Critical Psychotherapy and the Psychosocial Conceptualisation of Psychopathology

Thesis completed in partial fulfilment of a

Master of Arts degree in Psychotherapy,

School of Arts, Dublin Business School,

Dublin

by

John Kearns

under the supervision of

Dr. Mary Peyton

June 2019

Department of Psychotherapy

Dublin Business School

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Acknowledgements

Many thanks to Dr Mary Peyton for her support and helpful feedback, and for giving me space.

Abstract

This is a theoretical consideration of a dilemma posed in 2016 by Richard Brouillette: How should psychotherapy approach the issue of clients whose distress originates with difficult life conditions? After the problem is introduced and research area charted, Chapter 2 assesses what can be gleaned from psychotherapeutic discussions of psychopathology relating to the *DSM* and psychoanalytic diagnostics. Brouillette's dilemma also raises questions of "normality" (is Brouillette's client "normal" in the sense of mentally healthy? Are her working conditions normal?), thus this notion is interrogated in Chapter 3, referring to the Rosenhan Experiment, Allen Frances and Erich Fromm. Chapter 4 provides psychosocial perspectives, like the potential for the vulnerability-stress hypothesis to conceptualise psychotherapeutic challenges, and David Smail's social materialist psychopathology. The conclusion plots future research trajectories.

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Introduction

This work was inspired by an article published by Richard Brouillette in the *New York Times* titled "Why Therapists Should Talk Politics" (Brouillette 2016),[1] which suggested that it may be more effective for clients in therapy to address and try to change issues in the external world in which they live, rather than try to develop internal resilience and coping strategies to live with these issues. Furthermore, Brouillette suggests that it is the therapist's role to identify when such "external" factors may be present and relevant to the client's presenting problem, and to work with the client to see about ways in which she or he can confront them. A more detailed explication of the article is presented in Chapter 1, along with some of the issues it raised among those who commented on it, and other theoretical issues which it gives rise to.

One of these issues – the conceptualisation of the client's 'problem' in psychopathological terms – is identified as particularly interesting from a therapeutic viewpoint, and it is this which the thesis addresses. After outlining the challenges the problem poses, the first chapter concludes with a survey of the research areas relevant to the topic, and a review of the relevant literature.

Chapter 2 examines the topic of psychopathology as it is discussed in professional psychotherapy circles. This is a discussion that has typically tended to revolve around the contentious *Diagnostic and statistical manual of mental disorders* (*DSM*), and thus a recent debate among therapists in a professional journal will be presented for the depiction it presents of divisions in the professional therapeutic community regarding the matter of diagnosis. In particular, the fact that the *DSM* emanates from the psychiatric community rather than from psychotherapy will be discussed regarding its implications for taking stock

[1] The article is included in Appendix A.

of the external factors which Brouillette refers to in the assessment (and possibly diagnosis) of the client. This will then lead to a more general discussion of the role of psychopathology in psychotherapy, focussing on the premises underlying a separate attempt by Nancy McWilliams at developing modes of diagnosis from a psychoanalytic – rather than a psychiatric – background, to assess the extent to which such modes can accommodate or address the kind of action being proposed by Brouillette.

A central issue to psychopathology is the nature of the client's problem in relation to 'normality' or 'mental health.' Chapter 3 opens with a discussion of this issue particularly in terms of the issues raised by the Rosenhan Experiment (1973) and its legacy. Again in relation to the issue proposed by Brouillette, the significance of society and the external world in which the client lives and functions will be examined, and here the discourse of Critical Psychotherapy will be introduced with a discussion of Erich Fromm's *The Sane Society*.

Chapter 4 will continue this discussion of the role of critical psychotherapy in adumbrating some psychosocial perspectives on the dilemma, such as the potential for the vulnerability-stress hypothesis to conceptualise the psychotherapeutic challenges raised by the case and, building on the conceptualisation of distal and proximal factors in this apprach, an account of David Smail's social materialist account of psychopathology. It will be proposed that if the problem is to be conceived in "external" terms (relating to capitalism and societal power structures) then psychotherapy must acknowledge that as a discipline it too belongs among these same contingencies.

The work finishes with a brief conclusion, outlining other avenues potentially providing fruitful opportunities for investigation.

