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‘You Shall Not Replace Us!’ White supremacy, psychotherapy and decolonisation

Dwight D. L. Turner

SUMMARY: Through the lens of an experiential seminar, this article considers the role unconscious white supremacy plays within counselling and psychotherapy. Offering a plea for counselling organisations to consider whiteness studies as an integral aspect of their trainings, this article sees decolonization as a route towards this, and towards a greater engagement with the other both as trainees and as potential clients.

KEY WORDS: white supremacy, diversity, otherness, othering, decolonisation

Several years ago, I was running an experiential seminar in South East London for psychotherapy trainees. One of the participants was a white middle-class woman of a comparable age to myself. Perhaps because of this personal nature, I found myself being regularly attacked by her. Often, she would interrupt me, make tutting noises when I spoke, or sigh whenever I asked how everyone was. The attacks were also verbal, ranging from being told that I did not know what I was doing, to the fact that I could not possibly be a psychotherapist because I did not look like one, to my making her fearful because I was so aggressive. My every intervention was challenged and undermined, and at times the vitriol aimed at myself was difficult to hold. And yet, during the breaks in the day when

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I would normally sit with myself and ponder my own counter-transferences, I found myself feeling an unbelievable amount of shame; shame for not being right, for not being good enough, shame for not being able to measure up to whatever these students needed from myself.

A few weeks later though, during the next stage, she returned to the group saying that with the help of her therapist she had considered her position in relation to myself. She acknowledged to feeling an immense amount of shame for her actions towards me, acknowledging that her position of privilege and the impact of this upon herself had greatly influenced her interactions with me. Mentally checking in with myself as she spoke, I could feel the shame lift like a morning mist.

Whilst not ignoring the other means of understanding the interactions presented above, this article is based around the fact that for this participant, our racial difference played a major factor in how she treated me as a trainer. And that as this article is based around an exploration of both the conscious and, perhaps more importantly, unconscious nature of white supremacy, this article will explore this immense topic from within a psychotherapeutic paradigm. It also considers that to ignore white supremacy as a factor within psychotherapy out of a fear of political correctness is to force its influence into the shadowy depths of the unconscious. It also recognises that to do so means it will inevitably express itself in microaggressions, passive aggressive slights, and the ignoring of the other be they as trainees, practitioners, or even as theorists of difference who have written about our trade. This article therefore considers some of the colonial roots of racial distancing, how supremacy works as a construct both in the world and within psychotherapy trainings, and the steps psychotherapy would need to take to engage with the racialised other.

White supremacy

As I have discussed in other papers, explorations of race and difference within psychotherapy trainings, and also occasionally in practice as well, can prove problematic because of the struggle of the white majority to acknowledge their own cultural narcissism around difference (Turner, 2009, 2016). This is one of the reasons that potential clients and trainees of colour avoid some trainings or practitioners out of a fear that their difference will not be recognised or respected. For example, I often hear comments from minority students about how they often feel unseen or unheard, and when do find their voice and express their pain and dissatisfaction their invisibility is then pathologized.

One means of understanding these experiences is through the lens of whiteness, and for this article white supremacy. To understand how white supremacy originated in its totality is a longer and more complicated study than I have space for within this article. This does not mean there have not been extensive efforts to discuss this topic though. For example, Biewen (2017), in an excellent series of podcasts, looks at the formation of whiteness from a colonial perspective. Although from an American perspective, this formation of the black race holds echoes and distinct links to those here in the United Kingdom and Europe, his exploration of the many avenues that then led to the construction of the black race as a lesser counterpoint is also well made. His work offers a deep thought provoking explication of just how science, religion, and the political then all function to maintain a sense of white superiority over other races.

This is a point also raised by the British Ghanaian philosopher Appiah (2016) in a series of lectures where he challenges the formation of a racial other as more for the white culture's continued need to define itself against an other, than as a true study of that same other. The importance here is the recognition of the culturally created nature of the racial other, a formulation maintained in the modern era I will argue here not just by the white culture but also by these same racial minorities, echoing Hegel's and Fanon's ideas around the didactic nature of identity and power (Fanon, 2005; Hegel, 1976).

To offer another angle on how white supremacy originated it is also worth returning to the British schooling system, a system dating back a thousand years, and later built to create individuals who were malleable enough to be directed into battle during colonial times. Duffell (2014b) has written extensively about the wounds of those who were educated in boarding schools, and now run our country. His idea, termed the 'entitlement illusion' (Duffell, 2014a, p10) involves shining a light upon a schooling system which encouraged the objectification of the other, and a form of collective personal dissociation which allowed this to flourish. Schaverien (2004, 2011) roots this more within psychodynamic theories, suggesting that the passageway towards privilege was one where attachments were broken early on in life, leaving children with a traumatic wound that often continues into adulthood. This type of education Duffell (2014a) says, means that in the modern era our leaders cannot imagine a type of collective European project. No, they would have to have dominion over it.

This sense of superiority and entitlement though is not just rooted within the upper classes. Given the top-down nature of a good number of cultures in the Global North, this elitism is an aspect of our culture we have often been told to aspire towards achieving. What this means though is that although the idea of an educational system built upon privilege begins with the upper classes, its influence reverberates down through the layers of our differing cultures and societies. For example, through the projection of the American Dream, or the lexicon that immigrants adopt British values, or the valorisation of this same British education system by rich migrants from the former colonies, these speak of the valuing of the 'eliteness' of those who have already gained privilege and authority over the other. It is a system that is so embedded within our cultural education systems that it is only now, over the past hundred years, that university students have begun to regularly complain about the whiteness of the education they receive (Peters, 2015). Even as a transpersonal psychotherapist, during my training the preponderance of white male heterosexual theorists was often an issue raised by the Others within my year. Yet, this challenging of the curriculum was often problematised or pathologized as a negative aspect of the students' psyche.

This issue is so prevalent within our society, and we are so consumed by it, that we rarely question what else might be behind it; it holds elements of Freud's (1930) ideas that culturally many of us literally seek out subjugation by a majority. It is the maintenance of this superiority that the chart below explores further, with the varying levels of white supremacy and privilege. Figure 1, the Triangle of Overt and Covert White Supremacy (Various, 2005), offers a guide to how white supremacy informs the world that cultural others inhabit. It presents both the more overt forms of supremacy, the hatred of the other, and the more covert forms which are more subtle, and are more culturally acceptable, but I would argue inform the painful daily life of the racialised other.

Figure 1: Covert and Overt White Supremacy

For example, in the very last row, Freire (1970) in his excellent work wrote extensively about the White Saviour Complex, presenting it as a form of oppression of the other. In the modern era we see this as much within the need of 'first world countries' to save the rest of the world, and Spivak (1988) in her excellent writings discusses as much where she considers this inherent need within the colonisers to rescue the other. Yet, within psychotherapy trainings we view the wounded healer as being a desirable aspect of the trainee which trainers can hopefully mould into a fully formed psychotherapist, not recognising that is may also hold covert supremacist connotations.

Another example arises out of tokenism. Tokenism in this context becomes the apparent willingness of white cultures to accept the position of the other into their ranks, but without giving the other any real power, or a voice, with which they might effect change. Complaints about the lack of trainers of colour on psychotherapy courses sit within this bracket, as do the complaints of those trainers who are in positions on courses where their own voices are not heard and they occasionally feel marginalised. Often there can be a sense that the other has to be willing to be assimilated into the already established environment. This is problematic as on the one hand it pays service to the politically correct need for a more diverse workforce, even within psychotherapy, whilst on the other there is a refusal to recognise that assimilation is enforced from a position of power (Brubaker, 2001). It is therefore important when hiring through difference as psychotherapists we consider the considerable change that will come with a different perspective, and through the willingness to change in the organisation growth for both parties can occur.

Next, on training courses I often hear the 'we are just one family' line or claims of colourblindness, uttered by students and sometimes trainers, as a means of trying to placate, depress, or dismiss discussions of difference. Often these are presented from a 'well meaning' place within individuals from white culture, but what they unconsciously express is the covert superiority of that person. An excellent way to express this further is by recognising that if the discussion were about some other presentation from our clients, like abuse, issues around sex, or money, that the need to normalise, hide, or generalise the experience would not occur. In fact, it is a cornerstone of psychotherapy trainings that we should look at difficult presenting issues as they may have invaluable information for us about our clients, and also about ourselves as trainees and practitioners. So, returning to my example, whilst others in the group I was running were uncomfortable around discussions of race in the seminar with myself, it felt important for me to do so with the woman who had apologised for her actions as she herself had recognised the impact on her.

The only reason I have not covered more of these examples in this paper is because of a lack of space, but my point is when we consider how many of the more covert supremacist aspects are culturally accepted, we begin to recognise that there is a strong unconscious bias towards the other which holds sway within the world we live in, and therefore also within psychotherapy. The issue now is how is this maintained?

White fragility

One of the standout video clips from the Charlottesville troubles, and others, during August 2017, was the chant 'You will not replace us!" as shouted by a group of supremacists as they marched across the University of Virginia (Vice News Tonight on HBO, 2017). These sorts of demonstrations were not just limited to the US. When Saffiyah Khan stood up to the English Defence League in April 2017, she did so in the face of hostility at her difference (Horton, 2017). On the surface of it, whilst it could be assumed that the Virginia chant is about white American culture's belief in its own superiority, what both examples illustrate is an underlying fear of being supplanted by the other be they cultural, gendered, or otherwise.

Although the fear here is one presented in a more conscious fashion, one that sits at the top of the supremacist pyramid presented earlier, this fear of being supplanted is also an unconscious one. Examples of this emerge out of Mantel's (2017) excellent series of talks, which discusses the rewriting of history as a form of othering. For Mantel, this involves the pluralising of historical narratives to fit modern day sensibilities, or the excluding of characters who might have added much but were now seen as extraneous. Building upon her well-made point, I would though add a pair of important caveats. The first is that this need to change the historical past is also borne out of the difficulty the modern-day hero has with sitting with their previous perceived weakness, a weakness which is really created out of a judgement placed upon our past selves by those here in the present. A perfect example emerges out of the film Dunkirk (Nolan, 2017). Telling the story of the three hundred thousand soldiers who had to flee German occupied France between the end of May and early June 1940, the film has justly been accused of covert racism in its failure to recognise the role in the evacuation of three contingents of the Indian Army Service Corps who also played a significant part in these historical events (Soutik, 2017). This then leads into my second point, that this form of othering is often driven by white culture's struggle to acknowledge its own weaknesses and need for the other.

This contrasts with how minorities use their medias outlets, where there are regular presentations of honest accounts of their suppression and the struggles for equality. For example, the film Milk (Van Sant, 2008) depicts the gay rights struggle of that time, and the television series Roots (Beresford, Carter, Noyce, & Van Peebles, 2016), about the passage through slavery. The experiences of watching often range from painful to harrowing, but these accounts are important for the other in the grounding and recognition of their experiences. The problem with this inability of the white culture to stay with this same sense of reality is that it leads to an avoidance of the truth and an adoption of a supremacist position, a position of superiority over the weaknesses presented both on the screen and then internalised by the watcher.

This fragility in the face of the other is also prevalent within psychotherapy. During a recent seminar I attended on difference and diversity for psychotherapists, one of the three persons of difference in the room spoke up about one of their regular, and often difficult, encounters with racism. After she told her story, one of the white women in the room burst into tears. It is what happened next that interested me most of all, as several other white men and women sided with the woman who was crying, immediately calming her and making everything alright for her, with others speaking angrily to the facilitator accusing her of not doing her job correctly. At this same time, the original woman of colour was just sitting there, alone on her chair, totally ignored by everyone else in the room. The facilitator, with a surprised look on her face, did little to nothing to resolve the situation.

What is interesting about this example, is how the exression of fragility in the white woman led to a backlash against, a silencing and the making invisible of the other. This is cultural fragility at its most potent, a fragility masking microaggressions against the other where they are not seen or acknowledged (Sue et al, 2008; Torres-Harding, Andrade, & Romero Diaz, 2012). Not just in her expression of emotions, but also in her fellow participants' need to rescue her, and also in the impotence of the facilitator to challenge this display. One means of working with this material could have been by challenging the display; by asking all the participants to explore or to sculpt the roles they had adopted, in order for them to recognise just how readily they had disconnected themselves from, and therefore othered, the woman of colour in the room.

I have to acknowledge though, that working with otherness poses distinct unconscious challenges for those from white culture. So, for trainings, trainees and experienced practitioners to underestimate this simple factor, is to leave an enormous blind spot in all our growing cultural awareness. Experiences like this are just one of the reasons why so few persons of colour undertake the challenges of counselling and psychotherapy trainings, as this then leads to the regular complaints I have received from trainees from minority backgrounds about how on their courses, their particular difference was often not acknowledged except in the most perfunctory of fashions.

For white culture, one aspect of their continued conscious and unconscious exclusion of the other emerges out of a fear of the other that is driven by a sense of their own white fragility when faced with the other. Would a greater preponderance of trainers of colour on psychotherapy courses help? Possibly, but it would need for all of them (us) to have considered our own internalised prejudices as well.

It would definitely bring up material about the unconscious supremacist within most trainees, an aspect which could then be worked with. What this cannot be though is another form of the tokenism discussed earlier within this paper. And there would need to be a recognition that, for this to work, that both parties will be changed by the experience.

The challenge here is not an external one where white culture would have to engage with the other, at least not initially. Echoing Bhabha (2004), the fear for the liberal anti-colonial psychotherapist is that it would lead to white culture having to deal with its own cultural shadow; that of its own hatred, denigration, genocidal impulses, suppression, dehumanisation, objectification, and annihilation, of the other. But this leaves one obvious question. How does one do so?

White shame

Returning to the example presented at the beginning of this article, one of the things the participant did want to openly discuss was how her education had influenced her perspectives of difference. From an area of the country with very few minorities, she was sent to a boarding school at 13, an experience she found especially challenging. Yet, although this led to a career path through university and into a well paid career, her sense of the other centred around what she read in the media, and anecdotal conversations with friends. At the end of our time together, several months later, the participant recognised that although not totally rid of her prejudices, I had given her much to consider about how they had come into being.

At the beginning of this article, I located one central root for the creation and maintenance of white supremacy within the educational systems of the UK, and their valorisation by the colonies and other countries in the Global North. To challenge such a system of education is nearby impossible as there not the political will to do so as these schools are financially self-sufficient, thereby removing an enormous financial burden to educate the population from the government (Duffell, 2014a). This then means that the top down nature of Western cultures is never challenged, never observed for its flaws. Yet, one of the more successful aspects of denazification involved its implementation through the German educational system, where to this day the history and the lessons of those two World Wars are taught and absorbed by generations of German children, a whole country building a relationship in stark terms with what would otherwise become its unconscious other.

In a similar vein, psychotherapy at its essence is a relational pursuit based predominantly around the varying relationships with the other (Anderson & Cissna, 1997; Buber, 2010; Hand, 2009; Jacobs, 2003). These may be object relations based, where the learning about the primary other is an emergent theme of coming into life for a baby, or from a more person-centred perspective where the unconditional regard of the other for the client offers a route towards internalised healing. Where both of these positions, and many others, within psychotherapy suggest a humility within the therapist to engage with the client/other, within a post-colonial discourse this offers a different challenge. For a therapist who still holds, even unconsciously as previously explored, the experiences of being superior to the other, there has to be a willingness to recognise their own unconscious racism and to not only witness the pain and destruction wrought by their actions, but also to feel the shame, or even perhaps pride, at the colonial past.

There are post-colonial theorists who have written about this topic. For example, although Dalal (Dalal, 2012) locates his writing around this subject within the dyadic objectification of the other used to create one's own identity, he does though make the interesting point that there needs to be more discourse within psychotherapy about difference and diversity, discussions which would hopefully decolonise the therapist. His paper was written before the behemoth that is White Supremacy reawakened both in the United States and here in Europe. What none of us could have foreseen was the need for writings that challenge the sheer depth of hatred against the other which I am certain many therapists will continue to hold unless processed.

