wars' Strategic Defense Initiative funding on 'Surveillance, Acquisition, Tracking and Kill Assessment' using parallel distributed processing modelling – another area of research which was mainly supported by military funding (Bowers, 1990, p. 136). Having encountered political and technical problems this is now enjoying a resurgence with the move to new Missile Defence systems. Shallice (1984) has described the wide variety of psychological research topics that military and security services have funded including interrogation, 'brainwashing', 'mind-control', and voice and face recognition. Evans et al. (1991) detail an enormous amount of military-funded research in British higher education including funding of psychology departments. Ackroyd et al. (1977) have described a huge range of repressive techniques many of which are based on psychological theories applied in military and security settings. It is likely that current research draws heavily on psychological knowledge.

Statistical prediction of behaviour

One of the most worrying new technologies is that devised by the Information Awareness Office at the Defence Advanced Research Projects Agency (ARDA)

in the US Department of Defense. Originally called Total Information Awareness it has gone through a number of politically-induced name changes. Next it was called Terrorism Information Awareness and then the program was supposedly cancelled although ARDA's new Novel Intelligence from Massive Data (NIMD) program seems to be a replacement. Goldenberg (2002) notes that the purpose of TIA is to trawl through huge amounts of data on US citizens in order to 'predict potential terrorists by tracking a lifetime of seemingly innocuous movements through electronic paper trails for example academic transcripts, prescription drugs, telephone calls, driving licences, airline tickets, parking permits, mortgage payments, banking records, emails, website visits and credit card slips'. It was run by Admiral John Poindexter who played a central role in illegally channeling funds from Iranian arms sales to Contra guerillas in Nicaragua and was convicted of lying to Congress. Poindexter was forced to resign in August 2003 over another IAO project and Congress has cut the funds allocated to TIA and banned it from focusing on US citizens without congressional oversight (Borger, 2003). Given that previous attempts to block this project have foundered it is likely that it will continue under its new title: NIMD. Of course, the attempted prediction of behaviour through statistical modeling and computations has a long history in psychology and it is, again, likely that this project will be drawing on psychological knowledge. It is interesting that research in surveillance and TIA/NIMD technologies is largely conducted by businesses under contracts to government agencies since this decreases the amount of direct accountability for their work.

Psychological warfare: Information and perception warriors

There is a third main use of psychological knowledge by the security state: the use of psychological operations used in both overt and covert ways. Overtly, the British Army maintains a psychological warfare unit: the 15 (UK) Information Support Group. Its name changed from 15 (UK) PSYOPS Group in order to distance its work from so-called 'black' and 'grey' propaganda operations which it is claimed are 'not practiced today' (Jolly, 2001). It has a permanent staff of eight drawn from three services and a reservist group of 28 people drawn from the media, broadcasting and publishing. It is mainly involved in designing leaflets dropped to enemy troops and setting up radio stations. In March 2003 BBC News online reported that it had set up a radio station in Basra, run by Lt Col Mason, deputy chairman of Choice FM in London. The use of psychological operations by the US military is far more substantial than its British counterparts.

However, alongside these overt and openly reported operations it is clear that there are other more covert uses of psychological operations; propaganda for the citizens of countries sending forces abroad. In *Weapons of Mass Deception* (Rampton and Stauber, 2003) the authors detail a number of these. Remember the story about Iraqi soldiers removing babies from incubators in Kuwait in October 1990? One of the witnesses to the US Congressional Human Rights caucus, Nayirah, a 15 year old Kuwaiti girl, gave tearful evidence about this

but what was not reported at the time was that she was the daughter of the Kuwaiti Ambassador to the US and her evidence had been coached by Lauri Fitz-Pegado, the Vice President of Hill & Knowlton, one of the world's largest PR firms. This company had set up a front organization (a common PR strategy well-known to those observing how pharmaceutical companies set up 'patient's groups' to campaign for a particular company's products) – Citizens for a Free Kuwait – to which the Kuwaiti government channeled $11.9 million in six months (Rampton & Stauber, 2003). PR consultant, John W. Rendon has worked on extensive Iraq-related activities under contract to the Pentagon and the CIA including distributing American flags and the flags of other coalition countries to Kuwaiti residents to welcome coalition troops in Kuwait during the first Gulf War. He has described himself as an 'information warrior' and a 'perception manager'. The Pentagon defines perception management as the combination of 'truth projection, operations security, cover and deception' (Rampton and Stauber, 2003).

One of the main targets of such operations is the public at home in Western countries via the use of the media. One key technique is to get the media to focus on particular stories and to ignore others. John Pilger recently noted how, in the run-up to the recent Gulf War, the media had been distracted by reports of what now appears to be a much-exaggerated threat of Iraqi possession of Weapons of Mass Destruction and thus failed to recall statements like those made by both Colin Powell in February 2001 and Condoleeza Rice in April 2001 that Saddam Hussein had been contained and did not pose an immediate threat (Pilger, 2003). Alongside the publication of official reports it is clear that a more covert PR war has been waged using psychological operations techniques. One example was the February 2003 dossier presented to some journalists in private briefings written by the UK government's Coalition Information Centre headed by Alistair Campbell, then the Head of Communications Strategy at No.10 Downing Street. It was this dossier which unattributably used decade-old research from a PhD thesis obtained off the World Wide Web, strengthened the language to exaggerate the threat and merged it with information from the Intelligence Community. The aim of this was clearly to present 'new evidence' to make the case for stopping the UN inspections conducted by Hans Blix and to enable preparations for war against Iraq. David Cornwell, writing under his pseudonym of John le Carré, notes how successful this campaign was:

> How Bush and his junta succeeded in deflecting America's anger from bin Laden to Saddam Hussein is one of the great public relations conjuring tricks of history. But they swung it. A recent poll tells us that one in two Americans now believe Saddam was responsible for the attack on the World Trade Centre. (le Carré, 2003, p. 20)