Chapter 1

Conceptualising a Presenting Issue as 'External': Implications for Psychopathology

1.1. Brouillette: Should Therapists Talk Politics?

This study takes its lead from a 2016 *New York Times* article by Richard Brouillette, a therapist working in New York City, who describes one of his clients who is stressed and upset because of ever-increasing demands from her employer to work longer hours uncompensated. Tensions had been building in the client's workplace for some time and the woman, a mother, was experiencing stress both in the workplace and at the prospect of having to spend more time away from her children. While this was woman's story, Brouillette stressed that the scenario was one he was encountering more frequently in his practice. Faced with such clients – whose stress appears to be a reasonable response to unreasonable work or life demands that are being made of them – Brouillette considers what his role as therapist is, or should be:

> When people can't live up to the increasingly taxing demands of the economy, they often blame themselves and then struggle to live with the guilt. [...] When an economic system or government is responsible for personal harm, those affected can feel profoundly helpless, and cover that helplessness with self-criticism.
>
> (Brouillette, 2016: unpaginated)

As such, people seek therapy suffering from problems that they feel are either entirely within them, or are resulting from their interaction with the world, again experienced in their own psyche – guilt, stress, anxiety, etc. Brouillette's dilemma as a therapist is what to do when it seems plain to him that the 'problem' is not in the psyche of the client, but rather in the external life circumstances:

> Typically, therapists avoid discussing social and political issues in sessions. If the patient raises them, the therapist will direct the conversation toward a discussion of symptoms, coping skills, the relevant issues in a patient's childhood and family life. But I am growing more and more convinced that this is inadequate. … When therapists make the dialogue only about their patient's life narrative, without including a frank discussion of social and economic hardships, they risk reducing psychotherapy to a tool of social control. (ibid.)

And yet, while this may be a quandary for psychotherapy as a discipline, it is the client who may well be getting the rawest deal, working to pay for therapy that will attempt to help her or him to cope with work demands which are unfair in the first place:

> If the patient describes a nearly unbearable work situation, the therapist will tend to focus on the nature of the patient's response to that situation, implicitly treating the situation itself as unchangeable, a fact of life. But an untenable or untenable or unjust environment is not always just a fact of life, and therapists need to consider how to talk about that explicitly. This is, in ways, an old quandary in psychotherapy. Should therapy strive to help a patient adjust, or to help him change the world around him. Is

> the patient's internal world skewed? Or is it the so-called real world that has gone awry? (ibid.)

Brouillette's conclusion is that it is "therapists need to consider … political action in the consulting room as inherent to the therapeutic process" (ibid.).

The article generated considerable discussion in the comments section. Some respondents noted that there was great potential for unintended consequences in what Brouillette was proposing – a client becoming motivated to tackle injustices in the workplace might as easily result in that client getting fired as in getting improved employment conditions. Alternatively, the other colleagues in the workplace could suffer. R. Erle from Brooklyn commented

> As accurate as this therapist may be in defining his patient's situation, as a therapist one has to guard against using the patient as a tool for playing out one's own proclivities, resentments etc. which can become a slippery slope. … One can reinforce these feelings with the wrong person and then find out that the next day [she or he has] shot his boss and several co-workers. (ibid. comments section, April 5th 2016)

Some commenters noted the risks in the therapist bringing his or her own socio-political opinions into the therapeutic alliance:

> When I was a graduate student … I had a left-wing radical feminist for a therapist. She didn't let me grow into my own person, as I was made to feel that any thoughts that weren't her thoughts were verboten. Hence I knew everything about Karl Marx

> and Mary Daly … but nothing about my own crummy little life. (Pal Joey, ibid. comments section, October 10th 2016)

Nevertheless, the majority of those who commented appeared sympathetic to Brouillette, agreeing that the situation that he described posed challenges that therapy, for whatever reason, needed to confront.

1.2. The Present Study

What are these challenges that Brouillette's dilemma poses for therapy? The gauntlets thrown down are numerous: How to address the risk of therapy colluding in societal injustices, or of the therapist colluding with the client? Is a therapist always in a position to determine what is just or unjust with regard to a client? Can a therapist make such decisions about justice without disclosing his/her own values and, if not, is such self-disclosure warranted? Is what Brouillette is proposing dependent on the therapeutic modality within which the therapist is working?

This study will address just one aspect of the dilemma raised. If we take it that, excepting trainee therapists, the vast majority of clients come to therapy wishing to address a problem (usually of an emotional nature), how is the therapist to conceptualise that problem by taking stock of not merely the client's internal world or psyche, but also of the external world in which the client works and lives? If Brouillette is right and psychotherapy is becoming (if it has not always been?) a way of empowering the individual to confront and meet social and professional demands that may well be unreasonable, then it is easy to see the potential for such therapy to become not merely a lackey for the excesses of capitalism, but

more problematically a way of legitimating those excesses in the first place by assuming at the outset that the 'problem' – and consequently the solution – is not in changing the world, but in changing the individual.