So whilst the need to consciously decolonise psychotherapy in order to make it more amenable to the other is obvious, what is less apparent is how we do this for the therapists themselves (Nakata, Nakata, Keech, & Bolt, 2012; Phoenix, 2009). Considerations of the skills needed will be part of this process in aiding white therapists in accessing their shame, their guilt, or even the acknowledgement of their pride at their colonial past and will be an essential aspect of bringing to the surface the unconscious supremacist, wherever it sits on the triangle presented earlier. Whilst, for trainees from other cultures a close consideration of their unconscious position in relation to the coloniser is just as worthwhile and fruitful allowing them to challenge their own submissiveness perhaps, or retake the unconscious power given away. Creative techniques such as sand play, or gestalt work, when used properly are excellent means of accessing this type of difficult material, both for the psychotherapy trainee and the psychotherapy trainer, as they allow the shame and distress of discovering the supremacist, or the colonised within to be witnessed and held appropriately. This is important as these ways of working are also less likely to result in the repulsive reactivity I witnessed within the seminar discussed earlier within this article, where the supremacy of the 'vulnerable' white woman led to the exclusion of the other both by her peers and by the facilitator.

It would be naïve of me to suggest that decolonising psychotherapy is an easy process. Or that decolonising psychotherapists then leads to numerous apologies for the aggressions, micro, historical, or otherwise, perpetrated against the other. I believe that as we look at the unconscious internalisations within ourselves, this aspect is as important as any other. And challenging the internalised supremacist within therapists should be an essential aspect of their training in order that we all question what we have been left with as an unconscious legacy of colonialism.

Ending thoughts

I mentioned that one of the main complaints concerning why minorities do not engage with psychotherapy is that it is seen as a white, middle class, profession. Clients often hold a sense that should they enter the therapy room they have to leave their cultural difference behind, or that the therapist will not understand them. This plays into the hands of the unconscious supremacist I will argue here, as it is no different from a person of colour having to hide their accent, their Afrocentric name, their blackness, when they are out at work, with friends, or with partners.

In the group example I began this paper with, one means of working with the vitriol aimed at myself could have been by my adapting to the woman and silencing myself, or making myself subservient to her superiority. This would have held echoes of Fanon's (2005) idea where the colonised suppresses its own sense of otherness out of a need to be recognised by the coloniser. Yet I did not, and through not performing for my participant, we both managed to achieve some level of growth; through my supervision, and through her personal therapy. It is this type of adaptation within the psychotherapy room that needs to be recognised and then challenged; where white therapists recognise the unconscious power projected upon them or question the good compliant nature, or the unconscious acting out of the other, for what it could be, their struggle with the supremacy of the therapist.

It is also hugely important for white therapists to do the deep cultural shadow work needed in order to successfully work with cultural difference; where they recognise their own internalised supremacist; where they sit with the upset this aspect probably still causes when they, for example, don't see the other, or perform acts of tokenism; where they learn to recognise the humanity of the other, and their previous dehumanisation of the other, and feel the shame contained therein.

The aim of this article therefore has been to cajole those liberal therapists, trainees or otherwise, into a closer consideration of their own unconscious supremacist in a way which then allows a route for minority clients to also bring these difficult, sometimes taboo, issues into the therapy room. They are major aspects of who we are as clients, as trainees, and as practitioners, and if the only time we feel we can truly breathe is when with clients from our own cultural background, then this cultural shadow will never be challenged.

And it is time we did so.

References

Anderson R, Cissna KN (1997). *The Martin Buber - Carl Rogers dialogue. A new transcript with commentary*. New York, NY: State University of New York Press.

Appiah KA (2016). Mistaken Identities: Creed, Country, Color, Culture. *Reith Lectures*.

Beresford B, Carter T, Noyce P, Van Peebles M (2016). *Roots*. USA: History Channel. Retrieved from http://www.imdb.com/title/tt3315386/?ref_=ttco_ql

Bhabha HK (2004). *Location of Culture*. London: Routledge.

Biewen J (2017). Seeing White (Part 2 How race was made?). Retrieved 20 September 2017, from https://www.acast.com/cdspodcas/how-race-was-made-seeing-white-part-2

Brubaker R (2001). The Return of Assimilation? Changing Perspectives on Immigration and Its Sequels in France, Germany and the United States. *Ethnic and Racial Studies 24*(4): 531–548. https://doi.org/10.1080/01419870120049770

Buber M (2010). *I and Thou*. USA: Martino Publishing Limited.

Dalal F (2012). *Thought Paralysis: the virtues of discrimination*. London: Karnac Books Ltd.

Duffell N (2014a). *Wounded Leaders: British elitism and the entitlement illusion*. London: Lone Arrow Press.

Duffell N (2014b, June). G2: why boarding schools make bad leaders: The elite tradition is to send children away at a young age to be educated. But future politicians who suffer this' privileged abandonment' often turn out as bullies or bumblers. *The Guardian* pp1–5.

Fanon F (2005). *Black Skin, White Mask*. Silverman M (ed). UK: Manchester University Press.

Freire P (1970). *Pedagogy of the Oppressed*. London: Penguin Books Limited.

Freud S (1930). *Civilisation and its Discontents*. London: Penguin Limited.

Hand S (2009). *Emmanuel Levinas (Routledge Critical Thinkers)* (Vol 53). New York, NY: Routledge. https://doi.org/10.1111/j.1468-2265.2011.00689.x

Hegel G (1976). *Phenomenology of Spirit*. USA: Oxford University Press.

Horton H (2017). Saffiyah Khan reunited with woman she stood up for against EDL.

Jacobs M (2003). *Sigmund Freud - Key figures in counselling and psychotherapy* (2nd ed). London: Sage Publications.

Mantel H (2017). *The Iron Maiden*. Retrieved September 28, 2017, from http://www.bbc.co.uk/programmes/b08v08m5

Nakata NM, Nakata V, Keech S, Bolt R (2012). Decolonial goals and pedagogies for Indigenous studies. *Decolonization: Indigeneity, Education & Society 1*(1): 120140.

Nolan C (2017). *Dunkirk* (p1). USA/UK: Syncopy.

Peters MA (2015). Why is my curriculum white? *Educational Philosophy and Theory 47*(7): 641–646. https://doi.org/10.1080/00131857.2015.1037227

Phoenix A (2009). Decolonising practices: negotiating narratives from racialised and gendered experiences of education. *Race Ethnicity and Education 12*(1): 101114.

Schaverien J (2004). Boarding school: the trauma of the privileged child. *The Journal of Analytical Psychology 49*(5): 683–705. https://doi.org/10.1111/j.0021-8774.2004.00495.x

Schaverien J (2011). Boarding school syndrome: broken attachments a hidden trauma. *British Journal of Psychotherapy 27*(2): 138–155. https://doi.org/10.1111/j.1752-0118.2011.01229.x

Soutik B (2017). Does Christopher Nolan's Dunkirk ignore the role of the Indian Army. Retrieved September 28, 2017, from http://www.bbc.co.uk/news/world-asia-india-40724861

Spivak GC (1988). Can the subaltern speak? In *Marxism and the Interpretation of Culture* (pp271–312). https://doi.org/10.1590/S0102-44501999000200012

Sue DW, Nadal KL, Capodilupo CM, Lin AI, Torino GC, Rivera DP (2008). Racial microaggressions against Black Americans: implications for counseling. *Journal of Counseling Development 86*: 330–338. https://doi.org/10.1002/j.1556-6678.2008.tb00517.x

Torres-Harding SR, Andrade AL, Romero Diaz CE (2012). The Racial Microaggressions Scale (RMAS): a new scale to measure experiences of racial microaggressions in people of color. *Cultural Diversity and Ethnic Minority Psychology 18*(2): 153–164. https://doi.org/10.1037/a0027658

Turner D (2009). Strange relationship. *Therapy Today* (December): 26–28.

Turner D (2016). We are all of us Other. *Therapy Today June*(16): 18–21.

van Sant G (2008). *Milk* (p1). USA: Focus Features. Retrieved from http://www.imdb.com/title/tt1013753/companycredits?ref_=ttfc_ql_5

Various (2005). Building a multi-ethnic, inclusive & antiracist organization. Tools for liberation packet for anti-racist activists, allies & critical thinkers. *Safehouse Progressive Alliance for Nonviolence*. Retrieved from https://radicaldiscipleship.net/2017/07/05/white-supremacy-overt-covert/

Vice News Tonight on HBO (2017). Charlottesville: race and terror. Retrieved from https://youtu.be/RIrcB1sAN8I

A Person-Centred Approach to Breaking the Trans-Generational Cycle of Parental Rejection

Tracey Clare

SUMMARY: This article explores the concept of self-worth as related to perceived parental rejection.

KEY WORDS: childhood, core conditions, grief, perceived parental rejection, person centred counselling

Alongside many problems that clients present with can be a lack of self-worth, often stemming from childhood, and a deep-seated sense of feeling rejected by one or both parents. This belief may be based on explicit parental behaviour, condemned as 'abusive' by society, or it may be based on more subtle, implicit behaviour, which only the child was able to perceive. The experience of feeling rejected in childhood spans a continuum, but the documented effects are said to be cross culturally universal.[1] Perceiving parental rejection in childhood can present as a constellation of negative effects throughout the lifespan. An absence, or lack of parental warmth, is frequently at the heart of a client's distress and often, although not always, takes a substantial amount of time in therapy to resolve to any satisfactory degree.[2]

Becoming a parent whilst carrying the burden of unprocessed trauma from perceived parental rejection (PPR), can create a disorganised attachment style in relationship with one's own children, perpetrating a trans-generation cycle of perceived rejection in offspring.[3] Rejection of their own children is often the biggest, and most private fear of clients, who felt rejected by their own parents in

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childhood. Clients strive to make sense of their own childhood experience, often in the context of chaotic relationships with their own offspring. It is suggested that facing these feelings can, however, break this painful cycle.[4]

A psychodynamic approach has traditionally been the 'treatment of choice, in unearthing childhood issues, and establishing an awareness, and thus, enlightenment, in contemporary relationships. Contemporary research widely acknowledges, however, that 'the relationship is the therapy'. My own core model of therapy is the person-centred approach, and in my own experience, as both a client and a practitioner, engagement with this therapeutic model enables facing and processing of such experience, reducing the risk of perpetrating the trans-generational cycle.

Acceptance of a client's experience is at the core of person-centred therapy. This translates in practice to the acknowledgement of the perceived experience of parental rejection, and, crucially, to an acceptance of that experience in its totality. This can be difficult for all sorts of reasons. Perhaps the main barrier to offering total acceptance in a Judaeo-Christian society is the commandment of 'honouring thy father and mother.'[5] We tend to feel ashamed of 'disrespecting' our parents. It is therefore not only clients whom sometimes struggle to bring into awareness repressed feelings towards their parents, but therapists too, who often harbour 'blind spots' in this sensitive arena. To work therapeutically in a person-centred model, it then requires acuity of 'self', to facilitate the state of being fully open to client experience.

Based on ingrained cultural values esteeming parents, we as therapists, then find we are often working with feelings of rejection, complicated by secondary feelings of shame and guilt. Shame and guilt mask 'chronic sorrow', a grief for the parental acceptance, which sadly, never was.[6] Revealing the secondary emotional experience is the key to processing the primary emotion. In person-centred therapy, the client sets the pace of therapy, meaning that the 'gatekeeper' emotions are often the ones necessitating initial working through. This can present as slow, methodical, and repetitive work, as a client attempts to come to terms with their 'betrayal' of an imposed silence. Unpacking the layers, however, is often a vital part of the process, as a client 'dares' to 'speak the unspeakable', giving true voice to a terror of emotional abandonment in childhood.

'Lucy'

A case study is perhaps the best vehicle to study this process, constructed around my phenomenological experience as a counsellor with such a client, whom for this purpose, I will call Lucy.

Lucy was a middle aged, white woman, married with three children. She had grown up in a home characterised by alcohol dependency, and domestic violence.

She was the eldest of four children and had felt responsible for the care of her siblings throughout her childhood. She had also felt responsible for protecting both her parents against the violent behaviour of the other. Her experience of being a child in her home was exemplified by the message ‘children should be seen, but not heard’. She felt that her mother used her as a sounding board about every element of her own life, which included petty crime, and affairs with other men, complete with sexual details. She recognised, however, that her mother had no interest in her, and was privy to maternal criticism and humiliation at every available opportunity, where there was an audience which guaranteed her mother the attention she craved. She grew up feeling ashamed of not only her family but shamed to her core. Neither of her parents ever discussed her future with her or paid any attention to how she performed in school. When she left home at 16, neither parent expressed any interest in maintaining contact with her.

Lucy moved in with a boyfriend who was much older than her, and who drank heavily. He would often bring other girls back to their flat and have sex with them. Lucy felt in a constant state of despair and self-loathing, but felt that she had nowhere to go, and fundamentally, she didn’t believe she deserved any better.

Eventually, her boyfriend got another girl pregnant and Lucy decided to move out. A boy that she knew offered her his couch to sleep on, while she ‘sorted herself out’. Lucy ended up in a relationship with this boy, and again experienced a partnership much like her first. Lucy told me that this boyfriend also ‘dumped’ her when he found someone ‘better’. This time Lucy moved in with a friend from work and had an arrangement whereby she paid rent for her own room. She determined not to enter into a new relationship, but to focus on a promotion at work. She got the promotion, and a year later began a relationship with her manager. She told me that she was not ‘completely happy’ with the relationship, but it was the ‘best’ she could expect and agreed to marry him. She gave up her job when she had her first baby, and then in quick succession, gave birth to two more. She described feeling ‘very depressed’ and ‘trapped’ when her children were young. She said that her husband left the entirety of childcare and housework to her, while he worked, and spent his evenings ‘in the pub with his mates’.

When she came to me for counselling, her children were young teenagers, and she related that her ‘whole world’ revolved around them. She had an inscription of ‘anxiety and depression’, and a prescription for anti-depressant medication. She felt compelled to put the needs of others before her own. In our initial sessions, she was able to articulate that she constantly worried about her relationship with regard to her husband and children, and described feeling inadequate and worthless in comparison to other wives and mothers she knew. It was evident that she did not relate to herself with self-compassion and was highly critical of the shortcomings she told me she possessed. Even though she could speak of the rejection she had experienced in childhood, she told me that she knew that I must think she was 'awful' to betray her parents and say 'bad' things about them. She freely used the labels her parents had given her in childhood to describe herself, with no notion of feeling 'bad' in regard to saying such things about herself. Their words had clearly become internalised and morphed into self-rejection. She spoke of a terror of rejecting her own children and was already racked with guilt about the times she had lost her temper with them. She had not come to counselling out of self-care, but rather out of concern for the emotional wellbeing of her children.

As I tried to understand her attitude to her own life, it became increasingly transparent to Lucy also. She would often verbalise the belief, 'I'm not important, but my children are'. I would try to fully grasp the enormity of that statement by mirroring that back to her, 'You really have no importance as a person, but you strongly feel that your children do'. She told me that she had always felt, and still felt, that she 'didn't matter' to anybody, not even her husband or children. She continued by saying that, 'if I died they wouldn't even miss me'. I said, 'You don't matter, and your family wouldn't miss you if you were dead'. I then witnessed a wave of emotion and sat in silenced as Lucy wailed, witnessing her grief. She then said, 'I never cry – I hate feeling sorry for myself'. This appeared, however, to mark the beginning of a journey of self-compassion, where Lucy was able to get in touch with some sense of sadness for the unloved child, she perceived herself to have been.

I believe that my commitment to both understanding her, and offering her the core conditions of empathy, unconditional positive regard and congruency, encouraged Lucy to get to know herself better.[7] Slowly, Lucy began to challenge the idea that she did not matter, and demonstratively grew in her ability to think about herself as a person with needs, in contrast to a person whose only role was to fulfil the needs of others. In addition, she learned that she had the ability to express her most shameful emotions, and to self-soothe when her emotions became overwhelming.

Lucy began to report an increase in arguments with her husband, and this became increasingly worrying for her. She told me 'I am terrified that he might leave me, and I know that I can't live without him'. She then began to notice that the escalation of arguments was in direct proportion to her willingness to voice her needs in the relationship. She discussed this with him, and he agreed that he was not used to this 'new and assertive' version of his wife. Talking through these trigger points in their relationship curtailed the frequency of their arguments.

Lucy began to notice that she began to enjoy moments of 'happiness' and more 'peacefulness' when spending time in her own company and depended less on spending time with her husband. She told me that this feeling was 'liberating', and that she no longer felt that she 'needed' her husband quite as much. This appeared to have the knock-on effect of enjoying her time with her children, without feeling resentment towards her husband when he chose not to be with them. She told me 'I am beginning to like myself, and I think my children like me more too'. When her husband went away for a golfing weekend, she chose to take the children on a horse-riding holiday. On her return, she appeared invigorated. 'I was so nervous', she said, 'and was petrified of one of them hurting themselves, but they said it was the best holiday they had ever had. I feel like I can do anything now'. Lucy told me that they had spent the evenings playing games and watching films and that they had all grown much closer. She had been touched when they all gave her homemade cards telling her she was 'the best mum in the world'. She told me that she thought they really meant it.