It is also clear that the security services regularly hold unattributable briefings with selected journalists about the current threat posed by terrorists in support

of arrests made under current terrorism legislation (Bright, 2002; Cohen, 2002) – at the time of writing there are seven foreign suspects detained in the high security HMP Belmarsh. Rampton and Stauber note how the chief Nazi propagandist Hermann Goering described that a population could be incited to support war:

> … the people can always be brought to the bidding of the leaders. That is easy. All you have to do is tell them they are being attacked and denounce the pacifists for lack of patriotism and exposing the country to danger. It works the same way in any country. (p. 137)

It is interesting that many psychological operations at home are conducted by PR agencies. Whilst these may employ psychologists we can see that the use of psychological knowledge is more subtle – it may be drawn on to construct more effective messages in order to have psychological effects (e.g., to support military operations) but be used by anyone. In this context what, as critical psychologists, can we do? I think we should begin by taking these techniques seriously, analyzing them within their political and cultural context, understanding their functions and effects and resisting them either by co-opting them or by exposing them.

Resisting psychological operations I: Cultural and political analysis—the promotion of fear of the other as a justification for defensive and offensive operations

In his analysis of Cold War rhetoric, Kovel (1986) argued that, by projecting hostile intent onto other nations, it helped sustain the military/industrial complex and the nuclear state. This effect can be seen more generally, thus, in his history of MI5 Bernard Porter (1992) noted that accounts of IRA bombing campaigns seemed to 'justify the role of MI5 and the Special Branch' (p. 200). Indeed, with the demise of the USSR as a threat to national security, terrorism has become the officially recognised priority of British security services (Norton Taylor, 1993; Rimmington, 1994). Post-September 11 the Security State has grown massively. For example, the number of UK Special Branch officers (police officers with responsibility for security, intelligence, subversion and terrorism) has gone from 1,638 in 1978 to 2,220 at the beginning of the 1990s to at least 4,247 by February 2003 (Statewatch, 2003). A recent BBC TV series *TrueSpies* revealed how many of the stories previously seen as paranoid (e.g., surveillance of trade unionists and peace campaigners) turned out to have been more accurate than previously supposed.

Fear-generating processes also have consequences at a more domestic level. For example, Lopez (1991) has described how the cultivation of fear has led to the militarization of everyday life, with increasing emphasis on personal security and safety leading to political conservatism. Such a context can lead to the dominance of a 'text of fear' which then organises the experience of life, with people increasingly retreating to the private space of home, guarded by the

technology of the security industry (Lopez, 1991). This has a number of effects which are both economic (witness the growth in personal and home security alarm systems) and cultural (with society becoming dominated by suspicion and observation – the development of *Neighbourhood Watch* schemes in the UK is symptomatic of this). Noam Chomsky has made a similar point in a comment on the US international War on Drugs policy:

> The more you can increase fear of drugs and crime and welfare mothers and immigrants and aliens and all sorts of things, the more you control people. Make them hate each other, be frightened of each other and think that the other is stealing from them. If you can do that you can control the people. (Noam Chomsky in López et al., 1996, p. 14)

Adam Curtis' excellent 2002 BBC2 series *The Century of the Self* illustrated the extent of co-operation between big business and the new profession of Public Relations – founded in the US by Sigmund Freud's American nephew Edward Bernays, drawing on many of his uncle's insights. Curtis' thesis was that, in an affluent West, people no longer consumed out of need – instead corporations decided to sell by capitalising on people's desires and so we saw clever PR practitioners linking images of smoking with liberation: for example, cigarettes became 'torches of freedom' for women. Of course, this can also work by playing on people's fears. In his 2002 film, *Bowling for Columbine*, Michael Moore pushes this further by arguing that there is a link between the promotion of fear and consumer Capitalism. In other words, fear sells.

If fear-generating techniques are used in times of relative peace, they become much more overt in times of conflict – we have only to look at the kind of language used. Thus Billig (2001) has noted how the language of war was quickly mobilised in the US immediately after the World Trade Centre attacks as a way of attempting to categorise the incomprehensibility of the events. The Bush administration has intentionally drawn on dichotomous rhetoric – attempting to draw a dividing line between 'us' and 'them'. Ironically the rhetoric of Al-Qaeda follows a similar pattern. Cronick (2002) has shown rhetorical similarities between the rhetoric of George Bush and Osama Bin-Laden: the creation of a dichotomy between 'them and 'us'; the creation of a homeland; winning the approval of the audience; and citing the support of religious texts and God.

Resisting psychological operations II: Action strategies

Having developed an analysis of the context and effects of psychological operations what positive action can be taken? In one interview Sheldon Rampton has suggested a number of effective counter-strategies: to understand how propaganda works; to seek information from a wide variety of sources (and not just a narrow diet of mainstream media); and not to simply be passive recipients of the media but to actively engage in the real world and in active means of communication like debate and dialogue (Rampton, 2003). To this end I have

listed below a variety of websites that aim to provide a wide variety of information on: abuses of human rights; the security state; the Gulf War; propaganda; and campaigning organizations in which critical psychologists might wish to be involved. To Rampton's list one might add the need to reveal and question the implicit assumptions underlying political discourse. It is also important to delineate the networks of power and interests at work influencing governmental policy (see, for example the work of the Oxford Research Group) and to organize education and action campaigns against those networks. Within the discipline of psychology we can seek to influence journal editorial policies so that authors are required to state any interests or funding involved in their studies.

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World wide web links

Amnesty International: http://www.amnesty.org/

BBC TV True Spies website: http://news.bbc.co.uk/1/hi/programmes/true_spies/default.stm

Disinfopedia: http://www.disinfopedia.org/

The Fire this Time: http://www.firethistime.org/

Information Warfare Site: http://www.iwar.org.uk/psyops/

International Committee of the Red Cross: http://www.icrc.org/

Medical Foundation for the Care of Victims of Torture: http://www.torturecare.org.uk/

Oxford Research Group: http://www.oxfordresearchgroup.org.uk/welcome.htm

PR Watch: http://www.prwatch.org/

Privacy International: http://www.privacyinternational.org/

Psychologists Acting with Conscience Together (PsyAct):

http://www.vanderbilt.edu/community/psyact/

Psychologists for Social Responsibility (PsySR): http://www.psysr.org/

Psychology and peace issues: http://groups.yahoo.com/group/papcar

Scientists for Global Responsibility: http://www.sgr.org.uk/

Statewatch: http://www.poptel.org.uk/statewatch/

Guy
Holmes

What is Called Thinking?*

This article explores what it is we call thinking and the role of thinking in therapy.