The work that follows will consider the implications for psychotherapy of Brouillette's scenario concerning the relationship between psychotherapy and psychopathology. Expressed in its baldest terms, Brouillette's example raises the issue of whether the client's presenting issue exists 'in' the client (as one might conceive of a medical ailment) or in the environment in which the client functions. Naturally most clients in therapy bring with them issues relating to the interaction of internal and external factors. Yet while Brouillette is right in identifying the reluctance of therapists to discuss socio-political issues in sessions, this is counterbalanced by an awareness of the inadequacy of conceiving psychotherapy exclusively (or even primarily) along 'medical' lines.

Numerous psychotherapeutic theorists have shown how problematic it is to consider a client coming to therapy as suffering from an illness with manifest symptoms, and to then propose a treatment whereby these symptoms can be alleviated with the supposed aim of achieving full recovery. Nevertheless, as a profession whose practitioners continue to rub shoulders with health professionals, a profession where clients are often understandably attracted by the possibility of a 'cure', and as a profession whose theoretical premises are informed as much (if not more) by psychiatry as by philosophy, the non-medical conception of psychotherapeutic clinical practice can be hard for therapists and clients alike to envisage or conceptualise. One of the contentions of the present work is that it is this difficulty that has largely (albeit not exclusively) shaped psychotherapy's continuing relationship with psychopathology, and that an approach developed from current trends in Critical Psychotherapeutic thought may challenge psychopathology in interesting and beneficial ways.

1.2.1. Psychotherapy and the Going "Within"

There are two important caveats to be made here. Firstly, challenging the continued presence of the medical conception of psychotherapeutic care does not necessarily mean that we dismiss the idea that there are such phenomena as 'mental disorders', in the way argued by certain adherents to the anti-psychiatry movement such as Thomas Szasz (1961). Critical thought has evolved extensively in this regard in the past four decades and psychotherapy would do well to examine critically the responses and challenges from psychiatry, while realising that these responses have their provenance in a different discipline.

Secondly, challenging the apparent exclusivity of psychotherapy's preoccupation with going inwards – the assumption that Brouillette makes about apolitically changing oneself rather than the world in which one lives – is not to deny the effectiveness of many therapeutic techniques that do involve working on the psyche of the client, often through the client's body, including stress-response techniques such as mindfulness, meditation, yoga, autogenics, body therapy etc. Some of these techniques have proved particularly successful in recent years in addressing trauma, particularly in the work of van der Kolk, Rothschild, Ogden and others.[2] It is merely to say that this is not the *only* response that exists. A war veteran may well find body therapy helpful in addressing PTSD arising from military conflict, but this does not mean that she or he may not also find political engagement in addressing the causes of such conflict therapeutic in other ways.

There has certainly been a political edge to the writing of many of the major psychotherapeutic thinkers – Carl Rogers became concerned with the political implications of

[2] See van der Kolk (2014), Rothschild (2000), Ogden et al. (2006).

his work in his later years (Rogers 1980), while psychoanalysis has long been politicised, particularly with the work of Lacan in France after 1968 (Frosh 1987, Turkle 1992). Moreover, the past three decades have seen a growing concern with the more the general political positioning of therapy in society, as we will see when we come to discuss the rise of Critical Psychotherapy.

1.2.2. Psychopathology: Conceiving the Presenting Problem

Returning to Brouillette's example, we referred to 'the problem' – the problem that brought the client to therapy, the problem that keeps the client in therapy, the problem as conceived by the client, the problem as conceived by the therapist. But *what is* this problem? Is it just the one 'stable' problem, or a problem that can metamorphose according to circumstance and subject? Are we talking about different problems? Indeed, is it necessary to assume that there is a problem in the first place, or is the assumption of a problem tantamount to harnessing psychotherapy in a medical straitjacket – an approach, as noted earlier, that many of psychotherapy's most prominent theorists and practitioners have traditionally resisted? Therapy in its psychoanalytic conception, is a more general investigation of subjectivity, with benefits – including healing – occurring as a by-product of this investigation, rather than through a focus on addressing the symptom.