At the cessation of our sessions Lucy was able to report that she felt like she was a 'very good', if not 'excellent' mother. She knew that she was not fully happy in her relationship with her husband and knew that she had to pay close attention to her own needs in that regard. She no longer hated herself for marrying a man she did not really love and could accept that she knew no better at the time. She felt far more accepting of all the mistakes she said she had made, but rather than blame herself, now understood the 'powerlessness' that had engulfed her throughout her lifespan and dictated most of the decisions she had made. Her main learning from our sessions was 'I'm not cut from the same cookie cutter as my parents. I have a choice, and I choose to be different'.

Revaluing ourselves

Lucy came to counselling expecting that I could tell her how to be a better mother. Engagement in a non-directive therapeutic relationship enabled the exploration of her difficult relationship with her parents. Facing her introjected conditions of worth led to the processing of the disenfranchised grief that had dogged her during the course of her turbulent lifespan.

Naming, voicing and experiencing the trauma of perceived parental rejection in childhood, in a person-centred therapeutic relationship, where the therapist is an 'exquisite witness', facilitates the processing and integration of that experience.[8,9] Relinquishing the previously unacknowledged grief of perceived parental rejection would appear to be nurturing. The phenomenological effect of this is a transformative relationship with self, and the shift necessary in breaking the cycle of trans-generational behaviour experienced as rejection by offspring. In coming to know a different self clients can reject ancestral behavioural patterns and familial ways of valuing themselves.

References

1. Rohner RP (2004). The parental 'acceptance-rejection syndrome': universal correlates of perceived rejection. *American Psychologist 59*(8): 830.

2. Joseph S (2016). *Authentic: how to be yourself and why it matters.* London: Piatkus.

3. Solomon JE, George CE (1999). *Attachment Disorganization.* London: Guilford Press.

4. Egeland B, Jacobvitz D, Sroufe LA (1988). Breaking the cycle of abuse*. Child Development* Aug 1:1080–1088.

5. Miller A (2006). *The Body Never Lies: the lingering effects of cruel parenting*. London: WW Norton & Company.

6. Roos S (2002). *Chronic Sorrow: a living loss.* New York, NY: Routledge.

7. Joseph S (2004). Client-centred therapy, post-traumatic stress disorder and post-traumatic growth: theoretical perspectives and practical implications. *Psychology and Psychotherapy: theory, research and practice* 77(1): 101–119.

8. Jeffreys JS (2011). *Helping Grieving People – when tears are not enough: a handbook for care providers.* New York, NY: Routledge.

9. Clare T (2016). Processing perceived parental rejection through personal development. In: Gubi PM, Swinton V (eds). *Researching Lesser-Explored Issues in Counselling and Psychotherapy*. London: Karnac Books (pp93–128).

Do Children Inscribed with 'ADHD' have a Brain Disorder?

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SUMMARY: Contemporary literature is reviewed to determine whether there exists evidence supporting the notion that children inscribed with 'ADHD' have a brain disorder.

KEYWORDS: attention-deficit hyperactivity disorder, ADHD, brain disorder

'Attention-deficit/hyperactivity disorder' is portrayed as a neurodevelopmental disorder (American Psychiatric Association, 2013), even though 'no biological marker is diagnostic for ADHD' (p61). The subjective (eg, 'often talks excessively'; p60) and unreliable (Kirk, Gomory, & Cohen, 2013; Reid & Maag, 1994) criteria used to diagnose 'ADHD' has led critics to conclude that it is not a valid medical syndrome (Breggin, 2013) but rather, 'a grouping of socially disapproved behaviors falsely passed off as a disease' (Joseph, 2006, p246). Despite these criticisms, stimulants are being prescribed to millions of diagnosed children (Zuvekas & Vitiello, 2012), in-part, based on the belief that they have a brain disorder (Timimi, 2009).

Neuroimaging technology cannot aid in the diagnosis of 'ADHD' (Castellanos et al, 2002), and has many limitations (Satel & Lilienfeld, 2013; Reeves, Mills, Billick, & Brodie, 2003; Davatzikos, 2004). Moreover, neuroimaging research appears to have provided little justification for framing 'ADHD' as a brain disorder. For example, Baumeister and Hawkins' (2001) review concluded that 'the neuroimaging literature provides no convincing evidence for the existence of abnormality in the brains of persons with ADHD' (p8). Subsequently, it was reported that most

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studies (eg, Castellanos et al, 1994; Filipek et al, 1997) fail to control for the effects of stimulants (Leo & Cohen, 2003), which have been shown to alter the brain (Breggin, 2013). Cohen and Leo (2004) suggested that to determine the effect of stimulants on brain volume, researchers need simply compare medicated 'ADHD' children to a control group of age- and weight-matched medication-naïve 'ADHD' children. Bush and colleagues (2005) noted that many other factors (eg, caffeine use) are also 'under-studied and often ignored' (p1282), however, they neglected to mention *trauma*; which is associated with 'ADHD' (Ford et al, 2000; Kessler et al, 2010; Read & Mayne, 2017) and can alter the brain (Read, Fosse, Moskowitz, & Perry, 2014). Despite these issues, researchers have reported that 'ADHD' is associated with enlarged hippocampi (Plessen et al, 2006), and volume reductions in numerous other brain regions including the prefrontal cortex, anterior cingulate (Bush, Valera, & Seidman, 2005), caudate, putamen, globus pallidus (Nakao, Radua, Rubia, & Mataix-Cols, 2011), and cerebellum (Valera, Faraone, Murray, & Seidman, 2007). Although, Ioannidis (2011) has exposed considerable bias in the psychiatric neuroimaging literature.

The present review aimed to provide an updated, critical analysis of the 'ADHD' neuroimaging literature, to determine whether the limitations of prior studies (see Leo & Cohen, 2003) remain; or if as suggested by Cohen and Leo (2004), researchers have finally conducted an 'ADHD' neuroimaging study which controls for the confounding effects of stimulant drugs. The review's main conclusion is that defining 'ADHD' as a brain disorder remains unsupported by the evidence.

Review methods

Eligible studies were 'ADHD' MRI studies published since the update (Cohen & Leo, 2004) to Leo and Cohen's (2003) review. Studies needed to include a control group of age- and weight-matched medication-naïve 'ADHD' children, diagnosed using *DSM-IV, DSM-IV-TR*, or *DSM-5* (APA, 1994, 2000, 2013) criteria. Studies that supplied detailed medication histories, included a trauma survey (eg, ACE questionnaire; Felitti et al, 1998), and declared no conflicts of interest, were also preferred.

Review findings

An extensive search of electronic databases (PsychINFO, PsychARTICLES, and Google Scholar) was conducted between April and June 2017 using the following keywords: *attention deficit hyperactivity disorder, ADHD, brain differences, MRI, brain abnormalities, unmedicated*, and *medication naïve*. Forty articles were analysed for relevance, with the five studies that most closely mirrored the eligibility criteria included in the final review (see Table 1 for key details).

Table 1. Key details of five 'ADHD' MRI studies (see appendix for additional information)

Study	***N***	**Diagnostic criteria**	**Reported findings**
Hoogman et al. (2017)	3,242	Not specified	Volumes of several brain regions (inc. hippocampus) significantly smaller in 'ADHD' group
Villemonteix et al. (2015)	77	*DSM-IV-TR*	Never-medicated 'ADHD' children had decreased GM volumes compared to medicated 'ADHD' children and healthy controls. Compared to healthy controls, medicated 'ADHD' children had decreased GM volumes.
Posner et al. (2014)	65	*DSM-IV*	Reduced left hippocampus volumes and connectivity between left hippocampus and orbitofrontal cortex in 'ADHD' cohort compared to controls
Hoekzema et al. (2014)	86	*DSM-IV-TR*	Smaller ventral striatum volumes in medicated 'ADHD' participants compared to medication-naïve 'ADHD' participants
Semrud-Clikeman et al. (2014)	44	*DSM-IV*	Larger frontal, prefrontal, and caudate volumes in 'ADHD' cohort compared to controls

The largest neuroimaging study of 'ADHD,' to date (Hoogman et al, 2017), used data (*N* = 3,242) from the international ENIGMA Working Group collaboration to conduct a cross-sectional 'mega-analysis' comparing MRI brain scans of individuals (age range: 4–63 years) diagnosed with 'ADHD' with a group of undiagnosed controls. The study reported reduced volumes of the accumbens, amygdala, caudate, hippocampus, putamen, and intracranial volume, in the

'ADHD' cohort. However, effect sizes were small (*d* = -0.10 to -0.19), meaning that the mean brain volumes of the 'ADHD' and control group's largely overlapped. Also, only hippocampus volumes were significantly different in adolescents (15–21 years) and no significant differences were observed in adults (>21 years). Despite these small effects, the researchers concluded: 'patients with ADHD have altered brains; therefore ADHD is a disorder of the brain' (p2). This is a faulty conclusion because one cannot infer that *individuals* have disordered brains based merely on mean differences in pooled brain volumes (Corrigan & Whitaker, 2017).

Contrary to Hoogman and colleagues (2017), who observed smaller hippocampi in their 'ADHD' cohort, Posner et al, (2014) found that children diagnosed with 'ADHD' (*N* = 32) had enlarged left hippocampi compared to control participants (*N* = 33). This disparity may be due to the fact that Posner et al. studied medication-naïve participants, exclusively. However, an earlier study of both medicated and medication-naïve participants also reported enlarged hippocampal volumes in children and adolescents (Plessen et al, 2006).

Villemonteix and colleagues' (2015) cross-sectional study obtained MRI brain scans (*N* = 77) from both medicated and medication-naïve children diagnosed with 'ADHD,' and compared them to an undiagnosed control group. The researchers reported that medication-naïve children had decreased grey matter (GM) volumes in the insular and the middle temporal gyrus, compared to the medicated and control cohorts. Additionally, comparisons between the controls and medicated children showed that the latter group had decreased GM volumes in the middle frontal gyrus and in the precentral gyrus.

Semrud-Clikeman et al (2014) compared MRI brain scans from three groups (medication-naïve 'ADHD,' chronically treated 'ADHD,' and control participants) and observed larger prefrontal regions in the 'ADHD' cohorts, regardless of medication history, compared to controls. They also found that medication-naïve children had smaller anterior cingulate volumes compared with other groups. This study is limited by its small sample size (*N* = 44), although previous studies (see Bush et al, 2005) have also suggested that these brain regions contribute to 'ADHD.'

Hoekzema et al (2014) compared the brains (*N* = 86) of medication-naïve 'ADHD' adults, medicated 'ADHD' adults, and a group of control participants, obtained over a 4-year period. Additionally, they acquired scans before and after exposure to methylphenidate in a group of medication-naïve adults and children, diagnosed with 'ADHD.' Medicated 'ADHD' participants (both children and adults) were found to have smaller bilateral striatum volumes, compared to the medication-naïve cohorts. The researchers suggested that this difference may be due to stimulant-exposure rather than being a feature of 'ADHD.' This is a plausible conclusion given the brain changes that can occur whilst consuming stimulants (Breggin, 2013).

Medication

Hoogman et al (2017) categorised participants as either ‘ever’ (>4 weeks) or ‘never’ having consumed medication. This is problematic because the lasting effects of stimulants may vary widely based on ‘treatment’ duration (see Swanson et al, 2017; Breggin, 2013). Villemonteix et al (2015) and Hoekzema et al (2014) provided more detailed medication histories (see appendix), including both duration and dosage estimates; whereas Semrud-Clikeman et al (2014) provided duration but not dosage estimates. All of the participants in Posner and colleagues’ (2014) study were medication-naïve. Hoogman et al, claimed that the brain differences they observed were not caused by medication effects but neglected to report the proportion of adults versus children who were medication-naïve versus medication-exposed. This is a major confound that undermines the authors’ claim; especially given the fact that most of the statistically significant differences were unique to children (<15 years; Corrigan & Whitaker, 2017).

Conflicts of interest

Researchers from three out of five studies (Hoogman et al, 2017; Villemonteix et al, 2015; Posner et al, 2014) reported conflicts of interest; including the principal investigators, Villemonteix and Posner. These conflicts may have influenced study outcomes (Ahn et al, 2017; also see Whitaker & Cosgrove, 2015). Most notably, Hoogman and colleagues declared *over one hundred conflicts* (p9), including speaking fees from pharmaceutical companies, a patent for an ‘ADHD’ drug treatment, and royalties from a copyrighted rating scale used to diagnose ‘ADHD.’ Clearly the researchers stand to gain from the continued diagnosis and ‘treatment’ of ‘ADHD.’

Additional limitations

The studies under review suffer from many other limitations, only a few of which, are mentioned here. Firstly, in Hoogman and colleagues’ (2017) study, the diagnostic criteria were not standardised across the 23 scan sites. Therefore, different sites may have used different classification methods (eg, *DSM-IV*, *ICD-10*) to diagnose ‘ADHD.’ Secondly, none of the studies conducted a survey to control for the potentially brain-altering effects of trauma (Read et al, 2014). Thirdly, none of the studies controlled for participant body-size. Finally, none of the studies reported using a random sampling method – thus, their findings are difficult to generalise.

Inconsistencies and faulty assumptions

The reviewed literature remains hampered by myriad limitations, inconsistencies, and faulty assumptions, which do not justify defining 'ADHD' as a brain disorder. Firstly, all five studies assumed that 'ADHD' is a valid medical diagnosis that can reliably classify individuals. This is untrue (Kirk et al, 2013; Reid & Maag, 1994). Neuroimaging technology cannot distinguish 'ADHD children' from 'typically developing children' (Castellanos et al, 2002), and the use of the *DSM's* subjective criteria render all research in this field inherently confounded. Secondly, although all but one (Hoogman et al, 2017) of the studies directly compared age-matched controls to medication-exposed and/or medication-naïve 'ADHD' participants, none controlled for body size. Therefore, Leo and Cohen's (2003) request for researchers to simply compare age- and weight-matched medicated and medication-naïve 'ADHD' participants appears to remain unmet. Thirdly, three out of five studies (Posner et al, 2015; Villemonteix et al, 2015; Hoogman et al) disclosed conflicts of interest, which may have influenced study outcomes (Ahn et al, 2017). Of the two studies without conflicts, one suggested that stimulants may have caused the observed brain differences (Hoekzema et al, 2014), whilst the other suggested that the differences were not causally related to medication-exposure (Semrud-Clikeman et al, 2014). Even if differences in brain volumes are 'innate' rather than due to stimulant-exposure, there is still no reason to conclude that they represent a brain disorder (Reeves et al, 2003). Functional and structural differences in skilled individuals (eg, pianists; Rubia, 2002, in Leo & Cohen, 2003) and victims of child abuse (Read et al, 2014), have demonstrated the brain's neuroplasticity. Thus, it is not surprising to find differences in brain volumes based on what amounts to differences in behaviour and experience. Moreover, given the absence of recorded trauma histories in the reviewed studies, it's impossible to say whether the purported brain differences are the result of natural variation or adversity (eg, maltreatment). This is especially pertinent, given that trauma is associated with 'ADHD' (Ford et al, 2000; Kessler et al, 2010; Read & Mayne, 2017).

Although this review was limited by its modest scope, it has demonstrated fundamental shortcomings in the contemporary literature whose 'biologic tunnel vision' (Baumeister & Hawkins, 2001, p8) has continued to produce similarly unconvincing results to those of decades-past (Leo & Cohen, 2003). Future studies should include an adverse experiences scale to control for the potentially brain-altering effects of trauma (Read et al, 2014). However, this would not solve the underlying issue with research of this kind, which is that there is no way to objectively distinguish 'normal' and 'disordered' individuals (Kirk et al, 2013).