Key words: consciousness raising, Heidegger, cognitive therapy

After nine months of weekly psychotherapy, out of the blue a man I had been seeing said: 'You know, you really make me *think'* . One year later, after we had brought our sessions to an end, the same man wrote to let me know how he was getting on. Amongst the stories of the ups and downs of his life, he said: 'I still have my thinking time every Wednesday morning. Thank you for helping me get a new life and a new way of thinking.' This was not a cold, emotionless, intellectualising man; he was full of passion, frequently angry and irritated with lots of people (including me), he often cried during our sessions and at times was so wracked with pain that all he could do was rock backward and forward. His statements made *me* think about what it is people get from psychotherapy and I started to do something that none of my psychology lectures or texts had led me to do, I started to think about what it is to think.

To think is to . . .

Reason, deliberate, rationalise, calculate, problem solve, to work something out. It is also to attend to, pay heed to, have regard to, have the notion of, to bear in mind. It is to consider, meditate, ponder over, to reflect. And to picture in the mind, conceive, create, imagine, to conjure up. All of these words have their own nuances and give a different flavour to what thinking is. Philosophers have defined thinking in a variety of ways e.g., *a process that involves bringing concepts or ideas before the mind* (Descartes and Locke); *a process that constitutes a sequential series of ideas or images in the mind* (Berkeley and Hulme); *an activity that employs verbal images in a form of inner speech* (Hobbes) (Hendrick, 1995).

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Guy Holmes is a community clinical psychology working in Shrewsbury, UK and author of *Psychology in the Real World: Community based groupwork.* PCCS Books

These definitions differ regarding whether we think in words or express our thoughts in words, but all of them emphasise that thinking is a process and have at the heart of their conceptualisation the notion of mind. This has been criticised by Ryle (who called this the 'dogma of the ghost in the machine') and the radical behaviourists. For example, B. F. Skinner stated: 'The real question is not whether machines think but whether men do' (Skinner, 1969). However, most people who engage in what we might loosely term psychotherapy tend to accept as given some concept of mind and thinking.

In 1951 Martin Heidegger gave a series of lectures entitled *Was heisst Denken?*, a phrase for which there is no precise translation but means *What is called Thinking*? or *What calls for Thinking?* (Farrell Krell, 1993). In the lectures Heidegger challenged many of the things that people usually call thinking, questioning whether people have indeed learned to think:

> We come to know what it means to think when we ourselves are thinking. If our attempt is to be successful, we must be ready to learn thinking … As soon as we allow ourselves to become involved in such learning, we have admitted that we are not yet capable of thinking. (Heidegger, 1951, in Farrel Krell, 1993, p. 369)

Heidegger holds out some hope, as he feels it is possible to learn thinking, not unlike learning a craft or learning how to shoe a horse, although he does not imply this is an easy thing to do:

> We can learn only if we can unlearn at the same time…we can learn thinking only if we can radically unlearn what thinking has been traditionally. (p. 374)

Is having new ideas or changing our thoughts and beliefs thinking?

In George Orwell's *Animal Farm* the animals, following an impassioned speech from the boar Major, obtain 'a completely new outlook on life' which enables a revolution to take place on the farm. This permits new ideas, previously not possible, to come about and a new manifesto to live by: 'No animal shall ever sleep in a bed'; 'Four legs good, two legs bad'; 'All animals are equal.' Whilst I would not argue that this is a bad thing (some ideologies are better for both individuals and society in general than others), what seems crucial is that none of the animals learn *how* to think: all that has happened is that one set of rules or beliefs has been replaced by another. When the animals start to be exploited by the pigs, who gradually become like the human masters before them, the weaknesses of consciousness raising, adopting slogans and just changing one's beliefs become apparent. One by one the slogans are corrupted – as the pigs take to living in the farmhouse: 'No animal shall ever sleep in a bed with sheets'; when they emerge walking upright: 'Four legs good, two legs better'; and eventually, 'All animals are equal, but some are more equal than others'. The pigs are able to do this because of the power that they can exert over the other animals. Mau said power is at the end of a gun – the head-pig Napoleon has

trained ferocious dogs that terrify the animals not only into obedience, but also into not questioning or thinking. His deputy Squeeler has the power of intelligence and is articulate so is able to twist words and rewrite history persuading the animals to accept the new ideas.

In my opinion, mental health practitioners also frequently exert considerable power in attempts to get their clients to adopt new ways of seeing the world or their problems. Psychiatric diagnoses are proclaimed and frequently not thought about, consequently being both accepted and adopted by clients, not just as descriptions of their psychological states but as explanations of their distress, even though all psychiatric diagnoses as explanations of behaviour are circular and nonsensical. Cognitive therapists and behaviour family therapists provide good examples of how mental health practitioners can get people to change their beliefs, but like all therapies that utilise such techniques, these changes are fragile as they run the risk of being changed by more powerful others. In other types of therapy the power dynamics may be more subtle and the attempts to get people to change their ideas about themselves and the world more gentle, but I would question whether, at their heart, they aim to help people to learn to think.

Another problem with consciousness-raising is that historically it has not only been associated with introducing people to new ideas, but has also consisted of shutting down thinking. Orwell describes this brilliantly in *1984*, where societal control of what can be thought is paramount, and control of language instrumental:

> The object of Newspeak was not only to provide a medium of expression for the world view and mental habits proper to the devotees of Ingsoc, but to make all other modes of thought impossible … it was designed to diminish the range of thought. (p. 305)

One of the party's slogans provides a pertinent warning to therapists regarding their propensity to get people to see the world and themselves a different (i.e. the therapist's) way:

> Who controls the past controls the future. Who controls the present controls the past.