This does not, however, take from the fact that – as noted earlier – most people seeking therapy for purposes other than training do so because they have a problem. In Ireland, they may come to therapy on the strength of a referral from their GP or public health nurse, or on the recommendation from a friend, but very few will ever come with 'unproblematic' lives (if such lives exist), simply seeking self-discovery. Thus, in taking as

its focus the matter of psychopathology, this work will focus attention on the 'problem' that brings the client to therapy: is psychotherapy – as Brouillette suggests – more likely to privilege one understanding of where this problem is over another, and might this be to the detriment of the client?

1.3. Review of the Literature

1.3.1. Psychopathology

In the literature on psychopathology, psychotherapy is notable by its absence, or at least by the fairly pedestrian way in which it is treated. A landmark 800-page publication such as Blaney & Millon (2009) makes very few references to psychotherapy, almost all of which are to psychoanalysis. Maddux and Winstead (2016), another large-scale overview of the topic, features just one essay on psychotherapy (Stewart and Chambless 2016) that bizarrely ignores the issue of psychopathology entirely, focussing instead on the challenges of conducting research in the field. Despite humanist-integrative approaches being consonant with the socio-neuropsychological adopted by Lee and Irwin (2018), the book has scarcely a mention of psychotherapy (and only a single mention of psychoanalysis). In their consideration of what they call the paradigms of psychopathology, Stirling and Hellewell (1999) consider the psychoanalytic paradigm and humanist and existential paradigms (which they associate with therapy) alongside biological, learning and cognitive paradigms (18-19) and make occasional reference to psychotherapy – their work will be discussed later.

1.3.2. Psychotherapy and Psychopathology

One way of interpreting the lack of attention to psychotherapy in publications on psychopathology might be that it is reflective of more general interdisciplinary tensions, with psychiatry – which it might be argued enjoys a higher status as a medical discipline – being less interested in building bridges to psychotherapy than in ploughing its own disciplinary furrow. Another point that should be addressed, however, is whether or not it is *relevant* for psychopathological literature to consider psychotherapy and, concomitantly, whether psychopathology is *relevant* to psychotherapy, given the qualms noted earlier regarding the misappropriation of the medical model in psychotherapeutic literature. In this regard, it is our contention that it is not difficult to demonstrate the enduring fascination that psychopathology holds for psychotherapists.

In the space of two years, the journal[3] of the Irish Association for Counselling and Psychotherapy (IACP) featured two separate discussions of *The diagnostic and statistical manual of mental disorders* (*DSM*), giving rise to five separate articles (Mullen 2016, Peyton 2016, McHugh 2018, Lynch 2018, Comerford 2018).[4] These will be discussed in more detail in section 2.1., but are presented here to demonstrate the continuing relevance of debates about the diagnosis and nosology of mental disorders to many in the psychotherapeutic community. Indeed, in terms of content, many of these debates are not dissimilar to discourses that have been voiced in literature in psychiatry, with some of the key texts here being Wakefield (1992), Horwitz (2002), Double (2006), Pilgrim (2007), Horwitz and Wakefield (2007), Watters (2011), and Vanheule (2014 and 2017). It is important to note that the present work is not primarily an assessment of the merits or otherwise of the *DSM* or psychiatric diagnosis. In this respect, attention should also be paid to other attempts from

[3] Over the course of the publication of these articles, the journal changed its name from *Éisteach* to *The Irish Journal of Counselling and Psychotherapy*.
[4] Mullen (2016) also prompted a separate response in another journal: Comerford (2016).

within psychotherapy to address the issue of diagnosis (we will later discuss McWilliams 2011, which was the basis for Lingiardi and McWilliams 2017).

1.3.3. Critical Psychotherapy

As noted above, our discussion of diagnosis in psychotherapy, rather than being presented for its own sake or to critique the existing psychiatric models of nosology, will be focussed squarely on the reconsideration that Brouillette is proposing with regard to psychopathology and the problems that bring our clients to therapy.[5] Brouillette's remarks can be situated in the landscape of the recent political turn in psychotherapy in general, and in terms of Critical Psychotherapy in particular.