To summarise …

Millions of children are being prescribed stimulant medication, in-part, based on the belief that they have a brain disorder called 'attention deficit hyperactivity disorder.' Attempts to locate purported abnormalities in diagnosed children's brains have been inconsistent and hampered by confounding variables and other limitations. A review of contemporary neuroimaging studies was conducted in order to provide an updated and critical perspective on the status of 'ADHD' as a brain disorder. An extensive search of electronic databases (PsychINFO, PsychARTICLES, and Google Scholar) between April and June 2017 culminated in the selection of five publications that most closely mirrored the review's eligibility criteria. The reviewed MRI studies do not provide convincing evidence that children diagnosed with 'ADHD' have a brain disorder. The studies were limited by conflicts of interest and the use of invalid and unreliable diagnostic criteria. They also failed to control for the potentially brain-altering effects of childhood trauma. Future researchers should control for this confounding variable by including an adverse experiences scale in their studies. However, neuroimaging studies of 'ADHD' suffer from a more profound issue, which is that researchers are incapable of objectively distinguishing 'disordered' and 'typically developing' children. Until this issue is addressed, all studies of this kind will remain suspect.

References

Ahn R, Woodbridge A, Abraham A, Saba S, Korenstein D, Madden E, Boscardin W, Keyhani S (2017). Financial ties of principal investigators and randomized controlled trial outcomes: cross sectional study. *British Medical Journal 356*(i6770):1–9.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed). Washington, DC: Author.

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed, text revision). Washington, DC: Author.

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed). Washington, DC: Author.

Baumeister AA, Hawkins MF (2001). Incoherence of neuroimaging studies of attention deficit/hyperactivity disorder. *Clinical Neuropharmacology 24*(1): 2–10.

Breggin PR (2013). *Psychiatric Drug Withdrawal: a guide for prescribers, therapists, patients, and their families.* New York, NY: Springer.

Bush G, Valera EM, Seidman LJ (2005). Functional neuroimaging of attention-deficit/hyperactivity disorder: a review and suggested future directions. *Biological Psychiatry 57*: 1273–1284. doi:10.1016/j.biopsych.2005.01.034

Castellanos FX, Giedd JN, Eckburg P, Marsh WL, Vaituzis C, Kaysen D, Hamburger SD, Rapoport JL (1994). Quantitative morpohology of the caudate nucleus in attention deficit hyperactivity disorder. *American Journal of Psychiatr, 151*(12); 1791–1796.

Castellanos FX, Lee PP, Sharp W, Jeffries NO, Greenstein DK, Clasen LS, Blumenthal JD, James RS, Ebens CL, Walter JM, Zijdenbos A, Evans AC, Giedd JN, Rapoport JL (2002). Developmental trajectories of brain volume abnormalities in children and adolescents with attention-deficit/hyperactivity disorder. *Journal of the American Medical Association 288*(14): 1740–1748. doi:10.1001/jama.288.14.1740

Cohen D, Leo J (2004). An update on ADHD neuroimaging research. *The Journal of Mind and Behavior 25*(2): 161–166.

Corrigan MW, Whitaker R (2017). *Lancet Psychiatry needs to retract the ADHD-Enigma study*. (Accessed 27 June 2017) from Mad in America: https://www.madinamerica.com/2017/04/lancet-psychiatry-needs-to-retract-the-adhd-enigma-study/

Davatzikos C (2004). Why voxel-based morpometric analysis should be used with great caution when characterizing group differences. *NeuroImag, 23*:17–20. doi:10.1016/j.neuroimage.2004.05.010

Felitti V, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicin, 14*(4): 245–258.

Filipek P.A, Semrud-Clikeman M, Steingard RJ, Renshaw PF, Kennedy DN, Biederman J (1997). Volumetric MRI analysis comparing subjects having attention-deficit hyperactivity disorder with normal controls. *Neurology 48*: 589–601.

Ford JD, Racusin R, Ellis CG, Reiser J, Fleischer A, Thomas J (2000). Child maltreatment, other trauma exposure, and posttraumatic stress symptomatology among children with oppositional defiant disorder and attention deficit hyperactivity disorder. *Child Maltreatmen, 5*(3): 205–217.

Hoekzema E, Carmona S, Ramos-Quiroga JA, Canals C, Moreno A, Fernandez VR, Picado M, Bosch R, Duno L, Soliva JC, Rovira M, Bulbena A, Tobena A, Casas M,Vilarroya O (2014). Stimulant drugs trigger transient volumetric changes in the human ventral striatum. *Brain Structure & Function 219*: 23–34.

Hoogman M, Bralten J, Hibar DP, Mennes M, Zwiers MP, Schweren LS, van Hulzen KJ (2017). Subcortical brain volume differences in participants with attention deficit hyperactivity disorder in children and adults: a cross-sectional mega-analysis. *The Lancet 4*: 310–319.

Ioannidis JP (2011). Excess significance bias in the literature on brain volume abnormalities. *Archives of General Psychiatry 68*(8): 773–780. doi:10.1001/archgenpsychiatry.2011.28

Joseph J (2006). *The Missing Gene: psychiatry, heredity, and the fruitless search for genes.* New York, NY: Algora.

Kessler RC, McLaughlin KA, Green JG, Gruber MJ, Sampson NA, Zaslavsky AM, Aguilar-Gaxiola S, Alhamzawi AO, Alonso J, Angermeyer M, Benjet C (2010). Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *The British Journal of Psychiatry 197*(5): 378–385. doi:10.1192/bjp.bp.110.080499

Kirk SA, Gomory T, Cohen D (2013). *Mad science: psychiatric coercion, diagnosis, and drugs.* New Brunswick: Transaction.

Leo J, Cohen D (2003). Broken brains or flawed studies? A critical review of ADHD neuroimaging research. *The Journal of Mind and Behavior 24*(1): 29–56.

Nakao T, Radua J, Rubia K, Mataix-Cols D (2011). Gray matter volume abnormalities in ADHD: voxel-based meta-analysis exploring the effects of age and stimulant medication. *Mechanisms of Psychiatric Illness 168*(11): 1154–1163.

Plessen KJ, Bansal R, Zhu H, Whiteman R, Amat J, Quackenbush GA, Martin L, Durkin K, Blair C, Royal J, Hugdahl K, Peterson BS (2006). Hippocampus and amygdala morphology in attention-deficit/hyperactivity disorder. *Archives of General Psychiatry 63*: 795–807.

Posner J, Siciliano F, Wang Z, Liu J, Sonuga-Barke E, Greenhill L (2014). A multimodal MRI study of the hippocampus in medication-naive children with ADHD: what connects ADHD and depression? *Psychiatry Research: Neuroimaging 224*: 112–118. doi:10.1016/j.pscychresns.2014.08.006

Read J, Mayne R (2017). Understanding the long-term effects of childhood adversities: beyond diagnosis and abuse. *Journal of Child and Adolescent Trauma 10* (3), 285–297 doi:10.1007/s40653-017-0137-0

Read J, Fosse R, Moskowitz A, Perry B (2014). The traumagenenic neurodevelopmental model of psychosis revisited. *Neuropsychiatry 4*(1): 65–79.

Reeves D, Mills MJ, Billick SB, Brodie JD (2003). Limitations of brain imaging in forensic psychiatry. *Journal of American Academic Psychiatry & Law 31*(1): 89–96.

Reid R, Maag JW (1994). How many fidgets in a pretty much: a critique of behavior rating scales for identifying students with ADHD. *Journal of School Psychology 32*(4): 339–354.

Satel S, Lilienfeld SO (2013). *Brainwashed: the seductive appeal of mindless neuroscience.* New York, NY: Basic Books.

Semrud-Clikeman M, Pliszka SR, Bledsoe J, Lancaster J (2014). Volumetric MRI differences in treatment naïve and chronically treated adolescents with ADHD-combined type. *Journal of Attention Disorders 18*(6): 511–520. doi:10.1177/1087054712443158

Swanson JM (2017). Young adult outcomes in the follow-up of the multimodal treatment study of attention-deficit/hyperactivity disorder: symptom persistence, source, discrepancy, and height suppresion. *The Journal of Child Psychology and Psychiatry*: 1–16. doi:10.1111/jcpp.12684

Timimi S (2009). The use of psycho-pharmaceuticals to control boys' behaviour: a tale of badly behaving drug companies and doctors. *The Arab Journal of Psychiatry 20*(2): 147–160.

Valera EM, Faraone SV, Murray KE, Seidman LJ (in press). Meta-analysis of structural imaging findings in attention-deficit/hyperactivity disorder. *Biological Psychiatry* Issue? 1–9. doi:10.1016/j.biopsych.2006.06.011

Villemonteix T, de Brito SA, Kavec M, Balériaux D, Metens T, Slama H, Baijot S, Mary A, Peigneux P, Massat I (2015). Grey matter volumes in treatment naïve vs. chronically treated children with attention deficity/hyperactivity disorder: a combined approach. *European Neuropsychopharmacology*. Issue? doi:10.1016/j.euroneuro.2015.04.015

Whitaker R, Cosgrove L (2015). *Psychiatry Under the Influence: institutional corruption, social injury, and prescriptions for reform.* New York, NY: Palgrave Macmillan.

Zuvekas SH, Vitiello B (2012). Stimulant medication use in children: a 12-year perspective. *American Journal of Psychiatry 169*: 160–166.

Appendix – **Table 2.** Extended details of five ‘ADHD’ MRI studies

Study	Sample size and type	Neuroimaging technology	Diagnostic criteria & measures	Medication history	Trauma history	Conflicts of interest	Reported findings
Hoogman et al. (2017)	Study included data from 23 cohorts *N* = 3,242 (1,713 participants diagnosed with 'ADHD'; 1,529 undiagnosed controls) Median age: 14.0 (range 4–63) years.	Structural T1-weighted brain MRI data processed at the 23 sites.	No mention of the specific diagnostic criteria (e.g. *DSM-5*) used, or if the same criteria were used across the 23 sites. At 4/23 sites, no symptom scores are listed for the 'ADHD' cohort (Corrigan & Whitaker, 2017)	No dosage information given Participants described as either 'ever' (>4 weeks) or 'never' having been exposed to medication	None reported	Yes >100 conflicts disclosed	Volumes of the accumbens, amygdala, caudate, hippocampus, putamen, and intracranial volume significantly smaller in individuals diagnosed with 'ADHD'
Villemonteix et al. (2015)	*N* = 77 Aged 7.3 – 12.9 (*M* = 10.2) 'ADHD' cohort (*N* = 53) Control group (*N* = 24)	High-resolution, 3D T1-weighted structural scan using a 3 T Philips Achieva MRI scanner	Kiddie Schedule for Affective Disorders and Schizophrenia for School Aged Children-Present and Lifetime Version (K-SADS-PL) used to diagnose 'ADHD' based on *DSM-IV-TR* criteria. 'Symptom' severity measured using the 'ADHD' rating scale parent form.	Long-term stimulant use (*N* = 20) Dosages: between 0.3 and 0.5 mg of methylphenidate per kilo (per dose, three times a day) for a minimum of one year (medication duration: >one year, 11 children; >2 years, 7 children; 3-4 years, 2 children) Never medicated (*N* = 33)	None reported	Yes 2 researchers (including principal investigator) reported financial ties to Shire Company.	Never-medicated children diagnosed with 'ADHD' had decreased grey matter (GM) volumes in the insular and the middle temporal gyrus, compared to medicated 'ADHD' children and healthy controls. Compared to healthy controls, medicated 'ADHD' children had decreased GM volumes in the middle frontal gyrus and in the precentral gyrus.
Posner et al. (2014)	*N* = 65 (aged 6 – 13) Medication-naïve 'ADHD' (*N* = 32) Age- and sex-matched control group (*N* = 33)	1 GE Signa 3.0 T whole-body scanner	*DSM-IV* (ADHD-Combined Type, ADHD-Predominantly Hyperactive-Impulsive Type, or ADHD-Predominantly Inattentive Type) ADHD Rating Scale-IV Conners' Parent Rating Scales Revised Child Behavior Checklist	‘no study participant had prior exposure to psychotropic medication’ (p. 113-114)	None reported	Yes Dr. Posner (principal investigator) is a principal investigator on an investigator-initiated grant from Shire Pharmaceuticals.	Reduced left hippocampus volumes and reduced connectivity between the left hippocampus and orbitofrontal cortex observed in the 'ADHD' cohort compared to controls

Study	Sample size and type	Neuroimaging technology	Diagnostic criteria & measures	Medication history	Trauma history	Conflicts of interest	Reported findings
Hoekzema et al. (2014)	Adults (*N* = 86) Medication-naïve 'ADHD' (*N* = 23) Medicated 'ADHD' (*N* = 31) Control group (*N* = 32) 'ADHD' Children (*N* = 20)	Adult MRI images: GE 1.5T scanner Child MRI images: Philips 3T scanner	*DSM-IV-TR* Conners'Adult ADHD Diagnostic Interview for *DSM-IV* Wender Utah Rating Scale (WURS) ADHD Rating Scale Conners Adult ADHD Rating Scale (CAARS) Conners' Parent Rating Scale-short version (CPRS-48) Conners' Teacher Rating Scale (CTRS-39) Clinical interview of the *DSM-IV-TR* Child Behavior Checklist (CBCL)	Duration (adults): *M* = 31.43 months Dosage (adults): *M* = 0.81mg Duration (children): *M* = 7.49 months Dosage (children): *M* = 0.83mg	None reported	Authors declared no conflicts of interest	Smaller bilateral ventral striatum volumes observed in medicated 'ADHD' participants compared to medication-naïve 'ADHD' participants
Semrud-Clikeman et al. (2014)	*N* = 44 (aged 9 – 16 years) Controls (*N* = 15) Medicated (*N* = 16) Medication-naïve (*N* = 13)	Siemens Trio 3T system	Diagnostic Interview Schedule for Children-IV-Parent Version (DISC-IV-P; based on *DSM-IV* criteria) Conners Global Index Attention scale of the Behavior Assessment Scale for Children–2nd Edition—Parent report (BASC-II-P)	Duration: >18 months (*M* = 4.9 ± 2.9 years) Dosage: not reported	None reported	Authors declared no conflicts of interest	Larger total frontal, prefrontal, and caudate volumes observed in 'ADHD' cohort compared to controls

Sigmund and Michel, Alain and Mary Go Shopping: The commodification of misery*

Mark Rapley

SUMMARY: Misery, like anything, can be sold. Selling requires relabelling, promotion and, in the case of illusory Psy 'conditions', the prospect of 'cure.' This article explores the commodification of distress with particular reference to sexual 'problems' and ADHD.

KEY WORDS: ADHD, pathologisation, sex, Asperger's syndrome

Not so very long ago, in 1847, Charlotte Brontë's Bertha Mason offered a vision of madness, derangement and disorder familiar to our forebears. An essentially private, shameful, affliction, what we would now understand as a 'psychiatric condition', was to be disowned, denied and hidden from public view.[1] In 2011, reviews of David Cronenberg's *A Dangerous Method* – certainly in the British press – were more focussed on the frisson generated by Keira Knightley's (rather tame) spanking scenes than on the notion of psychoanalysis as a 'cure' for mental disorder.[2] Indeed, the very idea that derangement should be susceptible to talking therapy has become, it would appear, entirely unremarkable. No longer 'a most dangerous method' as William James had it[3] nor, it would appear, even a remotely dangerous idea, therapy is a cultural commonplace. The corollary of course, is that the issues now requiring 'therapy' are also themselves cultural commonplaces. Unlike Bertha Mason, Sabina Spielrein's contemporary successors do not need to be kept in an attic.

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Sabina's 'problem' was, of course, to do with sex. She was far from alone in this. The problem of masturbatory insanity had exercised medical men since at least the early 1700s and would continue to do so according to Hare – with horrific 'treatments' applied when the 'problem' was taken up by psychiatry[4] – until the latter part of the nineteenth century, when the idea that masturbation caused madness was quietly dropped for what Lesley Hall suggests were not 'scientific', but rather 'medico-political', reasons.[5] And of course, problems of sex still preoccupy contemporary purveyors of therapeutic guidance, although the nature of these problems is today, to coin a phrase, inverted. For example, writing in *Cosmopolitan* magazine, Kayleigh Dray suggests that, *contra* the insistence of nineteenth century psychiatry: 'masturbation may have a bad rep, but it's a great way to discover more about your sexual self. It's the ideal way to work out what you like, what you don't like, what turns you on and what makes you hot!'[6] Likewise, in her *Sexual Healing* column in the *Guardian*, celebrity psychotherapist Pamela Stephenson Connolly proffers advice to worried readers on questions such as these: 'My father-in-law is masturbating in my house: he uses my laptop to view internet pornography and I want it to stop' (3 June 2012); 'I'm a heterosexual woman, but pictures of beautiful younger women arouse me' (15 April 2012); 'I have impaired social skills – is it healthy for me to have so many one-night stands?' (29 September 2011) and, in a query that both Freud and Jung would no doubt have found resonant, from 28 July 2011, 'Am I in love with my mother? None of my girlfriends has ever compared to my mum for affection, attitude and sex appeal'.