Perhaps learning thinking rather than having new thoughts and beliefs might be a better aim for the therapeutic encounter.

What calls for thinking?

Heidegger said 'science does not think'. He would not have had much regard for evidence based practice either. *Was heisst Denken?* is a critique of what we call thinking, but it also refers to the other meaning of *call* – it asks what calls on us to think? Heidegger believed that:

> We are capable of doing only what we are inclined to do. And again, we truly incline toward something only when it in turn inclines toward us, toward our essential being ... We learn to think by giving heed to what there is to be thought about. (p. 369)

He believed that we incline towards what is thought provoking. What is most thought provoking is what is not being thought about. This is elusive and always withdraws. Heidegger believed thinking involves holding oneself in the draft of that which withdraws.

Stories of scientific and philosophical discovery, which often come during dreams or periods of not consciously and mechanically thinking about a problem, might be more illustrative of what Heidegger calls thinking than the scientific method itself. For example, Bertrand Russell, having stopped pondering and working on a proof of the existence of God, on leaving a tobacconist, threw his tobacco in the air and exclaimed 'Great Scott, the ontological argument is sound!' (Stenfert Kroese, 2001). Ted Hughes' poem *The Thought Fox* (Hughes, 1982), a poem about the creative process, also lends itself to insights about the type of thinking Heidegger describes. In it Hughes describes the arrival of a poem and how it comes not through deliberate conscious visualisation or writing, but through something more mysterious, through something he can only sense:

> Through the window I see no star
> Something more near
> Though deeper within darkness
> Is entering the loneliness

The fox/poem is somewhere both *out there* and *in him*. He senses it getting ever closer, bit by bit, moving quicker and quicker until:

> … with a sudden sharp hot stink of fox
> It enters the dark hole of the head.
> The window is starless still; the clock ticks
> The page is printed.

John Lennon said that many of his songs 'just arrived' in his head. Michael Angelo, when asked was it hard to sculpt the Venus de Milo, is purported to have said: 'No, what was difficult was finding the piece of stone that contained the Venus'. Perhaps most creative acts have this quality, and this comes closer to what Heidegger calls thinking. My own thinking for this paper (and lecture that preceded it) was not only triggered by sitting down and pondering on the subject, reading books, having conversations with others, and the writing/re-writing process. Many of the ideas seemed to come when I was not trying hard to think about the subject, seemed to come from the outside, or from some

outside place inside what might be called me, arriving sometimes with a 'sudden sharp hot stink', sometimes in a more whispery fashion. Holding oneself in the draft of what is thought-provoking, inclines to us and at the same time withdraws, is not easy. For me it often happens whilst walking the dogs. For Wolfensberger, who describes holding things in cubby-holes in his mind, it happens a lot in the shower (Wolfensberger, 1994).

Socrates attempted to hold himself in the draft of thought provoking things by continually asking questions, of himself and others, by never feeling he fully understood anything, and by never giving anything permanence by writing it down. Perhaps therapy can be an arena where such thinking is possible, and perhaps what people may take from therapy might not be a new set of beliefs but a capacity to think in everyday life? Perhaps supervisors and supervisees, in talking about therapeutic work, can also hold themselves in that draft. After all, Heidegger also said:

> What calls on us to think demands for itself that it be tended, cared for, husbanded in its own essential being, by thought. (p. 390)

Defences against thinking

Traditionally psychological theories have conceptualised psychological defences as defences against experiencing painful feelings, and therapies have been aimed at cathartic release or greater connection with that pain. Freud wrote extensively about repression, suppression and other ways of defending against certain memories and childhood fantasies. But these defences and associated problems can also be thought of as defences against thinking (not just against certain thoughts or feeling states). In *Ode to a Nightingale*, Keats said 'To think is to be full of sorrow'. The Depressive Position is aptly named, but Keats seems to be saying so much more than Klein. Poets noted, much earlier than mental health professionals, how people use alcohol – 'Ale man, ale's the stuff to drink/ For fellows whom it hurts to think' (A. E. Houseman, *A Shropshire Lad*). People with obsessions and compulsions and people in manic states have minds that are filled with thoughts but they are not thinking – 'They never taste, who always drink/ They always talk, who never think' (Matthew Prior, *Upon this Passage in Scaligerana*). Dementia can be thought of as a problem in thinking. A woman I sat with in a specialist unit once asked me (about her transport home): 'What time does the bus come?' '3.30', I replied. 'What time is it now?' '3.25', I would reply. We had this conversation over twenty times in three minutes, the only change being when I could gratefully add a minute to the time. Eventually I grasped a capacity to think, and said 'Are you worried that the bus won't come?' to which she replied 'Yes' and started to recount lots of stories about how she had been left stranded in the past and how she feared this again. By 3.30 we were back to our original repetitive conversation, but in the meantime both of us had been able to think; we had held ourselves in the draft of that which withdraws.

R. D. Laing wrote extensively about how the people he met had lost (or never had) the capacity to think, for example:

JILL You think I am stupid
JACK I don't think you're stupid
JILL I must be stupid to think you think I'm
Stupid if you don't: or you must be lying.
I am stupid either way:
To think I'm stupid, if I am stupid
To think I'm stupid, if I'm not stupid
To think I'm stupid, if you don't.
(Laing, 1970, p. 22)

People like Jill have a certain logic and rationality to their thinking, but in Heidegger's frame have not yet learned thinking.