The term "political" here is used in its most general sense to refer to the government of people. Integral to this, then, is the question of power – a theme that is also so central to the therapeutic relationship that it is difficult to conceive of how therapy could *not* be political. Yet in spite of the political edge present in the writing of many psychotherapeutic thinkers that we mentioned in 1.1.1., consideration of the political implications of power imbalances has only gained sufficient traction to be considered an identifiable research trend in therapy studies in the past three decades, in works such as Dryden and Feltham (1992), Samuels (1993, 2006, 2014a, and 2014b), Totton (2000 and 2006), Proctor (2002/2017), Proctor et al. (2006), Feltham (2010), Loewenthal and Samuels (2014), as well as the journal *Psychotherapy and Politics International* and in the work of the association Psychotherapists and Counsellors for Social Responsibility. Questions of power imbalances conceived in

[5] The phrasing here is significant – we are less interested in the problems that our clients initially bring to therapy than in the problems which bring our clients to therapy, as the two may be quite different. It is not unusual for a client to bring one problem to therapy only to discover that this is merely a symptom of a much different, much deeper issue towards which the real therapeutic work will be directed.

political terms were central to the development of Narrative Therapy by Michael White (White 2007:25) and one theorist who was integral to his work – and to much of the other thinking here – is Michel Foucault, particularly his book *Madness and civilization* (1964). Nevertheless, in spite of this blossoming of research, there remains scant examination of the implications of this turn in psychotherapy on psychopathology, and it is this paucity of research that has occasioned the present work.

The term 'Critical Psychotherapy,' while referring to this relatively recent current in psychotherapeutic thought, can nevertheless be understood in different ways. Conceived of narrowly, it refers to a way of thinking of psychotherapy generally associated with certain British and American psychotherapists and psychotherapeutic scholars, notably Del Loewenthal, Andrew Samuels, Keith Tudor, Gillian Proctor, Colin Feltham, and Kenneth J. Gergen. Loewenthal (2015b) has identified these theorists' thinking as generally emanating from three different intellectual traditions. Firstly, there is the tradition of anti-psychiatry represented by Thomas Szasz, R.D. Laing, David Cooper and others (Cooper 1967). Heaton (2006) provides a good account of the trajectory from anti-psychiatry to critical psychiatry[6] and much of his critique of traditional psychiatry holds true as a motivation for the development of Critical Psychotherapy. The impact of anti-psychiatry can be seen most directly in the approaches adopted by Cotton & Lowenthal (2015), Proctor (2006), Proctor (2002/2017), MacDonald (2006), Oakley (2012) and most of the other contributors to Itten & Young (2012), and others, though anti-psychiatry's critique of the medicalisation of mental disorders is a more pervasive theme underlying much of the writing in this field. An important landmark in the anti-psychiatry movement was the Rosenhan Experiment in 1973m which will be discussed in Chapter 3.

[6] For more on the related – though distinct – field of Critical Psychiatry, see the contributions to Double (2006).

Secondly Loewenthal identifies two strains of critical theory which have exerted a significant influence on much Critical Psychotherapeutic thought. The first is that of the Adorno, Horkheimer and the Frankfurt School of theorists with its focus on the extent to which we are imprisoned by ideology, which is entrenched in the language that we use (Loewenthal 2015b:6). In Chapter 3 we will consider the work of a theorist who, in his early years at least, was associated with the Frankfurt School, Erich Fromm. The second, more popular strain of critical theory in Critical Psychotherapy is that of the tradition of philosophical scepticism – the questioning of essentialism and the possibility of certainty in knowledge – which, though stretching back to Greek philosophy, can be seen more recently in the work of Heidegger (himself a major influence on existential therapy), Levinas, Derrida and Wittgenstein – examples of this intellectual tradition in Critical Psychotherapy can be seen in Cooper (2006), Groarke (2015), and Verhaeghe (2014). In this respect, in the final chapter, we shall examine David Smail's social materialist perspective on psychotherapy.

Yet this is merely the topography of Critical Psychotherapy as delineated by one of its theorists, a theorist who makes it clear that one of his fears for this current of psychotherapeutic thought is that it will be reduced to just that – a single current:

> My concern … is that once the field of critical psychotherapy, psychoanalysis and counselling is established, it will become a minority module on mainstream [education and training] programmes, with the implication that (as with psychiatry and psychology) mainstream psychotherapy, psychoanalysis and counselling become by definition primarily 'uncritical'. (Loewenthal 2015b:6)

Thus, to obviate this ghettoization of Critical Psychotherapy, it is worth considering it more broadly in terms of the more general political turn that one can see in psychotherapeutic

scholarship and writing in recent years, and thus it is this broader understanding of Critical Psychotherapy that will be adopted here.