But it is not just questions of sexual and social skills, sexual decorum and sexual identity that have departed the austerity of the clinic for the public forum of the newsstand. Simply being bad tempered, or an 'angst-ridden' teenager, may now be serious issues in need of specialist attention. And of course 'the public' needs to be educated about such contemporary medical breakthroughs. Thus, in the 'health' section of 5 June 2012 edition of the *Daily Mail*, Anna Magee asks her readers if their 'Husband [is] a right old grump?' and then suggests that: 'he could be one of thousands who have Asperger's without realising. Asperger's is a 'high-functioning' form of autism where sufferers often have very high IQs'. Illustrating the intersectionality of media convergence on psychiatric diagnosis (popular film, self-help books, and the pedagogically-inclined *Daily Mail* itself), the story continues with a nicely honed human interest angle:

> When martial arts teacher Sandra Beale-Ellis discovered one of the children in her class had Asperger's syndrome, she set out to discover more about the condition. 'I'd seen the film *Rain Man*, but that was the extent of my knowledge about autism,' says Sandra, 44, who lives in Herne Bay, Kent. 'So I bought a book about Asperger's to read up about it.' Autism is a developmental disability causing difficulties with communication and relating to other people.[7]

If ill temper isn't 'really' Asperger's there is, however, another, more worrying, possibility. Your adolescent loved one may have a different – and much more serious – form of mental disorder. An unnamed reporter in the 6 July edition of the *Daily Mail* alerts (potentially) worried parents to the fact that their teenager may not actually be in the grip of presumably expectable 'teenage angst' but, rather, be suffering from a 'mental illness' called 'IED', which the paper helpfully points out, in a neat cultural reference to the ongoing Anglo-US wars in Iraq and Afghanistan, is also the acronym for 'improvised explosive device', viz:

> One in 12 American adolescents is on such a short fuse that they could be suffering from IED – intermittent explosive disorder, psychologists have said… The condition, which shares the same initials as 'improvised explosive device', is characterised by persistent and uncontrollable anger attacks… A new study, based on a household survey of 10,148 young teenagers in the US, found that nearly two thirds had a history of anger attacks involving real or threatened violence… It also found that one in 12 met strict criteria for a diagnosis of IED. Across the country, that would equate to almost six million individuals… The research also indicated that IED was not being properly treated.[8]

Fortunately, what one imagines are now-very-worried parents can, however, take comfort from the psychiatric expert recruited at the end of the story. Here again the *Daily Mail* endorses a call to encourage the abandonment of long-established cultural constructions of phenomena such as grumpiness or the existential 'angst' that is widely understood as characterising the teenage years, and instead prevails upon its readers to seek urgent diagnosis and prophylactic 'treatment'. Interestingly, this encouragement appeals both to notions of responsible parenting (the prevention of 'psychopathology' in one's child) and also of responsible citizenship (obviating, via 'effective treatment', the social ill of 'future violence perpetration'). Thus, a senior academic figure, a 'Professor Ronald Kessler', described as hailing from the highly prestigious Harvard Medical School, is reported as saying: 'if we can detect IED early and intervene with effective treatment right away, we can prevent a substantial amount of future violence perpetration and associated psychopathology.'

The popular media are not only awash with (educational) stories about specific forms of 'mental disorder', tips as to their identification in others, and recommendations of the solicitation of formal, professional diagnosis and treatment, but there are also numerous – and thriving – popular periodicals, with well-developed cross-platform reach strategies, devoted precisely to the identification, dissection and management of one's own troubled or troubling interiority. Thus we see, on the homepage of the June 2012 UK issue of *Psychologies: The magazine for those who want to know more and grow more* a helpful solicitation and promise. 'Got a question about mindfulness or meditation? Tweet it to us and @Andy_headspace will reply tomorrow during our twitter chat'. Should the reader 'keen to know more and grow more' find this assistance helpful, they are enabled via hyperlinks to follow *Psychologies* on Twitter and Facebook. Should they, unfortunately, be away from their desktop, the page also offers users the facility to 'Get *Psychologies* On Your iPhone, iPad, Android and Blackberry'. And the range of difficult, psychologically troubling, issues that *Psychologies* proffers advice upon? Listed as the most popular tags are: 'relationships/wellbeing/society/emotions/personality/health/happiness/beauty/families/self-knowledge'. But, aside from a nagging doubt, how is the reader to know that they need assistance? *Psychologies* offers not only therapeutic advice, but also diagnostic assistance. The 'Top 5 Tests' in June 2012, are, it seems: 'Are you ready to lighten your load? What's your creative style? What is your father/daughter relationship? What do your clothes say about you? Do you know how to be happy?'[9]

There is, then, clearly a huge market for popular media devoted to matters of distress and their therapeutic resolution. But therapy is no longer purely a technique solely for the cure of individual souls or the prevention of social disorder. *Soi disant* philosopher, Alain deBotton , sharing a page with an interview with Mary 'Queen of Shops' Portas in the *Guardian*, suggests that therapy is also the cure for Britain's recession-struck high streets. In his contribution to '*Can anyone save our high streets*?' where various experts – retail guru Portas, an artist, a retailer, an architect and the editor of the fashion magazine *Elle* – offer ideas on ways to rescue the retail centres of Britain from austerity and economic catastrophe, philosopher (!) deBotton suggests 'mak[ing] psychotherapy like a visit to the hairdresser'. With an unacknowledged nod to Foucault, he outlines his idea as follows:

> 'My suggestion is that therapists should be secular society's new priests… Therapists are hidden away. You don't see them on the high street…We don't make a place for them among other needs like those for bread or electrical goods. Imagine if the need for therapeutic dialogue was as honoured and recognised as the need for a haircut or a go on an exercise machine… Moving psychotherapy onto the high street seems a natural progression. It means recognising that the high street is a natural place to take care of psychological needs that were previously attended to out of sight. Consulting a therapist should be seen as no less normal than going to a nail bar and a lot more useful.'[10]

We thus appear, at least in what have become the consumer societies of the West, to have witnessed a dramatic shift in popular understandings of derangement and distress. We have moved from the mid-nineteenth century's shame and sequestration of madness, via the embedding of the arcane practices of psychoanalysis and other 'therapeutic techniques' as cultural commonplaces, to high street therapy for an ever more banal array of 'mental disorders' being promoted by 'philosophers', no less, as both a mechanism for social and economic good and, simultaneously, as just another consumer product which putatively meets human 'need[s] like those for bread or electrical goods… for a haircut or a go on an exercise machine'. How has this state of affairs come to be?

Crippling the citizen: moral panics, disease mongering and the production of mundane 'disorder'

Via an array of linked social phenomena, including the incitement of moral panics over novel diseases, their celebrity endorsement, 'product placement' in the professional journals of record, the grooming of the popular media, and the straightforward manufacture (or, perhaps more accurately, purchase of consent[11] what is in essence a sustained marketing campaign that Ray Moynihan and colleagues have described as 'disease mongering'[12] – of which the 'conditions' above are some of the less egregious examples – has, over the course of the twentieth and early twenty first centuries, ensured the solidification of the, by now several centuries old, transformation of culturally shared notions of distress from the florid but socially unspeakable business of the mad doctor or alienist, itself a development from the earlier public spectacle of lunacy at Bedlam and other asylums documented in both historical sources and nineteenth century cultural representations, into the mundane concern of the newspaper journalist or popular magazine agony aunt; from the stuff of nightmares to the banalities of everyday disorder.

This transfiguration of the nature of madness and distress in popular culture, begun in the mid-nineteenth century with the development of the idea of madness as a medical phenomenon amenable to scientific study, and apparently accelerating unstoppably ever since, is neither accident nor the consequence of benign advances in medical science being translated into the quotidian: rather it is an upshot of the quite deliberate construction and popular marketing of particular representations of disease, distress and risk by the pharmaceutical industry and, in the case of 'mental disorder', by professional psychiatry. Psychiatry is disparaging of the 'mental health literacy' of the public (which, in essence, amounts to the public failing to endorse the preferred descriptions of distress and interventions prescribed by 'mental health professionals', and an apparent public preference for media sources and portrayals of madness for information over the pronouncements offered by psychiatry). The response of psychiatry and its backers in the pharmaceutical industry (of which more below) to this state of affairs has been twofold: firstly to engage in formal, official, overt 'public education campaigns', often with the backing of national governments, and, secondly with covert propaganda campaigns to pathologise everyday life via massively funded advertising (in the case of the drug companies[13]) and, on the part of psychiatry, the regular revision and expansion of what is commonly known as the 'psychiatrists Bible' – the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association, a process which has: 'prompted successive editions... to proliferate pages and disorders, like the *Yellow Pages* on steroids.'[14]

Such activities, and critical commentaries upon them, of course become a part of, and reflect, popular culture themselves: from Ken Kesey's indictment of the banal violence of institutional psychiatry in the heyday of the anti-psychiatry movement in *One Flew Over the Cuckoo's Nest* to John Le Carré's forensic portrayal of the pharmaceutical industry in *The Constant Gardener* at the beginnings of increasing public suspicion of the corporate world, some literary and film treatments have attempted to offer a counter-hegemonic voice. This, to date, appears to have had as little effect in the wider culture as did Lear's raving in the tempest, with more recent, and more 'on message' portrayals of 'mental disorder', not infrequently in the form of biopics, arguably securing greater cross-platform penetration and contemporary popular recognition (films such as *Rain Man* (Autism) – Academy Award for Best Film, 1988; *As Good as it Gets* (Obsessive Compulsive Disorder) – Academy Awards for Best Actor and Best Actress, 1997; *A Beautiful Mind* (Paranoid schizophrenia) – Academy Awards for Best Picture, Best Director, Best Adapted Screenplay, and Best Actress in a Supporting Role, 2001; *Girl, Interrupted* (Borderline Personality Disorder) – Academy Award for Best Supporting Actress, 1999*; The Shining* (1980) ('psycho killer') and *The Silence of the Lambs* (criminally insane serial killer) – 'Big Five' Academy Award Winner, (1991).

Intriguingly, but perhaps unsurprisingly, the most striking recent development in this historical process is for supposedly disinterested 'scientific' bodies – key actors in the definition and diagnosis of 'mental disorder' – having claimed proprietary 'medical' expertise as the last word on 'serious mental illness' (depression, schizophrenia, bipolar disorder and the like) – and added angst, grumpiness and masturbatory ineptitude for good measure, now to actively solicit consumer feedback on their diagnostic pronouncements .[15]

Psychiatric drugs and, more recently, psychiatric disorders themselves have now become sought-after consumer products in their own right. In an historically unprecedented cultural turn there is now, courtesy of the promotional outlay on marketing to doctors and the popular cultural penetration of the APA and Big Pharma's direct to consumer (DTC) marketing, a shopping list of assorted 'mental disorders' that people quite literally *want* to have.[16] The Kaiser Foundation (2003) reports that: 'promotional spending by pharmaceutical manufacturers has risen steadily in recent years, more than doubling from $9.2 billion in 1996 to $19.1

billion in 2001, an average annual increase of 16 per cent. While most promotional spending (86 per cent) remains directed at physicians, a growing proportion is directed at consumers, especially through television ads'. It is, further, noted that drug company DTC promotion 'works':

> The public has certainly become more aware of DTC advertising in recent years – the percent saying they had seen or heard an ad for a prescription medication grew from 63 per cent in 1997 to 85 per cent in 2002. And the ads are resulting in consumer interest in prescriptions – nearly a third (30 per cent) of adults say they have talked to their doctor about a drug they saw advertised, and 44 per cent of those who talked to their doctor received a prescription for the medication they asked about. This means that 13 per cent of Americans have received a specific prescription in response to seeing a drug ad.[17]

Bhanji and colleagues note that 'approximately 20 per cent of the 50 most advertised drugs in the US were medications used to treat psychiatric and neurologic disorders. Antidepressants [and] antipsychotics... are among the top five most heavily advertised classes of medicine'. Further, 'DTC advertisements increase both new diagnoses of a condition and the proportion of prescriptions specifically for the advertised drug'.[18] Writing in 2008 and drawing on Healy,[19] Amy Shaw describes the lucrative upshots of this activity: 'every additional dollar spent on advertising in medical journals generated approximately $5 worth of sales, and an extra dollar spent to sponsor continuing medical education and professional meetings yielded approximately $3.56 in sales In addition, every dollar spent on physician-detailing generated sales worth approximately $1.72, except for the most aggressively marketed drugs, which generated sales of more than $10.'[20] David Healy points out that addition to supporting and distributing a literature, which drug companies have been doing since the 1950s, there are a number of other well-known techniques that pharmaceutical companies can use to promote a change in cultures, some of which have operated for decades and others, are more recent. From the 1950s, celebrity endorsement in advertisements and articles in the lay media have played an important role in the marketing of drugs.[21]

Perhaps one of the clearest examples of the popular cultural penetration of APA/Big Pharma disease marketing is Attention Deficit Hyperactivity Disorder, which we met above. In the case of ADHD, not only are the drug companies assiduous in their marketing of the disease via advertising, and via their funding of front organisations such as ChADD, but also many 'sufferers' increasingly now take advantage of social networking opportunities (particularly *YouTube*) to proselytise for public acceptance of ADHD-as-Disease (now available for adults!) via first person testimonials of their own creation, often purporting to be 'documentaries', or via 'human interest' appearances in mainstream media news and current affairs programmes.[22]

As long ago as 2003, the effects of the widespread popular acceptance of the notion that badly behaved children had a brain disorder best treated with what then was already known in the vernacular as 'kiddie speed', was causing significant concern in many parts of the Anglophone world. In Australia the combination of the ascendant ideology of market capitalism with uncritical popular acceptance of ADHD-as-brain-disease not only lead the State Government to set up a parliamentary enquiry into the diagnosis of ADHD and the out of control prescribing of psychostimulants, but also prompted Sergeant Gill Wilson of the WA Police, writing in '*Choppers Copper Column*', part of a health briefing note for GPs produced by the Drug and Alcohol Office of the State Government, to muse on the fusion of these two cultural trends:

> '… [T]here is a substantial black market for dexamphetamine in our community. Much of this market is synonymous with young people and their school environments. Some would suggest that dexamphetamine provides the more imaginative young person with the chance to hone their entrepreneurial marketing skills in the lucrative business of illicit drug dealing. Extortion, fraud, theft and violence are other very dubious skills they are likely to gain.'[23]

References

1. Currer Bell/Charlotte Brontë (1847). *Jane Eyre: an autobiography*. London: Elder & Co.

2. *A Dangerous Method* (2011). David Cronenberg (dir). Screenplay by Christopher Hampton.

3. Skrupskelis I, Berkeley E (eds) (2004). *The Correspondence of William James* (vol 12). Charlottesville, VA: University Press of Virginia.

4. Hare EH (1962). Masturbatory insanity: the history of an idea. *Journal of Mental Science CVIII*: 1–25.

5. Hall LA (2003). It was affecting the medical profession: the history of masturbatory insanity revisited. *Paedagogica Historica 39(6)*: 685–699.

6. Dray K (2012). A beginner's guide to masturbation. Cosmopolitan. (http://www.cosmopolitan.co.uk/love-sex/tips/beginners-guide-to-masturbation-sex).

7. Magee A (2012). Husband a right grump? (http://www.dailymail.co.uk/health/article-2154689/Husband-right-old-grump-Aspergers-Thousands-realising.html#ixzz1wzZ8iOIn)

8. Daily Mail Reporter (2012). Teenage angst or mental illness? Harvard study finds one in 12 adolescents suffer from 'anger disorder' 6 July 2012 10:35 BST. (http://www.dailymail.co.uk/news/article-2169625/Harvard-study-finds-1-12-adolescents-suffer-anger-disorder.html)

9. http://www.psychologies.co.uk/

10. deBotton A (2012). The idea: make psychotherapy like a visit to the hairdresser. In: *Can*

Anyone Save Our High Streets? Guardian.co.uk, 28 April 2012 19.27 BST (http://www.guardian.co.uk/society/2012/apr/28/high-streets)

11.Herman ES, Chomsky N (1988). *Manufacturing Consent: The political economy of the mass media*. New York,NY: Pantheon.