Thinking in therapy and supervision

The education system should be the place where people learn how to think. But people of all ages, from pre-schoolers to university graduates, are being fed (and consequently learn to passively want) facts and knowledge rather than being given a chance to learn how to think. Hours and hours of homework which involves repetitive tasks, such as downloading information from the internet that is later uncritically regurgitated, results in children being denied opportunites to learn to think outside school. I am not arguing that therapists should grab the role of helping people to learn to think from educationalists and others (as they have grabbed the role of offering guidance on how to live from priests). Going to an art gallery might be a more effective way of enabling this process than going to a therapist. It just strikes me that this is one thing that we can try to do with the people that we meet. Therapy has been thought of as a place where people can introject a capacity to bear difficult emotional states. Why can't it be a place where people introject a capacity to think? After all, many of us meet people in quiet rooms without prefixed agendas or a history of relating to our clients in a certain way. Mindful of power differences between ourselves and our clients, we do our best to create an environment where a person feels comfortable enough to 'think aloud'. I agree with Paul Gordon that good therapists, like good poets, need 'an attitude of reverie, a capacity for waiting, for allowing, for not getting in the way of what might emerge … their tasks are to give words what has been wordless' (Gordon, 1999, p. 126). The phenomenological approach involves taking the stance of the sceptic (from *skepticos*, meaning thoughtful, reflective, paying attention to); the sceptic does not diagnose, seek or impart knowledge, but attends to where the shoe pinches (Gordon, 1999). In so doing both therapist and client (or supervisor and supervisee) might thus spend time trying to hold themselves in the draft of that which withdraws, that which is thought provoking, that which inclines towards our essential being, that which calls on us to think.

Heidegger thought it was difficult but possible to think and to 'learn thinking', but then he did spend much of his life in a quiet log cabin in the middle of the Black Forest. Whether such an approach is possible in the 'New' NHS is open to question. Therapists can struggle to find a quiet place to see people, let alone have time and space for thinking. Demands to reduce waiting lists lead to short-term therapy which, however we dress it up, is inevitably more like advice and instruction than help to think things through and to learn how to think. Expectations on us to attend meetings that never involve any reflection or lead to any action, having our minds filled with mindless edicts from senior managers, pressure to focus on risk but not to take risks and ever changing reorganisation all interfere with opportunities to think. Government initiatives like the National Institute of Clinical Excellence, National Service Framework and Best Value are prescriptive and pressure staff to take a textbook approach to 'delivering care'. If staff are not encouraged or able to think or learn how to think, it will be difficult for them to help their clients with this endeavour. Somehow we need to find a little bit of that Black Forest in our work.

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Ron Cattrall 1952–2014

Ron Cattrall died on 10 July, 2014. He had been a mate, provocateur, sage, clinical psychologist, Zen aficionado, artist, psychotherapist, supervisor, Aikido teacher, bus conductor, drummer, computer wiz, accountant, mechanic, colleague, chilli grower, chef … you get the picture. Jung once talked of cutting the bough from underneath the therapist if the relationship isn't nurtured. Ron was one of the boughs on which I have sat for almost thirty six years. We saw each other through some pretty grim times; changes in partners, divorces, deaths of friends, shifting jobs, houses, continents, frankly outrageous escapades where we both inhaled and retirement from many years in the NHS. Ron's retirement was meant to be a time for long hours of drinking in local hostelries, then continuing the evening at home. But the smoking ban put paid to that and the subsequent ban in Spain stopped another move in its tracks. Despite an apparent wildness to Ron, he was a much sought after psychotherapy supervisor and – for some of us – solid as the proverbial rock. He rarely raised his voice, would often listen for long periods only speaking when he felt his contribution might clarify and, if sitting in his kitchen, would only get up to refill people's glasses.

Kevin Sullivan, Ron and I met at interviews for probationer posts in Dorothy Rowe's Lincolnshire clinical psychology department. Duly installed along with another successful candidate and future house-mate of Ron's, Dave Nash, we went about our merry ways learning, sharing lifts to Leicester for the academic teaching and generally working and playing hard. Hours were spent solving the world's problems in the Wig and Mitre (where Steve Baldwin, now also part of the past rather than future, eventually became a companion), or discussing therapy and Psy on the road to Leicester. The Departmental style was therapeutic eclecticism involving Personal Construct Theory, Rational Emotive Therapy, Transactional Analysis and Psycho-analysis. As members of *The Psychology and Psychotherapy Association* both of us sought out some way of escaping the broader *Zeitgeist* of behaviourism and found, in Marcia Karp's Psychodrama School, a method more in keeping with our physical style.

Post-Lincoln Ron moved to Southend and studied for a further post-graduate qualification focussing on the human-computer interface, a discipline that helped him utilise various technologies in later years. From Southend he

joined Miller Mair's Department in Dumfries which lead him to take over the secretarial role in the PPA. Miller's style suited Ron, as did the culture within the department and town.

Then it was time to move again, this time to Shropshire where our friendship now incorporated my role as his boss and sometime clinical supervisor. Ron was enormously valued by the other clinical psychologists and counsellors and made his customary impact in the Central Wrekin CMHT. It was from that post that he retired seven years ago hoping to take up a life of leisure.

We played in two short-lived bands together – WOMM (When Old Men Meet) and Urtalkin. Ron's djembe playing was simultaneously metronomic and inventive, the beat somehow toying with Reggae, Soul and straight 4/4 in the space of a few bars. As in everything he did, he would practice and perfect until he was satisfied. There are numerous rehearsal recordings and two professionally produced CDs that Ron liked less as there had been little room for improvisation.