Chapter 2

Psychopathology and Discourses of Diagnosis in Psychotherapy

2.1. Therapists and Psychiatric Psychopathology: Attitudes to the *DSM*

In the previous chapter, we mentioned exchanges on the topic of diagnosis in general – and the *DSM* in particular – that took place in the journal of the IACP in the two-year period, from 2016 to 2018. The articles are salutary for our present purposes as they reveal much about how, rightly or wrongly, contemporary psychotherapists see the role of diagnosis in their work, and it is primarily in this regard that they will be discussed, rather than for what they have to say about psychopathological nosology. It would be easy to make such nosology the focus of this discussion – as it is the focus of the critics of the *DSM* in this IACP debate, as well as in Frances (2013), Vanheule (2014, 2017) and elsewhere – but our purpose here is primarily to examine the role of what diagnosis should be with regard to therapy, particularly with regard to the matter of whether and how the "external" factors mentioned by Brouillette are to be accommodated in any diagnostic model, and this thus requires a consideration of the relationship of psychotherapy to psychology and psychiatry in the first instance, prior to any critique of the tools of these disciplines. This is significant – after reading authors such as Frances and Vanheule, the contributions of those extolling the virtues of the *DSM* in the IACP debate may well seem naïve; they may, however, be considered important in terms of what they reveal of the tacit assumptions and ideologies that prevail among the psychotherapeutic community (as indeed, in a different way, may those of their respondents).

Of the two advocates for the *DSM* in the IACP discussion, the more enthusiastic was Denise Mullen, whose assertion that the *DSM* is "recognized as the Bible of the psychology

world" (2016:20) is revealing in terms of how she situates psychotherapy in relation to psychology. She sees knowledge of the *DSM* as necessary for us to "be on board with our psychotherapy and counsellor peers in the EU and the US" (20)[1] and thus as determining the discourse of the professional psychotherapy community. Moreover, Mullen sees diagnosis as integral to successful psychotherapy: "my hunch is that a wide range of potential clients are being encountered and then lost largely because of a lack of clear knowledge of how to diagnose properly" (2016:20). This she links to assessment in that "we need the diagnostic equipment … in order to assess accurately the presenting issues," (ibid.) though the possibility of such terms playing a role in pre-determining the outcomes of assessment is not considered. Furthermore, while a link between diagnosis and assessment is identified, the precise nature of this relationship is not elaborated.

It is easy to pick holes in the thoroughness of Mullen's arguments – though she acknowledges that there are objections to the *DSM* from those who "feel it labels people… [or who] practice from a Rogerian perspective and [feel] the disorders described by the *DSM* fall outside their scope," (2016:20), these objections are not examined. Indeed, regarding how therapists should learn to use the *DSM*, the tone of Mullen's advice might raise some eyebrows:

> If the book looks huge, imposing and scary to wade through… then don't. Look at what you specifically need: is it a clear definition of depression or adjustment disorder? Casually look at the descriptive portion, allow room for the stuffy sounding

[1] It is also worth noting that Mullen tacitly appears to regard "counselling" and "psychotherapy" as synonymous. The nature of this distinction (or indeed, whether it exists at all) is a major matter of contention in the professional counselling/psychotherapy community in Ireland and one which has led to a rift between two major professional bodies, the IACP and the Irish Association for Humanistic and Integrative Psychotherapy (IAHIP). While a discussion of the implications of the distinction between counselling and psychotherapy for psychopathology is beyond the parameters of the present study, the matter of modality is important. As such, "psychotherapy" in this study will be taken to refer to "humanistic-integrative psychotherapy" in the Rogerian tradition.

> words, and keep going. Then look at the list of criteria and, more importantly, how many need to be ticked in order to warrant the diagnosis? [sic] Then take a client that [sic] you feel meets a lot of the criteria and carefully attempt to match their specifics with the listed descriptions. This practical, do-able exercise will teach you a great deal in a short period of time. (Mullen 2016:22)

Nevertheless, despite its non-academic tenor,[2] Mullen's article is salutary for our current purposes in the way it mixes pusillanimity with bravado in its depiction of the therapist. Mullen's depiction of the *needs* of the therapeutic community is certainly pusillanimous: we *need* to diagnose because our clients *need* diagnoses; we *need* to diagnose as a way of displaying our knowledge base; we *need* to be familiar with *DSM* parlance because this is the language of our masters. Its bravado comes in the less-than-rigorous approach that Mullen adopts to *DSM* implementation: don't worry about the big words – just diagnose. While it may not be revealing about the nature of psychopathology, it is very telling about the appeal of diagnosis to therapists and arguably, by extension, about professional therapeutic insecurities.