12. Moynihan R, Heath I, Henry D (2002). Selling sickness: the pharmaceutical industry and disease mongering. *British Medical Journal 324(7342)*: 886–891.

13.Healy D (2003). *Let Them Eat Prozac: The unhealthy relationship between the pharmaceutical industry and depression*. Toronto: Lorimer. See also: http://www.healyprozac.com/

14.Scull A (2010). A psychiatric revolution. *The Lancet 375(9722)*: 1246–1247.

15. American Psychiatric Association (2012). *DSM-5: The Future of Psychiatric Diagnosis.* http://www.dsm5.org/Pages/Default.aspx

16. Moncrieff J, Rapley M, Timimmi S (2011). The construction of psychiatric diagnoses: the case of adult ADHD. *Journal of Critical Psychology, Counselling and Psychotherapy 11(1)*: 16–28.

17. Kaiser Family Foundation (2003). *Impact of Direct-to-Consumer Advertising on Prescription Drug Spending*. Menlo Park, CA: Henry J Kaiser Family Foundation. Available from: ww.kff.org/rxdrugs/upload/Impact-of-Direct-to-Consumer-Advertising-on-Prescription-Drug-Spending-Summary-of-Findings.pdf (p5).

18. Bhanji NH, Baron DA, Benjamin DA, Lacy W, Gross LS, Goin MK, Sumner CR, Fischer BA, Slaby AE (2008). Direct-to-consumer marketing: an attitude survey of psychiatric physicians. *Primary Psychiatry 15(11)*:67–71.

19. Healy M (2007). The payoff: in short, marketing works by targeting consumers and doctors -directly and indirectly - drug makers are driving sales. Why mess with success? *Los Angeles Times* (ppF6).

20. Shaw A (2008). Direct-to-consumer advertising (DTC) of pharmaceuticals. *ProQuest Discovery Guides*. Available from http://www.csa.com/discoveryguides/discoveryguides-main.php

21. Healy D (2004). Shaping the intimate: influences on the experience of everyday nerves. *Social Studies of Science 34(2)*:19–45.

22. See, for example: *Adult ADHD – Myth or Reality?* (Part 1 of 2). http://www.youtube.com/watch?v=dxNxIJ7rzw8; *Adult ADHD - Myth or Reality?* (Part 2 of 2): http://www.youtube.com/watch?v=SbfXdODPySk and CBS News: '*Women and Attention Deficit Hyperactivity Disorder'* (ADHD), http://www.youtube.com/watch?v=ri2BagoDwvI).

23. Wilson G (2003). Choppers Copper Column. In: *Drink, Drugs and Doctors: Attention Deficit/Hyperactivity Disorder 2003 Update*. Perth: Drug and Alcohol Office, State Government of Western Australia.

What Do You Get When You Collaborate? Reflections on the experience of writing a chapter together

Rachel Purtell, Gemma Budge, Olivia Fakoussa,
Mandeep Kallu & Annie Mitchell

SUMMARY: The authors reflect on their experience of collaboration in contributing to *Teaching Critical Psychology: international perspectives.*[*]

KEY WORDS: learning, reflection on collaboration, power, subjugation

In this invited article there will not be any searing critical theory; no Horkeimer, Adorno, Marcuse or Wittgenstein. What we have written here is subjective and makes no claims to be otherwise. There will be genuine thoughts about collaboration, from the five very different people who together wrote a chapter, and with a 'takeaway', should the reader wish, of five useful points for others who may wish to try doing the same. Rachel Purtell (RP), scholar–activist, guided our reflections with a series of questions for the other chapter co-authors: Olivia Fakoussa (OF) who led the chapter writing as a recently qualified clinical psychologist, Gemma Budge (GB) and Mandeep Kallu (MF) who were trainee

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[*] Fakoussa O, Budge G, Kallu M, Mitchell A, Purtell R (2018). What can teachers of critical and community psychology learn from their learners? In: Newnes C, Golding L (eds). *Teaching Critical Psychology: international perspectives.* Abingdon: Routledge (pp100–122).

Olivia Fakoussa qualified as a clinical psychologist in 2015 and is working with the voiceless in infant mental health. Gemma Budge qualified as a clinical psychologist in 2017 and is endeavouring to work collaboratively in adult mental health.Mandeep Kallu attended the clinical psychology programme at Plymouth University, UK, where his clinical work focused on working with marginalised groups. Annie Mitchell first qualified as a child clinical psychologist in 1976 and remains an enthusiastic learner, teacher, practitioner. Rachel Purtell is a former director of Folk.us. She does not work as a psychologist.

clinical psychologists at the time of writing and Annie Mitchell (AM), academic and practising clinical psychologist. This piece comprises quotes from our email exchanges in response to questions set by RP.

We have again chosen to collaborate and to question one another (and the process) in pulling together a selection of quotes from our email exchanges. We recognise the danger of disappearing into a Droste effect of endless repeats as we could now write again about collaborating to write this article! '… and wonder about another question threaded through all maybe – along lines of how did you manage power differentials between you as a writing group…?' (AM). 'I do agree, but I suppose I was hoping the 'what was difficult' might include power issues rather than a question that assumes there were ones.' (RP).

Who decides what goes in and what stays out?

'To be able to debate passionately, one has to feel safe and secure in one's position within a group and whilst the group itself certainly did provide this as far as possible, the context of both the chapter itself and this reflective piece have been less able to provide these necessary feelings to all of us in equal measure (perhaps this is always inherent to collaborative endeavours of any kind of course and different people will respond to these perceived dynamics in different ways).' (OF). 'I felt both a sense of being stifled that many of the topics I wrote about didn't make the final version, but also a sense of gratitude to those involved in producing the final edit and for their skill in producing a focussed piece of writing. At the time, I shared my gratitude, but not my sense of being stifled!... One of the most difficult things about writing collaboratively was the sense of loss of control over the direction of the piece and over the sections of writing I had put together.' (GB). 'Who was it that said too many cooks spoil the broth? In the context of the chapter, this translates to the forces of influence regarding agenda-setting and ultimately the power given to those agendas and topics. This meant that as a default, topics which may have been important for me and the context of the chapter, were diluted from their original form and meaning which I wanted to convey… this is the move from ownership to submission, that we have to give a part of ourselves away to move forward.' (MK). 'I think my, perhaps correct, feeling that those with more experience knew best and importantly my personal experience of the pain that can accompany conflict held me back in sharing my passion whatever the outcome.' (GB).

'With five very distinct voices, difficult editing decisions had to be made in order to create a 'coherent' and 'flowing' whole and due to only meeting once in person as a whole group, this process couldn't easily be done with consensus decisions by all but had to be led by one and then fed back for review by the others. As lead author and main editor, I found this process anxiety provoking and inevitably felt I was cutting parts of other people's voices out at times, making a decision on their behalf regarding what was more or less relevant to the whole piece. In terms of sharing power, this felt awkward.' (OF).

'I was surprised that so many disparate voices (including those of others beyond our writing group) could be woven into a coherent account that also acknowledges tricky tensions. Rachel's question: what does 'lived experience' mean – does it contrast with 'dead experience'? unsettled, surprised and intrigued me – how can we make our language less distancing? The phrase 'contradictory uncertainty' has stayed with me too.' (AM).

Reflecting on power in collaboratively writing

'It was a challenge to be lead author of a chapter that in my gut I knew and felt did not really 'belong' to me. Four of five of us hadn't been asked by the book editors to contribute a chapter. One of us – the person in the most powerful, academic position had been asked and she thoughtfully distributed this privilege, this invitation for her thoughts, to others, yielding less power.' (OF). 'In particular I invited Olivia because I had been supervisor for her research and so was witness to her exceptional writing capability and high levels of pro-active organisation and determination to stick with her values and principles… I found it hard but a relief, too, to step away from my sense of responsibility and desire to be in control. I am aware of this inner and outer conflict even more as I approach retirement age – it's hard to let go, but in doing so, I feel the freedom, joy and hope of knowing that the ones coming after me are strong, powerful and effective'. (AM). 'Looking back, I also recognise the influence of power imbalances and the writing process itself as barriers to debate.'(GB).

'To act as the outsider commenting in the role of Provocateur, which is how I view my role, is useful particularly when a profession is looking in on itself. It can, however, be an uncomfortable position when everyone else appears to agree with each other. What worried me with this piece was that though I didn't make many comments all of them were used. I wondered if it was over-earnest or even a little patronizing to not have them challenged, too much power being given uncritically. But when I saw how they had been used to provoke thought and debate I thought it was really skilfully done and didn't feel at all it was over-earnest or patronizing.' (RP)

And in reflecting in order to write this piece, we noted further power imbalances.

'Even this article now, has been written in a rush as we were asked late in the day close to publication 'to balance out the male professors', who presumably though, had been considered and asked to contribute their thoughts first. I think these dynamics made true 'collaborative' writing and passionate debate almost impossible. I certainly remained mindful throughout that I was writing in a way under someone else's reputation and my thoughts hadn't really been considered as important by those in the highest position of power and still now seem to remain a tokenistic afterthought rather than being considered of equal value (rightfully so in some ways) to those already sitting in positions of high power and experience.' (OF).

'If it was me, I would refuse all together to submit; as Olivia has said, it feels rushed, which is under a tokenistic umbrella of gender equality. This issue is a big one at present and we have to think where we stand with it. It would be great to get another publication, but at what cost to the soul? Unless the publication is prepared to take this criticism on board?… Sometimes collaboration can be blind faith, a subjugation to forces of power (as what I see in this case).' (MK). 'Mirroring the process of writing the chapter... I am feeling a little exposed sending this [answers to questions for the article] through but thought it would give us something to start off with at least!' (GB).

'I believe I would [write collaboratively again], but certainly with added awareness of the complexity of the undertaking and perhaps with a clearer framework from the beginning about how different contributions should/will be edited and if possible, prioritising more face to face or video meetings to get a clearer and regular shared understanding of the 'whole'. I think the richness that emerges from such a process of a meeting of many minds is without a doubt worth the effort and anxiety involved, but I do think when undertaking such work, space and time should be dedicated to the process itself. I feel perhaps regular meetings should be held in which people can voice and reflect on their experiences of the writing and editing process in addition to just content and editorial based discussions.' (OF).

'I would [collaborate again] and with enthusiasm, but also with the experience to know that this process requires time and critical reflection to produce a cohesive piece of writing that truly represents the perspectives of all those involved. I'm curious as to how I would experience and interact with the process now my position has changed from a 'learner' to a 'graduated' psychologist. Would I feel I have more experience or power to speak from? And could that be a barrier to the critical process?' (GB).

'I would collaborate again. There is a value to it as it can only ever broaden your own thinking. It is a refreshing process to be able to let go of something you hold dear, knowing that it is a contribution that allows a more diverse perspective. I think there needs to be thought about timescales, content and creativity, and how to achieve all without a compromise to anyone individually. I think the initial phases may be important for this, where the scope for the writing is formulated.' (MK).

'Yes, definitely – as long as I feel a bond of trust (mutual respect? love? care? willingness to challenge and disagree?) with the folk I am intimately writing with – so we can be honest and open and that our words and views may be questioned but not disrespected.' (AM).

'I have always written in collaboration with other people. This time I found it really liberating to be involved in writing something that I had no ultimate responsibility for after 14 years in an academic post writing about how to involve patients, service users and carers in research and about culture change that is needed.' (RP).

Five useful takeaways (and they don't include chips):

1. Like and trust the people you want to write with.
2. Don't be afraid to lead if that is your role, chances are someone else will be relieved you're going to.
3. Talk to each about what you are thinking in terms of process (not just the content).
4. Don't be afraid to say no or walk away if your really can't make it work with your beliefs and views.
5. Embrace the process as difficult but worth it.

Power, subjugation and collaboration

The discussions and issues raised here are important for anyone undertaking collaborative writing collaboratively. However, the issues are as much reflections on writing in the world of academia as on collaboration. The issues of time, power and subjugation and the potential to be hurt have been part of academic writing as far as most of those involved in it can remember. It may be that the act of collaboration, for all its flaws, might actually help to mitigate and protect us from the more negative impacts of written scholarship.

'The passion for me was one of knowing that creativity and grace and beauty and eloquence often (usually?) is held by those with less overt power, and that insofar as I have any privilege/power it should be used to big up the voices of those with less overt privilege /power. Though I recognise that I had the privilege of inviting, I chose those who in my judgement would add texture and nuance and clarity to the issue of learning critical community psychology and not shirk both love and controversy - and who would be able to be better critics and writers than I am.' (AM).

Electroshock: Opposition, Oprah Winfrey, precision and Peake[1]

Craig Newnes

SUMMARY: Electroshock is again receiving publicity around its use and renewed efforts for both its re-invention and banishment. This article uses examples from past texts and contemporary writing and media to illustrate some industry myths concerning electroshock, Psy's history and status as a science.

KEY WORDS: electroshock, myths, protest, pseudo-science, Oprah Winfrey, Mervyn Peake

There have been campaigns against most Psy treatments for well over a century – from the Alleged Lunatics' Friend Society of the mid-nineteenth century to Witness today.[2] There are several websites devoted to critiquing electroshock.[3] Facebook and related media are a vibrant source of information from electroshock survivors.[4] Campaigners aim to make the practice more *visible.* Thomas Szasz rightly says that campaigns and electroshock-opposition, though understandable, miss the target. If psychiatry doesn't 'cure' real illness then debates about which treatment is bad or best miss the point.[5]

In the late 1990s my Shropshire neighbour's 40-year-old son was killed in a climbing accident. By now almost 80, the neighbour was overwhelmed with grief. A few days after the accident his wife called to say he had been admitted to the local psychiatric hospital and the consultant psychiatrist was considering electroshock.

Craig Newnes remains a reasonably independent scholar. His latest books are *Inscription, Diagnosis, Deception and the Mental Health Industry: How Psy governs us all* from Palgrave Macmillan (2016), *The Critical A–Z of Electroshock.* The Real Press (2018) and, with Laura Golding *Teaching Critical Psychology.* Routledge (2018). His novels *Tearagh't* (2017) and *Paris* (2018) are available via Amazon from The Real Press. His fingers ache.

Though employed in the same organization as a clinical psychologist, I visited in my capacity as a neighbour. I reminded my neighbour that he was a voluntary patient and couldn't be compelled to undergo treatment.

Asked to sit in on his case conference as an advocate I entered into the tail end of a discussion about a previous patient, just at the point where a nurse was telling the consultant that the patient's spirits 'seemed to be lifting a bit' after her second bout of electroshock. The consultant nodded sagely and recommended that the 'course of treatment' (four more sessions) should be completed.

During his own case conference my neighbour refused further shocks and, supported by his wife, was discharged the following day. That day I was called to the Director of Mental Health's office and informed I had been banned from the ward.

Meanwhile, the bus from Ellesmere to Shrewsbury continues to be a source of inspiration. The 501 is a community of travellers (usually holders of over-65 or disability passes) chatting on four or five days each week with only a vague idea of where each other actually lives – imagine a train journey where you find yourself saying all sorts to a stranger or listening in as a fellow passenger makes long calls on a mobile phone. I have sold and given away copies of CDs on the 501, have written 000s of words for various projects and I am now writing this to email to myself later.

Over a decade ago I met a couple who would sit chatting to each other or fellow passengers. Two years back I noticed that the man was often asleep. He once overheard my remark to his partner that I admired his ability to doze and he angrily responded. A year later I discovered he was in hospital with an undiagnosed problem. During a recent conversation with his partner I was told he had been in and out of the local psychiatric unit for twelve months. He has been inscribed with depression and received electroshock as well as Lithium. He is 80. He shows no sign of change and his partner is uncertain whether or not to suggest to the consultant that he returns home for her to care for him. Her diagnosis? 'Grumpiness.' She is confused about the inability of 'well qualified' consultants to get to the root of his problem – if problem it is; grumpiness isn't yet a disorder and she wonders aloud if 'intolerance of grumpiness' is her problem. Her solution – to care for him as if she has marriage vows to fulfil – will be as challenging as any partnership on the ropes.

Unlike many others, and partly through the shame of letting people know what's been happening, she won't be helped by other carers and activists. As yet, she has not identified with any particular group – activist or otherwise. Perhaps this is for the best – groups, particularly strident protest lobbies, tend to be absorbed by the system of governance against which they are speaking out.