Ron was a passionate man. The passions were frequently long-lived and easily mistaken for anger. He was capable of dropping his involvement as dramatically as he had previously been engaged. Drumming came, went and returned; during the long initial phase he travelled to the Gambia repeatedly searching for sun and djembes. His fury at the smoking ban was both highly personal and political. He abhorred what is still being done to working class pubs and wrote dozens of letters to his MP and the Department of Health. One memorable response included the line, 'Supporting public smoking is political suicide.' He was a committed drumming teacher, Aikido teacher, psychotherapy supervisor and, for thirty five years a constant in the lives of Kevin and myself. These words in no way do the man justice. Perhaps they will help him live a little longer …

Craig Newnes

For David Smail (1938–2014)

Aged 76, David Smail died on Sunday 3rd of August this year. As co-ordinating editor of *Clinical Psychology Forum* I put together only three special issues specifically dedicated to individuals whilst still with us – one to Dorothy Rowe, one to John Clements, the other to David. Clinical psychologists queued up to write for all three. David, ever modest, was taken aback when his copy came through the letter box. By then he knew how much his work had influenced my roles as writer, editor and Director of Psychological Therapies. Over a whisky in Nottingham we talked a little of how ironic it was that we both emphasized the individual in context but when it came to putting those we admired on pedestals there was no room for all the other factors involved in that elevation. (To add to the irony I had succeeded him as Chair of the Psychotherapy Section of the BPS.) Fluent in French with a rich understanding of philosophers like Sartre and Merleau-Ponty, David would have been admirable if he had never entered clinical psychology.

He trained at Horton Hospital in Epsom and then at Claybury Hospital in Essex and entered my life when he came to speak at Leicester University in the late 1970s. He had been the first editor of the *Psychology and Psychotherapy Association Newsletter* after co-founding the PPA with Miller Mair and Don Bannister. The *Newsletter* became *Changes* which I was asked to edit in 1988 and a few years on changed again to *JCPCP.* Ten years earlier Dorothy had recommended David's *Psychotherapy – A Personal Approach* and some of us in her department became immediate converts. One reading of *PAPA* was that therapists might *attend* more to what patients were actually saying about their lives, a commitment that required months or years of regular meetings rather than quick-fire behavioural or psycho-dynamic constructions. There was something both alarming and humbling about discovering just how many challenges were faced by those in the mental health system. These weren't challenges that therapy could possibly fix.

David was head of clinical psychology services in Nottingham (UK) until 1993 and retired from the NHS in 1998. He held the honorary post of Special Professor in Clinical Psychology, University of Nottingham, from 1979 to 2000.

One role at the university was as part of the student counselling service, a position he likened to being an encouraging dad to young people struggling with being away from home and crushed by the expectation to succeed. He gave up his counselling role when he found himself being kept awake on Sunday nights ahead of counselling sessions on Mondays. It was typical, I think, of David that his caring should lead to sleeplessness. Not content with a life of full retirement he continued to write and was a founder member of the Midlands Psychology Group.

Curiously, in *Forum* and *JCPCP,* I have reviewed all of David's books with the exception of his last – *Power, Interest and Psychology - Elements of a Social Materialist Understanding of Distress*. PCCS Books, 2005. Guy Holmes and I were commissioning editors for the latter. David had left us with pretty much nothing to do. As in in public talks, the text was precise, the humour sardonic and the sources broad; Tolstoy and Jung get three references, Foucault six and Skinner and Thatcher one each (the same number as Hitler, Christ and Toscanini).

The next issue of *JCPCP* will be a tribute to David. This time he won't be around to read it but I shall raise a glass anyway.

Craig Newnes

Further reading

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Book Reviews

Unravel: To unwell and back
Greg Ralls
Vivid Publishing, 2014, Au$24.95
ISBN: 9781922 204639

There is a minor industry in testimonials from psychiatric survivors. They take the form of plays, documentaries, films, books and articles, both academic and populist. Many are critical, some suggest alternatives and few sell many copies. You might speculate that highly personalized accounts of psychiatric treatment, whether couched in terms of outrage or journeys of self-discovery are really only of interest to those close to the writer who are reaching for a way of accounting for madness and the system's response.

Greg Ralls tells a curious tale – of a pretty standard Australian child-hood, adolescence and early adult-hood, followed by break-down, involuntary commitment, diagnosis and a kind of recovery – that gives no clues at all to what the events depicted as late as page 91 (of a 163 page book) were all about. Up until then, 'one of the biggest disappointments' of his life had been missing a Van Halen concert (p. 86). You get the picture. Greg had been a top pupil, played in a band, won an academic award at university and done his fair share of climbing and cycling. He was a fan of Extreme and Van Halen and, no doubt like many of his peers, remains interested in celebrities – to the extent that several pages are devoted to bumping into this or that star and on page 66 he treats the reader to an account of a friend seeing Mel Gibson's dick in a public toilet.

The days leading up to his breakdown were marked by overwork, sleeplessness and (apparently reasonable) fears that a backhoe operator at an excavation site was out to get him. Locking himself in his room Ralls started suspecting surveillance devices and receiving messages through the TV. Not long after he was made redundant and had joined a church. Then, early in 2000 he became convinced that a neighbour had been murdered and was admitted to a psychiatric unit with a diagnosis of paranoid schizophrenia. A month later he was out.

The tale bears comparison with other stories in the same canon. Unlike other authors Ralls seems happy to accept he has a 'condition.' In his case this is treated by six monthly visits to a consultant psychiatrist and, 'taking prescribed atypical antipsychotic medication' – Ablify. Nor does he dispute the diagnosis even though, 'Delusions and hallucinations are thankfully non-existent. There are no voices in my head; in fact I never heard voices' [Rawls thought he could hear the thoughts of others] … 'I happen to be high-functioning and exhibit no noticeable social and occupational impairment'. Ralls might be seen as someone who had a few odd experiences after being exhausted for days while working in a failing industry and then fell foul of a psychiatric system committed to the use of diagnosis, drugs and hospitalization. Unlike many others, he found that system relatively benign,

even while comparing it to a prison. His parents refused permission for him to have ECT and he went on to marry and have a son who he clearly adores. His momentary lapse of reason he puts down to genetic pre-disposition (p. 128); the lapse returned seven years later when, again exhausted by work, he was admitted for a week in the same unit.