The second advocate of the *DSM* in the debate, Eugene McHugh, is more circumspect, displaying a greater cognisance of debates around the shortcomings of diagnosis ("I am fully behind the idea of not labelling our clients and in meeting them wherever they are" (2016:21)). Again, he sees the benefits of the *DSM* in terms of providing a discourse that enables dialogue with other professionals and in terms of enhancing client assessment, though again the relationship between assessment and diagnosis is not examined with any rigour, and indeed later in his paper he conflates the two, despite acknowledging that assessment can involve separate yardsticks such as Beck's Depression Scale or the Clinical

[2] In fact, it might well be argued that Mullen's avowedly non-academic, come-hither tone makes her *more* representative of rank-and-file counsellors and psychotherapists outside academia.

Outcome in Routine Evaluation – Outcome Measure (CORE OM). While acknowledging that emotional health and mental health influence each other, McHugh nonetheless sees them as separate, with the former being the proper concern of psychotherapists (23). It could thus be alleged that McHugh leaves himself vulnerable to allegations of blurring disciplinary boundaries here, an impression reinforced when, following a defence of the disciplinary autonomy of psychotherapy, he then asks "should professional counsellors embrace a medical approach in order to aid our work?" (2018:24). It is as though the "medical approach" is another therapeutic modality that can be leveraged in an integrative therapeutic model, though as we have seen, numerous therapists would see the dynamics of the medical model as incommensurate with those of humanistic-integrative therapy.

Indeed, as regards the responses to the articles from Peyton, Lynch and Comerford, the medicalisation of emotional disorders was one basis on which criticisms were levelled ("There are no biological markers for most of the disorders named in the *DSM*," Peyton 2018:5). Yet the challenges which the *DSM* poses for what can be considered a "condition" transcend the medical – Lynch cites Rosenberg (2013), who notes that strict adherence to the *DSM-5* would result in 50 per cent of people being diagnosed with a mental disorder by age 40 (Lynch 2018:5), a statistic which raises obvious questions of both validity and of what can be considered normal and the matter of normality and mental health will be discussed in greater detail in Chapter 3. Mullen's praise for the *DSM* as a "bible" of the psychology world is countered by the former director of the U.S. National Institute of Mental Health Thomas Insel, cited by Lynch:

> While the *DSM* has been described as a 'bible' for the field, it is, at best, a dictionary, creating a set of labels and defining each. The strength of each of the editions of the

> *DSM* has been 'reliability' - each edition has ensured that clinicians use the same terms in the same ways. The weakness has been its lack of validity.
>
> (Insel 2013, cited by Lynch 2018:5)

The prioritisation of reliability over validity has been noted by various commentators and linked in particular to the development of the *DSM* from its third edition onwards, where a shift is evident from aetiologies informed by psychoanalytic, psychotherapeutic and psychiatric approaches to a more exclusively psychiatric approach in a reliance on biology. Nancy Andreasen has been one of many to echo Insel's concerns: "Validity has been sacrificed to achieve reliability. *DSM* diagnoses have given researchers a common nomenclature – but probably the wrong one" (Andreasen 2007, cited by Lynch 2018:6). As Comerford notes citing Pete Sanders, "historically the construction of the *DSM-5* was shaped by an epistemology that is 'doxic,' in turn creating a classification that is arbitrary" (Sanders 2017:16, cited in Comerford 2018:5). Does the notion of reliability over validity sound inherently contradictory? Certainly the lack of validity is critiqued by many of the numerous sources quoted by Lynch, particularly Spitzer's account of the process of consensus by which thresholds were determined (why did they decide on five criteria as a minimum threshold for depression "Because four just seemed like not enough. And six seemed like too much" (Carlat 2010:53, cited in Lynch 2018:7)). Thus, the problem in moving towards a more exclusively psychiatric conception of psychopathology is not simply that it involves a move towards a more biological understanding of mental illness (which is problematic in itself), but that in doing so biology itself is not the primary aetiological criterion – the primary criterion at the time the *DSM* was being revised was consensus among psychiatrists. Therein lies a contradiction in terms that must be addressed even before – or at least at the same time as – consideration may be paid to the external factors that Brouillette discusses.

While acknowledging the possible use of the *DSM* in providing a common psychopathological terminology for clients who have received diagnoses prior to psychotherapy, Peyton notes that it remains possible for us as psychotherapists to have a different relationship with diagnosis, adding that "many clients are not served by a diagnosis and some are significantly harmed" (Peyton: ibid.). So is there *ever* a role for diagnosis in humanistic psychotherapy? Peyton believes that there is not – "as humanistic therapists we are not in the business of diagnosis, diagnosis takes no account of subjectivity or relationship" (Peyton 2016:6) – but concedes that a framework within which we can work with clients may be beneficial, especially with very vulnerable clients. This is a topic that shall be returned to later.