Social psychologists have classified the ways people may be clustered in terms of referent and nominal groups. Broadly, a referent group has importance for group members in terms of shared identity while a nominal group has demographic and potentially environmental significance. For example, a feminist collective will identify with a shared political agenda of citizen rights. If the group is predominantly women they may share nominal similarities that can be ignored or exploited by other agendas, for example, advertisers will target a perceived demographic as potential mothers, wage-earners, consumers with the power to purchase products aimed at 'women' etc.

Psy has similar strands. Nominal identities (over 60, male, female, [un] employed, adolescents and so on) may be noted in anonymised research publication. For those receiving Psy interventions there are numerous self-inscribed identities available. As evidenced by Facebook and other social media, many groups identify with formal inscriptions such as bipolar, ADD, etc. For the psychiatric protest movement self-inscription includes: survivors, patients, recipients, people, experts by experience, consumers, consumed, clients, activists, citizens and users. The survivor movement prefers the term 'survivor' due to the, '… inhumane, hurtful, degrading and judgemental …' nature of Psy.[6]

Oprah Winfrey

Carrie Fisher was inscribed as manic depressive and then bi-polar. Addicted to alcohol in the 1980s she wrote her first novel, *Postcards from the Edge*. Soon after her death from a heart attack, feminist culture writer Anne Thériault posted a tweetstorm, a series of thoughts about how people celebrate Fisher as Princess Leia, but, for her, the real hero is General Organa – 'the older, tougher, franker version of the character seen in *The Force Awakens*.' Fisher's ashes were placed in a giant Prozac pill, a favourite possession.

In February 2011 Fisher had revealed live on television to Oprah Winfrey that she had 'maintenance' ECT every six weeks. Winfrey's surprise was shared by millions and a storm of activity on the Web ensued. This enabled people to revisit one of the most passionate critics of electroshock; Leonard Roy Frank speaking out about psychiatry on Youtube.[7]

Elsewhere on the Net some myths about electroshock were repeated and other commentators took the opportunity to promote other interventions. Liz Lockhart, for example, says in *Mental Healthy*, 'ECT uses bursts of electricity in the brain to produce a mild seizure. It is not known with certainty why this works although specialists believe it releases neurotransmitters in the brain and stimulates underactive parts of the brain.'[8] In fact, there has been agreement for many years that it is the electric charge rather than the convulsion that is of most importance in producing the 'electrical lobotomy.'[9]

In populist journalistic style Tim Jarvis at Oprah.com uses the headline

'Breakthroughs for Depression are on their way.' Again, he promotes the seizure and effectiveness myths suggesting, 'To date, electroconvulsive therapy (ECT)… is widely acknowledged as the most effective weapon for treatment-resistant depression in a psychiatrist's arsenal, and often the last resort.' Enter magnetic seizure therapy, promoted by Sarah Lisanby, MD, chief of the division of brain stimulation and therapeutic modulation at Columbia University. Lisanby uses the trope of safety as part of MST's appeal: 'We want to take advantage of the efficacy of ECT but try to make it more available by making it safer.' Jarvis goes on to suggest, '… radical – and exciting for the treatment-resistant depressed – are brain implants that work like pacemakers to keep a lagging neural area up to speed.' The implants transmit a constant low-voltage current to an area called the subgenual cingulate region, or Brodmann area 25 (deep brain stimulation; DBS).[10] Carrie Fisher is no longer with us. Psy's addiction to electrical magic continues.

Precision

Narratives within psy are rarely precise. A shared language may give the appearance of mutuality but different words at different times mean different things to different people. Stories told and re-told enter the discourse and become mythic; as the adage says, 'Nostalgia is a yearning for a time that never was.' Myths are reified within any historical writing and the history of psy carries myths illustrative of arguments for and against psy praxis. This is due to a failure by researchers to return to original sources, the challenge posed by understanding what previous generations may have meant by popular psychiatric inscriptions (some, for example, carus simply disappeared from the lexicon; others, for example schizophrenia changed over time and across countries) and, in part, by the desire of certain writers to castigate previous psy theoreticians and practitioners as villains and fools or promote them as heroic and prescient.

An example is provided in the posthumous celebration of Pinel, acclaimed for humanizing French psychiatry at the end of the 18th century by, quite literally, releasing the inmates from their shackles at the Salpêtrière asylum. The famous illustration used in numerous history texts is accompanied by the date 1792. In fact Pinel's assistant Pussin unshackled the maniacs in 1797 – two years after Pinel left.[11]

Similarly, Egas Moniz is usually credited with being the psychiatrist responsible for the first lobotomies and was awarded the Nobel Prize in 1947. In 1890, however, in an attempt to alter the behaviour of six severely agitated patients, Gottlieb Burckhardt, superintendent of a privately run psychiatric clinic at Marin in the Swiss Canton of Neuchâtel, drilled holes in their heads and extracted sections of the frontal lobes; two patients died. Moniz was, in any case, a neurologist and the operations were performed by his assistant, Lima.[12]

Myths have flourished in relation to psy institutions as well as regimes and individuals. For example, although the York Retreat is frequently put forward as the first asylum to practice moral therapy its founder, Tuke simply systematized an already common approach. The approach fitted the disciplinary nature of Quakerism thus adding to the myth. Foucault analysed the regime as one which rendered inmates their own gaolers controlled by guilt and shame rather than shackles. Anne Digby has shown, however, that, though it is true to say that the Retreat used severe restraint less than was common at the time, in the first fifty years of its establishment a pharmacopeia including opium, laudanam and morphia was employed.[13]

In similar vein 'Bedlam' has become a short-hand for wild and uncontrolled conduct in noisy, untidy and unhygienic places. The term is based on the supposed chaos that ruled at the original Bedlam (the Bethlehem Royal Hospital in South London) necessitating the caging of deranged lunatics. Patricia Allderidge notes the regular appearance of Bedlam in psychiatric histories as a kind of symbol of the worst excesses of in-patient alienism but also remarks on the fact that only *two* histories of the hospital are based on original sources. One of these, she tells us is the, ' … practically unreadable *Story of Bethlehem Hospital* by E G O'Donoghue, published in 1914.'[14]

Allderidge goes on to review evidence for chaining of inmates and the filth, lack of care and general mayhem in a place where, it is said, thousands of visitors paid to see mad folk. She finds little to substantiate any of these claims finding instead a regime where the occasional dangerous lunatic (there are records of just two notorious cases) was ill-treated but otherwise cared for its pauper population at least as well as any similar institutions and rarely incarcerated people for more than a year. Visitors came but in nothing like the numbers claimed and were certainly not charged a penny a time – records in the collection boxes reveal virtually no small coinage. Again, the myth is more important than the reality; 'Bedlam' serves as a benchmark against which modern 'more progressive' regimes can gauge their efforts.

Dramatic points can equally be made by historians of electroshock – either to contrast the 'barbaric' procedures of the past with enlightened more cautious contemporary approaches or by quoting selectively from original documents (as an article like this is equally bound to do). Valenstein and Shorter respectively give subtly different versions of Bini and Cerletti's first human experiment with electroshock.[15] More recently Shorter and Healy report in more detail covering both the first days of experimental electroshock (when the voltage was increased each time) and the outcome.

The majority of conflicting accounts cover only the first session with 'Enrico X' crying out, 'Not another one, it's deadly' (the preferred translation amongst activists). For Shorter and Healy – essentially pro-electroshock – the phrase instead is rendered, ‘Attention! Another time is murderous.’

After the second shock, a week later, the patient/guinea pig Enrico X recovered but had no memory of what had occurred. Enrico had a total of 11 electroshocks and returned to work. Then, a page further on the reader is informed that in March 1940, two years after the electroshock Enrico X’s wife wrote to Bini to say her husband was in the Mombello psychiatric hospital.[16]

This more nuanced account doesn’t prevent the authors repeating the Pinel myth as: ‘... the celebrated loosening of the chains of the inmates of the Bicêtre Asylum in Paris by Philippe Pinel …’[17]

Just as precision is an impossible goal in historical research it is absent in the prescription of all psy interventions – from electroshock to psychotherapy – and equally absent in their application. There is, for example, no research justifying any given number of therapy sessions recommended for a patient; the number is based on what the patient, insurer or state will pay and sometimes what the therapist wants to earn. Patients in psychoanalysis frequently pay for sessions when the analyst is on vacation on the basis that it is a way of ensuring the analyst’s ongoing fidelity yet no research can confirm the ideal therapeutic length of the analyst’s absence. Similarly, counselling clients may be offered contracts in multiples of six. A contract of six, twelve or eighteen one hour sessions may offer the illusion of precision but the basis for the number again reflects economic imperatives and no research exists comparing, say, nine 45 minute with thirty one 17 minute meetings. As ever, there is a touch of magic to the proffered session duration – 12 mirrors the number of apostles (the reason hospitals often had twelve-bedded wards), six the traditional number for a carton of eggs.

The historical and contemporary practice of psychopharmacological prescription is similarly imprecise. Medicine favours an empirical approach; dosages are increased or decreased and drugs changed until the desired effect is achieved. Sandison’s experimentation with LSD and *Rauwolfa serpentinia benz* at Powick Hospital in the 1950s is the tip of a considerable iceberg.[18] *All* prescriptions of psycho-active agents are best guesses – or sometimes just guesses. On a daily basis physicians use drugs not recommended for particular inscriptions or in excess of manufacturer guidelines and patients self-medicate in non-prescribed ways. To a limited extent non-sanctioned prescribing practices are seen to be controlled by professional, manufacturer and government guidelines or ‘best practice.’ General practitioners and other psychotropic prescribers, however, rarely – if ever – do precise checks of a person’s body-mass index or metabolic rate before prescription; again empiricism is the norm.

From its inception there has been an empiricist approach to electroshock. Bini tried one burst of electricity with no success; ‘Enrico X’ ended up with 11 sessions of different voltages (see above). Although electroshock recipients may have the same number of shocks, the voltages and anaesthesia differ according to the preferred practice of the prescribing psychiatrist and the type of device used. Again, physical parameters like body-mass index are ignored.

Precision will not be found in either the reports of 'successful' electroshock or its adverse effects. We are informed that people may have a 'generally improved mood' or, in many historic accounts were 'able to return to work.' Beneficial and adverse effects – especially those in recipient accounts – tend toward all or nothing reporting. Kitty Dukakis, for example, talked of her demons being banished after electroshock.[19] Other personal accounts suggest the recipient 'can't remember anything' from before the shock.

The type of adverse effects highlighted is also subject to the prevailing *zeitgeist*. In an interview for *The Psychiatric Times* Jonathan Sadowsky, author of *Electroconvulsive Therapy in America: The anatomy of a medical controversy*[20] discusses some factors influencing accounts of memory loss resulting from electroshock: 'What struck me most about this history was how inconclusive it is. Some advocates are convinced permanent retrograde losses are rare, and some critics are convinced they are very common. But many researchers have stressed how elusive certainty has been.' He adds that from the recipients' perspective, '… complaints about memory loss seem to appear more in recent patient accounts than they do in earlier ones… This may simply be an artefact of the growth of illness memoirs, making more evidence available. It could also reflect how awful some of the more serious adverse effects were before the use of anaesthesia and muscle relaxants became widespread.'

Sadowsky touches on the issue of *zeitgeist* citing historian Laura Hirshbein who proposes that the increase in accounts of memory loss might be related to an increased privileging of cognition in an information-based society.[21] Finally, underlining the lack of precision in psy accounts he says, 'None of these hypotheses are easy to prove empirically. I do think the narrative evidence shows that permanent losses may be more common than some clinical manuals allow.'[22]

Attempts to make assessments of the impact of electroshock via psychometrics are hampered by the low reliability and lack of construct validity of psychometric tests though some precision has been achieved by researchers looking at the extent of brain damage suffered by recipients.

The overall lack of precision is summarized by US lawyer James Kelley, 'Patients and their families need to know that psychiatry is an uncertain branch of medicine, that well-qualified psychiatrists frequently disagree, that they deal more in judgement calls than in answers, and that the risk of a bad outcome is sometimes high.'[23]

Mervyn Peake

Teenage years are a good time to more or less disappear into Mervyn Peake's *Gormenghast*. Steerpike is powerfully alluring, Fuchsia is growing into an independent woman an obscure, unattainable object of desire while Titus seems like he might turn out to be just another rich kid. I read the trilogy in the wrong order; *Titus Groan* second and *Titus Alone* a couple of years later. *Titus Alone* is deeply strange, a gothic world with flying *cars*. Peake was born the son of a medical missionary in China, in 1911. By the time of his conscription in 1939 he was an established artist and author. Between 1943 and 1948 he finished *Titus Groan* and *Gormenghast* and illustrated Lewis Carroll's *Hunting of the Snark* and *Alice in Wonderland*, Samuel Taylor Coleridge's *The Rime of the Ancient Mariner*, and Robert Louis Stevenson's *Strange Case of Dr Jekyll and Mr Hyde*, as well as producing countless poems, drawings, and paintings.

For ten pounds he designed the logo for Pan Books. His book of nonsense poems, *Rhymes Without Reason*, was published in 1944. In 1945 the *Picture Post* commissioned Peake to visit France and Germany for the magazine. He was among the first British civilians to witness the remaining prisoners in Belsen; too sick to be moved, they were dying. In 1946 the family moved to Sark, inspiration for the wonderful *Mr Pye*. *Gormenghast* was published in 1950, *Mr Pye* in 1953.

Increasingly erratic, by 1957 Peake was hospitalized with the early signs of dementia. He was given electroshock and over the next few years he gradually lost the ability to draw steadily and quickly, although he still managed to produce some drawings with the help of his wife. *Titus Alone* was published in 1959. Among his last completed works were the illustrations for Balzac's *Droll Stories* (1961).

Peake's health subsequently declined and he died on 17 November 1968 at a care home run by his brother-in-law, at Burcot, near Oxford. His death was the result of dementia with Lewy bodies.[24]

Written some time during the Second World War and published posthumously *The Threads Remain* is Peake's attempt to 'classify his loves' because of his 'disorganized desire to live.' It ends:

> 'So now I know myself and I
> Can start my life anew,
> Half magical, half tragical
> And half an hour, or two'[25]

Notes

1. This article is an edited version of the letters O (Opposition and Oprah Winfrey) and P (Precision and Mervyn Peake) from *The Critical A–Z of Electroshock* (2018) The Real Press.

2. Formerly, The Prevention of Professional Abuse Network (POPAN) Witness campaigns for professional bodies to develop standardised complaints procedures which are sensitive to the possible distress caused to patients. Witness runs a helpline for patients who have been abused: a third of callers claim to have been abused by counsellors or psychotherapists. http://www.wherecanifind.net/cgi-bin/callentry.cgi?255 (accessed 15 March 2017).

3. See, for example, http://intcamp.wordpress.com/ban-ect/ and http://camhjournal.com/2012/04/24/2004-a-campaign-against-direct-ect/

4. See, for example, ECT Global Support https://www.facebook.com/groups/414257808688052/ and Mind Freedom Ireland http://www.mindfreedomireland.com/

5. Szasz T (1987). *Insanity: the idea and its consequences*. New York: Wiley.

6. Unzicker R (1989). My own. A personal journey through madness and re-emergence. *Psychosocial Rehabilitation Journal 13*: 71–75.

7. https://www.youtube.com/watch?v=F4WygjHKA8k

8. http://www.mentalhealthy.co.uk/news/379-oprah-shocked-that-electroconvulsive-therapy-ect-still-used-today.html (accessed 17 January 2018).

9. See, for example, Breggin PR (1991). *Toxic Psychiatry: Why therapy, empathy and love must replace the drugs, electroshock, and biochemical theories of the 'New Psychiatry.'* New York: St Martin's Press & Breggin PR (1998). Electroshock: scientific, ethical, and political issues. *International Journal of Risk & Safety in Medicine 11*: 5–40.

10. http://www.oprah.com/spirit/beyond-prozac-depression-treatment-breakthroughs

(accessed 17 January 2018).

11. Weiner DB (1994). Le geste de Pinel: the history of a psychiatric myth. In: Micale M, Porter R (eds). *Discovering the History of Psychiatry*. Oxford: Oxford University Press (pp232–247).

12. Julius von Wagner-Jauregg was the only psychiatrist to receive the Nobel Prize – in 1927. Over the previous decade he had injected patients with malaria as a cure [fever therapy] for shell-shock and general paresis. It was introduced into the US in 1922; the practice all but disappeared except for treating cases of general paresis over the next twenty years.