It is hard to know who will get much from this account. Ralls reverses the usual style of memoir of this type. Two thirds is about the author's uneventful early life even though the only thing of any real interest to potential readers is his breakdown and treatment at the hands of Psy. Apart from the author's own appeal to 'genetic predisposition' no theory is presented to explain his collapse. Nor is there any acknowledgement that the theory is spurious – easily dealt with by suggesting that some people have 'genetic predispositions' to believe theories like this with no need of evidence. The theory gets him off the hook of course but, actually, Ralls did nothing *wrong* to get his diagnosis. He just happened to ask for help from people with only one agenda. In his case, it seems to have worked.

Perhaps, it is the mundaneness of Ralls' account that fascinates. An ordinary, if bright, Australian, prone to celebrity-worship and a faith in authority encounters the psychiatric system. Here, a psychiatrist, entirely in good faith and in keeping with professional mores, diagnoses and prescribes a lethal drug. Both participants in the drama collude with the notion that one person is ill and, years on, that person seems back on track. Ordinary and remarkable; it's what makes the world go round (and I bet you thought it was 'Money, money, money.')

Craig Newnes

Breaking Down is Waking Up: Can psychological suffering be a spiritual gateway?
Russell Razzaque
Watkins Publishing, 2014, £9.99
ISBN: 9781780286662

Identity is vital for all human beings. Core roles and relationship, founded on systems of belief, all go to underpin a professional identity, psychiatry not excepted. This book is less remarkable for its content than for being written by a Consultant Psychiatrist, embedded in the NHS. It relates how he listened to the message of his own experience of spiritual opening, arrived at through pursuit of Buddhist mediation practice, in both its disturbing and liberating aspects. Further, he had the courage and humility to hear how his journey related to that of his patients. The implication that their journeying beyond the limitations of rationality and individuality could no longer be dismissed as symptoms of illness, rather recognized as a potential path for growth, must represent a truly Damascene conversion for Razzaque, while resonating with a growing body of opinion (for instance represented by www.SpiritualCrisisNetwork.org.uk, the organization founded to support those on this journey and promote this understanding).

The book needs to be read as a personal journey, and is engagingly written as such. It displays the naivety of the recent convert, blithely unaware of long and rich tradition. Theories and authorities cited, Lukoff, Buddhist and Hindu teachings, Acceptance and Commitment Therapy, bits of quantum physics and Freud, represent signposts stumbled upon by the journeyer seeking meaning in unfamiliar territory, resulting in idiosyncratic conclusions. Classics of spiritual emergency such as Grof (e.g., Grof & Grof 1990), comprehensive contemporary

authorities (e.g., Lucas 2010), the Spiritual Crisis Network, as well as the research strand that compels attention to this perspective (e.g., Brett, Heriot-Maitland & Peters 2013) are nowhere to be found. Instead, we have a personal cobbling together of ideas from the 'signposts' cited above.

That criticism aside, this is a brave and sincere personal testament that makes the case for a holistic revisioning of Psychiatry. I welcome it.

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Isabel Clarke

How Deaf Children Learn: What parents and teachers need to know
Marc Marschark & Peter C. Hauser
Oxford University Press, 2011, £15.99
ISBN: 978019538975-3

The authors aim to present complex information in an easily understandable way, and largely have achieved this. It is refreshing to read a book about such an interesting and complex topic that is not written for a purely academic audience.

The authors provide an overview of the various ways in which deaf children can acquire language, how they learn to read, problem solve and their differences in memory recall compared to children who can hear. Common myths are challenged about deaf children and their acquisition of language and learning processes, including that they are 'not just hearing children who cannot hear'!

In reality, a book could be written about each of the topics highlighted for discussion. The authors have done a great job at condensing huge topics that can be relatively easily absorbed by the reader. Some may consider the information to be overly condensed, but there are sources of extra reading for each area of discussion.

The book highlights some of the changes in our understanding of how deaf children learn, and particularly focuses on the developments in the past 50 years. On a more practical level, it could be used as a guide by parents or teachers in how to give deaf children the best opportunities to learn as much as their hearing peers.

Nikkita Osiadacz

Self-help that Works: Resources to improve emotional health and strengthen relationships
J. C. Norcross; L. F. Campbell; J. M. Grohol, J. W. Santrock; F. Selagea & R. Sommer
Oxford University Press, 2013, £32.99
ISBN: 9780199915156

This fourth edition of an excellent resource presenting a critical review of self-help materials available for a wide variety of problems is aimed at mental health practitioners and the public.

The authors attempt to use their expertise as practitioners and research evidence from twelve US studies to recommend self-help resources, including books, films and online resources. The studies involved surveying a large sample of US psychologists for their evaluation of the resources. In some cases, however, resources were only evaluated by five practitioners, so readers must be wary of

subjectivity of ratings provided.

The book is well organised and easy to read, with problems covered in alphabetical order and resources discussed in order of those strongly recommended, recommended, potentially recommended subject to research evidence and not recommended, with a synopsis of each resource given.

Included is a useful chapter for consumers of such resources to help them select appropriate resources and one for practitioners on how to integrate self-help materials into their approach.

Sadly, online resources were only included if they had been researched meaning that many of these resources originated from academic work. This excludes many potentially valuable resources; such as user-led websites; an oversight, given that many people may seek help online in the first instance.

Overall, this is a thorough and worthwhile guide, which would suit any practitioner working in a mental health setting and would prove a useful reference to consult when working with clients with specific difficulties.