13. Digby A (1985). *Madness, Morality and Medicine: study of the York Retreat, 1796–1914.* Cambridge: Cambridge University Press (pp78–82).

14. Allderidge P (1985). Bedlam: fact or fantasy? In: Bynum WF, Porter R, Shepherd M (eds). *The Anatomy of Madness. Vol II Institutions and Society.* London: Tavistock.

15. Valenstein E (1986). *Great and Desperate Cures: the rise and decline of psychosurgery and other radical treatments for mental illness*. New York, NY: Basic Books. Shorter E (1997). *A History of Psychiatry: from the era of the asylum to the age of Prozac*. Chichester: John Wiley & Sons.

16. Shorter E, Healy D (2007). *Shock Therapy: a history of electroconvulsive treatment in mental illness.* New Brunswick, NJ: Rutgers University Press (p41).

17. *Ibid* (p181).

18. Sandison R (2001). *A Century of Psychiatry, Psychotherapy and Group Analysis: a search for integration.* London: Jessica Kingsley Publishers (p21).

19. See: Kindness and Kitty Dukakis. In: Newnes C (2018). *The Critical A–Z of Electroshock.* London: The Real Press (90–93)

20. Sadowsky J (2017). *Electroconvulsive Therapy in America: the anatomy of a medical controversy.* London: Routledge.

21. Hirshbein L (2012). Electroconvulsive therapy, memory and self in America. *Journal of the History of Neurosciences 21*:147–169.

22. http://www.psychiatrictimes.com/history-psychiatry/ect-history-psychiatric-controversy/page/0/2 (accessed 25 January 2018).

23. Kelley JL (1996). *Psychiatric Malpractice: stories of patients, psychiatrists and the law.* New Brunswick, NJ: Rutgers University Press (p207).

24. Demetrios S J (2003). Dementia with Lewy Bodies and the neurobehavioral decline of Mervyn Peake. *Arch Neurol 60(6)*: 889–892.

25. Peake M (1972/1974). The Threads Remain. From: *A Book of Nonsense.* (Originally published 1972) London: Pan Books (p82).

Book Reviews

Therapeutic Song-Writing: Development in theory, methods and practice

Felicity A Baker

Palgrave Macmillan, 2015, £24.99
ISBN 978 1 137499 22 6

The latest book from music therapist Felicity Baker builds upon Baker and Wigram's work *Songwriting* some ten years earlier. The work takes us on an international journey through this rapidly developing area of therapeutic practice. The book is diverse in terms of clinical and cultural practices, and I believe something that clinicians within most frameworks and backgrounds could benefit from.

Therapeutic Song-writing is divided into four sections. Part one provides a succinct introduction, useful for those who have yet to engage with song-writing. Part two examines factors effecting song-writing, from the role of music (conveying meaning, building identity, etc), group factors (size, cohesion, etc), individual factors (emotional wellbeing, personality, etc) to the physical space. Part three takes the reader through an extensive journey of methods to approach the practice. This section is succinct, readable, and eminently practical, enabling any therapist to consider how they might approach using song-writing, and the potential challenges and outcomes - regardless of their musical experience or skill level. It includes literature reviews for each method, and a handy diagram of each process. Part four is possibly the most complex and thought-provoking part of the work, where Baker breaks down major practice frameworks and explores song-writing's place within each.

The approach Baker has taken to song-writing showcases its great potential within therapeutic work and helps us see its applicability to a range of fields, whilst also moving music therapy towards a more professional, measured interventionist perspective. The text will certainly become a definitive guide to the topic, and I would recommend it as an accessible, appealing read to music therapists, students, and those engaged in arts and health research

Kate Gee

Tearagh't: a novel

Craig Newnes

The Real Press, 2017, £8.99 paperback
£1.99 kindle edition
ISBN 978 1 912119 62 2

A novel about a recurrent theme – a relationship where lovers are parted by war with an uncertain outcome; but in a specific historical context.

Bringing together these two elements doesn't work all that well for me – perhaps I'm nit-picking. The author seems to suggest (by writing part one in old English and part two in a modern vernacular) that lovers separated by war is an eternally recurrent theme. But how can he be sure that they would think the same way about sex and love and write about it in the same way as we might today? The description of lust is very self-aware 21st century therapist. Would a 16th century converso woman be so self-aware and so capable of writing openly about her lust? There are two things one can say about this – what makes it more difficult for me to judge is that I have no Jewish background and secondly I never lived in the 17th century. But I'm aware that in history, sexual mores, openness and self-awareness change dramatically in just a few decades; see Stephan Zweig's description of Austria and Vienna pre-World War One and afterwards. It was the same in the UK in the '50s and the '60s and then different again in the late 1970s. I don't believe the author's 1588.

Both main characters write through a diary – an interesting device for getting an inward and reflective view in both characters. I looked to see and found it was not unknown at this time for people to write reflective diaries but I think two highly literate people with a passion for writing would surely stand out as remarkable in the world at that time.

I found the voice and narrative of Beatriz particularly difficult to believe partly because of reference to things like shops and schools – but then perhaps that's more a reference to Jewish religious education tradition and economic roles. It's ironic that in 1588 there was no state education – that had to wait till the early to mid-17th century when Amos Comenius found enthusiasm for his project of formal teaching rather than letting people learn things in a vernacular unorganised way. So I find a woman character who articulately writes down the minute stuff of everyday life and exchanges completely open reflections about her sexual feelings to close relatives and onto paper implausible.[1]

Ivan Illich writes about this historical epoch.[2] His work is particular interesting and relevant because it is about language, and writing and vernacular culture and the politics of that. If you were going to have an empire you not only needed Armadas you needed to teach everyone to speak the same grammatical Castilian... of course Franco was still trying that a few centuries later and it's still bubbling in Catalonia as a result.

There's lots of Craig Newnes in the book – particularly with the woman character especially about writing and being driven to be doing. I wish him luck with the next.

Brian Davey

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1. https://garnlebaron.wordpress.com/sexual_relations_in_renaissance_europe/
2. http://www.preservenet.com/theory/Illich/Vernacular.html#RISE

Trauma, Culture, and PTSD

Fred C Alford

Palgrave Macmillan, 2016, £45.00
ISBN, 978 1 137575 99 9

Well structured, thoughtful and written in such a way that the rigour and critical engagement the author brings to his topic does not reduce the pleasure in reading this volume. The author communicates complex ideas without obscuring them. The book starts from the assumption that whilst the diagnostic framework of PTSD is problematic and reflects current socio-political positions around suffering it remains a useful starting point in understanding the role of trauma in individuals and communities.

Alford engages with a broad range of research and models of trauma though his focus is on psychoanalytical perspectives. The book elegantly summarises the relevant models and how they might apply to an understanding of trauma. Alford clearly sees merit in several therapeutic perspectives but is also able to succinctly point out the shortcomings of those models. The book reserves a particularly critical perspective for work linking trauma models to neuroscience and provides a broad but compelling critique of this area in general before looking at some of the specific problems which are raised in research with those who have been traumatised.

Of particular interest is when Alford looks at wider political concepts of trauma and what the growth of this diagnostic category says about Western perspectives on mental health. The thinking about the cross-cultural application of this idea has breadth but the brevity of the book means that it is a topic that does not get the depth it deserves. There is, however, an excellent summary of key points in this field.

The book does not engage with the literature on what interventions might work with traumatised individuals; this would have been very helpful. It is likely to leave the reader inspired and curious about this topic but therapists would still need to look elsewhere for signposts to interventions.

Dr Andrew Beck

Transcultural CBT for Anxiety and Depression (Routledge 2016)

Interpersonal Relationships and Health

Christopher R Agnew & Susan C South

Oxford University Press, £48.99, 2014
ISBN, 978 0 199936 63 2

At a time when services in the UK are being asked to develop integrated healthcare models with an increasing need to draw on a bio-psychosocial perspective; this book is a valuable resource. Most health and social care professionals have exposure to the bio-psychosocial model in core training, but it is arguable that it is more often discussed than applied in practice. In bringing the social element into focus and its interrelationships with the psychological and physical, the book demonstrates evidence as to why there should be closer collaboration in health and social research. The focus on social relationships is welcome as while these are understood to influence health and impact on health behaviours, the processes underling the influence are perhaps not so well understood. The book concludes that developments in prevention and intervention will be informed by such research.

The introduction by the two editors, a social and a clinical psychologist, leads the reader directly into the challenges of research in this area. It asks why mental and physical health are still viewed as separate so many years after Descartes and reflects that there is a need to appreciate the bi-directional influence between relationships and health so that while relationships influence health, health also impacts relationships. In discussing social relationship theory it is posited that while models such as attachment theory recognise the impact of disrupted attachment on physical health, biological variables are not always integrated into psychosocial research.

The first of the two major sections in the book examines the biology of interpersonal relationships and the second section looks at the evidence base related to marriage, family, social relationships and health and wellbeing. The first section summarises the development of the field of psychoneuroimmunology (PNI)) which links social relationships, psychological factors and biology. It points out that while the biological factors studied are nuanced, psychological factors tend to be conceptualised simplistically under the generic term 'stress'. It is argued that social researchers could better integrate models of PNI into their work so contributing to the evidence base. The section then looks at cardiac research and the positive and negative influences relationships can have on the cardiovascular system. Further chapters look at the impact of family relationships on cortisol and there is a chapter on divorce and health outcomes.

The second section usefully brings in lifespan issues. A chapter looks at how marital discord and community group conflict impact on the wellbeing of children and there is a chapter looking at health outcomes and relationships in older adults. Sexual issues including risk behaviours are also discussed as is the impact of intimate partner violence.

Methodology is not neglected and the summary chapter argues that detailed measurement of physiological and psychosocial variables of interest must be undertaken in order to further this research field. The authors advocate that longitudinal and multi-method design is likely to be most fruitful.

The book will be of interest to both researchers and clinicians. It is likely that as social change brings ever more complexity into relationship and social structures this field of research will grow.

Angela Busuttil

The Therapy Relationship: a special kind of friendship

R Hallam

Karnac, 2015, £24.99
ISBN, 978 1 782202 52 3

The title of this book is enough to trigger panic in the average therapist. The notion of therapists being friends with their clients goes against everything indoctrinated into mental health practitioners upon entry into services. Once you get past the unsettling title, Hallam makes a compelling argument. Hallam does not advocate the complete abandonment of boundaries, but instead attempts to address the misconceptions about therapy by drawing parallels with friendship. The qualities valued in a therapist are akin to those you would use to describe a good friend. This does not mean that anyone could be a therapist; the selfless role of the therapist in carrying the woes of their client departs the therapy friendship from that of the usual friendship dynamics he explains.

There are parts that would appeal more to the philosopher or sociologist, than the psychologist or mental health practitioner; for example, examination of historical texts on friendship provide a level of detail not necessarily of much practical use. The highlight of this book is the consideration of the ethical guidelines of therapy delivery, and how these interact with the idea of the therapists being a friend, and the ever present fear of malpractice allegations.

Hallam clearly does not care for making any friends of his own in the writing of this book. He challenges the very notion of evidence based practice in therapy, pokes a stick at the three dominant schools of therapy, and rubbishes the branding war amongst therapy developers. It is refreshing to read a book that is written with conviction; even if you don't agree with Hallam, you can't help but admire his inability to sit on the fence. For the open minded, this book will make you think and question every assumption of accepted psychological practice.

Cassie Hazell

Therapy, Culture and Spirituality
Greg Nolan & William West

Palgrave Macmillan, 2014, £63.00
ISBN, 978 1 137370 42 6

In *Therapy, Culture and Spirituality* Nolan and West bring together writings exploring the interconnectivity of culture, religion, spirituality and 'race' in the context of therapeutic practice and research. The book is a welcome addition to the increasing scholarly interest in interrogating artificial dichotomies such as 'nature'/'culture' and 'objective' science and medicine/'subjective' counselling and therapy in understanding and working with human distress. Indeed, religion and spirituality have historically posed problems for psychology and psychiatry as disciplines concerned with making sense of and managing distress. Through well-researched articles, the book presents multiple ways of working through the seeming contradictions and arriving at solutions that could enable counselling practices better suited for a multicultural society. The chapters explore lived realities of 'race', culture and spirituality as well as applications of therapeutic traditions ranging from Native American healing, Jungian analytical psychology, pastoral care, spiritual accompaniment and so on.

One area in which this book falls short is a lack of focused discussion of whiteness in relation to 'race' and culture and practices of spirituality and religion within counselling spaces. Discussions in the context of therapy and counselling tend to posit a Euro-centric 'we' whose job is to counsel an alien 'they' for whom spirituality and religion are relevant. While this problem and the need for self-reflexivity is touched upon (for example, in chapter 5 by William West), none of the chapters explore it in-depth. Roy Moodley, one of the contributors, has previously argued that white majority trainees on counselling courses should engage with their white identity and that discussions on multiculturalism should include white people as clients. A discussion on whiteness as 'race' and culture and its implications for embodied practices of spirituality and religion within therapeutic spaces would have enriched this important book further.

Dr Jayasree Kalathil
Independent researcher Survivor
Research

Applications of Group Analysis for the Twenty-First Century

Jason Maratos

Karnac, 2016, £29.99
ISBN, 978 1 782201 13 7

This is the second book in a two volume collection of previously published papers on group analysis. The first volume ‘Foundations of group analysis for the twenty-first century’ focused on seminal conceptually orientated papers from the beginnings of group analysis and across its subsequent development. This text in contrast focuses on the applications of group analysis in diverse fields and contexts of practice. The thirteen papers selected by the editor of both volumes, Jason Maratos, are divided into nine sections: forensic psychotherapy, family dynamics, organisational consultancy, anti-discrimination/feminism, supervision, education, combined therapies, research and addictions. Only the sections on family dynamics and research have more than one paper so inevitably it is only possible to get a limited sense of the work in most of these areas but the intention of the book is precisely to provide just such a selective overview.

Whereas the first volume could easily be read from cover-to-cover as a cumulative historical introduction to the development of group analytic thinking I would imagine that this collection of applied papers is more likely to be used for selective reading or reference according to an individual reader’s personal interests.

Some readers might be a little surprised to find that eight of the papers come from the twentieth century given the title of the collection. I had certainly jumped to the mistaken assumption that the foundations volume would focus on the field’s history and development leaving this book to showcase practice today with a strong eye to the future. The papers in fact range from 1974 to 2014 and as such provide a range of both contemporary and a little more distanced exemplars of context and practice. This of course has its own value but I was left feeling a little disappointed that it wasn’t quite the explicitly forward looking volume that I had anticipated. The book, however, works well as an illustration of the broad influence and relevance of the group analytic paradigm and includes some interesting and rich papers to start from in exploring many of the areas covered.

Michael Maltby

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. Reviewers will be sent a subscription form for the journal.

Conyne, R. *The Oxford Handbook of Group Counselling.* OUP.

Duke, N. & Mallette, M. *Literacy Research Methodologies (2nd Ed.)* Guilford.

Franklin, C. et al (Eds.) *Solution-Focused Brief Therapy.* OUP.

Heller, M. & Pollet, S. *The Work of Psychoanalysis in the Public Sector.* Routledge.

Jensen, M. *Hypnosis for Chronic Pain Management.* OUP.

Johnson, B., & Koocher, G. (Eds) *Ethical Conundrums, Quandaries, and Predicaments in Mental Health Practice.* OUP.

Klein, R., Bernard, H. & Schermer, V. *On Becoming a Psychotherapist: The Personal & Professional Journey.* OUP.

Kenny, D.T. *The Psychology of Music Performance Anxiety*. Oxford University Press.

Kottler, J. & Carlson, J. *Duped: Lies and Deception in Psychotherapy*. Routledge.

Luiselli, J. *Teaching and Behaviour Support for Children and Adults with Autistic Spectrum Disorder.* OUP

Piechowski, L. *Evaluation of Workplace Disability.* OUP.

Norcross, J. *Psychotherapy Relationships that Work.* OUP.

Otto, M. & Smits, J. *Exercise for Mood Disorder.* OUP.

Stanton, M. & Welsch, R. *Specialty Competencies in Couple and Family Psychology.* OUP.

Thornicroft.G. et al. (Eds) *Oxford Textbook of Community Mental Health.* Oxford University Press.

Wachtel, P. *Therapeutic Communication: Knowing What to Say When.* Guilford Press.