Lucy Leonard

Food and Addiction: A comprehensive handbook
Kelly D. Brownell & Mark S. Gold (Eds.)
Oxford University Press, 2012, £75.00
ISBN: 9780199738168

Sixty-six chapters covering just about everything that academics currently know about the addictive properties of food make this a substantial resource book . Given the dire predictions about the state of the developed world's relationship to food this makes this a timely and in some senses disturbing read. This is not an easy book, covering as it does both the biology and neuropsychology of our addiction to food; it is also an immensely enlightening read. The disturbing aspect of the work relates both to our inbuilt need to consume food, something which separates it from other artificially induced addictions and secondly the powerful addictive pathways that are formed by many unhealthy and heavily promoted types of food. Taking the first point, it is a truism that food addiction is about harm minimisation and healthy patterns of consumption rather than simply saying no. The majority of work around non-food addiction has irrespective of its success rates an abstinence model that clearly works for some and operates as some form of gold standard for those who find themselves dependent upon either drugs or alcohol. This cannot be simply transferred across to food. The second point is that our biology is arguably more primordial when it comes to food. We consume not just to function, but to exist. Add to this a food industry voracious in its search for profits and where the maximum profit is derived from cheap unhealthy food often available on a 24 hour basis, a plethora of contradictory evidence regarding what food is good for us and a pattern of food consumption that is established early in life by significant others and the issue of free will in relation to food becomes somewhat debateable. *Food and Addiction* covers these political questions as well as individual therapeutic approaches to food management both psychologically and pharmacologically and whilst not exactly giving a blue print for change does at least make you think about what is on the end of your fork and perhaps more importantly how it got there!

Robert Hill

Exercise for Mood and Anxiety: Proven strategies for overcoming depression and enhancing well-being
Michael W. Otto & Jasper A. J. Smits
Oxford University Press, 2011, £9.59
ISBN: 9780199791002

It is well known that exercise can be very effective in overcoming depression and helping to relieve anxiety and this book explains why and how to use the approach to the best effect. Exercise might seem like a simple enough solution but of course if it was that easy everyone would be doing it! I know as a practitioner that persuading patients to use this approach is not always as easy as it sounds; this is where this book comes in, explaining how approaching the undertaking is important if it is not to be self defeating.

I always judge a book as successful if I take just one idea and use it repeatedly. For me it is the notion that exercise has to provide an instant reward if it is to be sustained long enough for it to be therapeutic and therefore goals need to be realistic. If the exercise chosen is punishing or makes the patient feel like they have 'failed' then it is counterproductive. There are many more useful ideas here and for anyone who wants to look at the role of exercise in mental health in more than just a superficial, 'oh yeah that's a good idea' way, then this book is for you.

Jean M. Berry

High-quality Psychotherapy Research: From conception to piloting to national trials
Areán, P.A. & Kraemer, H.C. Oxford University Press, 2013 £38.99
ISBN 978-0-19-978246-8

Randomised controlled trials (RCTs) are great, the gold standard of empirical research. The only thing better than RCTs are systematic reviews of lots and lots of RCTs. (So the story goes.) The reader may have noticed that RCTs evaluating CBT for psychosis have been vigorously debated for many months after a review was published in the British Journal of Psychiatry. Maybe not everyone agrees that RCTs are great (disclosure: I have analysed a couple), but I think it's fair to say they are unavoidable whether you are trying to design or demolish them.

High-quality Psychotherapy Research sets out to be a 'practical, step-by-step guide' to designing and running RCTs. So why bother with an RCT? Observational trials, the authors explain, might involve studying participants who choose one of two or more interventions of interest by simply observing how they get on. This is problematic as differences in outcomes might be due to whatever factors led to them ending up receiving an intervention rather than the effect it had. RCTs use randomisation to overcome this problem so that people differ only in terms of the intervention received. That's about it for the 'why': don't expect debate on the epistemology.

The book's strengths emerge as it develops: it catalogues issues that should worry study investigators and the authors draw on their own experience to offer hints. The Delphi consensus-building approach is introduced to solve the problem of developing an intervention manual and examples are given of how to word a letter asking for feedback on the proposed result. Randomisation techniques are introduced including horror stories of how they have gone wrong and invalidated RCTs. Ideas are provided for control groups, e.g., waiting list, usual care, and 'gold standard' controls, and their strengths and drawbacks. The importance of not using pilot study results to determine sample size choices is explained.

Guidance is provided on the people required; for example you need three or more therapists, at least two research assistants in case one takes ill, and a good statistician amongst other people. The Appendix includes a sample budget justification. All practical advice.

The text runs to under 200 pages so this could never be a comprehensive guide to all aspects of RCTs. What this book does do well is provide a systematic menu of options and ideas for things to consider. It might possibly give some ideas of what to demolish too, should you be so inclined, but this book is really only for those who are already sold on RCTs and want to get on with the seemingly painful task of designing and running one.

Andrew J. B. Fugard

Values Clarification in Counseling and Psychotherapy: Practical strategies for individual and group settings
Howard Kirschenbaum
Oxford University Press, 2013, £25.00
ISBN: 978-0-19-997218-0

I was drawn to this book as this is something that is fundamental to Acceptance and Commitment Therapy (ACT), a therapeutic approach that I enjoy using and learning about. After a short history of values clarification, Kirschenbaum considers the seven valuing processes which clarification questions should aim to explore, before presenting a chapter on value-clarification questions in more depth; how they work, what makes a good clarifying question, and examples of questions in different settings. Following this, there is a chapter on the 'clarifying interview', referring to the more lengthy process of determining values, identifying options and problem solving potential means to move towards these values, and finally committing to act in a way to achieve these values. There is a very useful chapter suggesting strategies for values clarification which offers the reader practical suggestions for implementing these ideas in practice. Later chapters consider potential dilemmas that the counsellor may face and potential solutions to these, and how value-clarification may be applied, ranging from human sexuality to supervision, albeit very briefly. The book ends with a brief discussion of how value-clarification fits with different therapeutic approaches as well as theory and research.Overall, the book offers a clearly written and broad consideration of value-clarification, what it means and how it can be applied. In the main, It would be most suited towards either non-mental health settings such as schools, or for therapists who are just starting out and are looking for practical suggestions as to how to help their clients move towards their values and goals. I am not convinced that this would offer many insights for experienced professionals.

Selina Thorrington

Books Received

Readers wishing to review these, or any other books, are encouraged to contact the Joint Book Review Editor – Anne Cooke, Clinical Psychology Training, Salomons, David Salomons Estate, Broomhill Rd., Southborough, Tunbridge Wells, Kent, TN3 0TG. Please note; reviewers keep any volume they review. It is appreciated if reviews are received within two weeks of receipt of the book.

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