We have given scant attention so far to Comerford's response to McHugh – it takes the form of a near-line-by-line excoriation of McHugh's article which might well be more successful in generating sympathy for the misguided-but-beleaguered McHugh than in further convincing its reader of the troublesome nature of the *DSM*. Comerford makes it clear at the outset that he is writing from the Rogerian perspective of client-centred therapy and attacks what he sees as McHugh's tendency to "discount" the principles of client-centred therapy, discounting being "…when people minimise the parts of themselves, others and the environment" (Feltham & Dryden 2004:66, cited by Comerford 2018:5). Thus, discounting betokens a crisis of confidence, though one might question the efficacy of vitriolic attack as a strategy to generate and nurture such confidence.

In addressing this tendency to discount, Comerford cites the core conditions of Client-Centred Therapy (CCP), noting in particular how Carl Rogers regarded them as "necessary and sufficient" (Comerford 2018:6); he refers to Rogers's core belief in the "actualising tendency" of clients (ibid.) – person-centred therapy can enable the client to gradually "discover that his own organism is trustworthy, that it is a suitable instrument for discovering

the most satisfying behaviour in each immediate situation" (Rogers 1961/2015:18, cited by Comerford 2018:6). The message is simple: Why look to the *DSM* when Rogerian therapy has all the answers?

What if this question is not taken as rhetorical? In Comerford's understanding, the urge to reach for the *DSM* – and perhaps the urge to diagnose in general[3] – is representative of a lack of faith in the core conditions, whether this be understood as "discounting" (in Comferford's terms) or what we referred to as "pusillanimity" in our discussion of Mullen earlier. In client-centred counselling, the therapist alone is enough, and failure to acknowledge this adequacy is failure as a therapist. To this stance we would like to propose two challenges:

i) Do we then take the enduring interest in diagnosis in the psychotherapeutic community as professional ineptitude? Is the fact that one might *consider* the matter of diagnosis at the outset a betrayal of one's professional – perhaps even personal – insecurities?

ii) Returning to our consideration of the problem posed by Brouillette at the outset, in Comerford's terms it is as worthy of dismissal as the notion of therapeutic diagnosis – the core conditions will suffice in the therapeutic scenario to facilitate self-actualisation and thus the injustices faced by the client in her or his life can be addressed. And yet the philosophical and political challenges remain – we may well say that the solution lies within the client to change his or her life circumstances, but how does this position therapy in socio-political terms?

[3] Comerford reserves his ire for the DSM alone and does not refer to any other psychopathological nosologies.

2.2. Why Diagnose? Psychopathology from a Psychotherapeutic Standpoint

While, as Comerford notes, diagnosis does not fit in the CCT modality of psychotherapy, this does not mean that no psychotherapeutic models of diagnosis have been elaborated. As such, we shall consider two here with regard to the alternative conceptualisation of psychopathology which they propose to the psychiatric model underlying the *DSM*, and in particular we shall relate our discussion to the issue which we started out with in Chapter 1 – that of the challenge of considering life circumstances in our assessment (diagnosis?) of a client in the manner proposed by Brouillette.

The mode of psychotherapeutic psychopathology that will be examined will be Nancy McWilliams's presentation of psychoanalytic diagnosis (particularly in terms of the rationale which it proposes for psychotherapeutic diagnosis) (McWilliams 2011) that subsequently formed the basis for the *Psychodynamic diagnostic manual* (Lingiardi and McWilliams 2017). It should be noted that this model has never achieved anything like the fame (or indeed the notoriety) of the *DSM*, nor have others emanating from a psychotherapeutic background (e.g. Shedler-Westen Assessment Procedure (SWAP) (Shedler and Westen 2007)). Furthermore, McWilliams is writing about psychoanalysis (or perhaps psychoanalytic psychotherapy) – quite a distinct modality from CCT, though the mere fact she is coming from a psychotherapeutic rather than a psychiatric tradition makes her work interesting to contrast with the *DSM* or *ICD*.[4]

[4] ICD = International Classification of Diseases, which also covers psychopathology. The ICD is used as an alternative to the DSM in certain countries.

2.2.1. Psychoanalytic Diagnosis

McWilliams acknowledges that some psychotherapeutic objections to diagnosis carry a certain validity: diagnoses are prone to misuse, diagnostic terms tend to assume pejorative connotations ("insults with a pedigree") and there are numerous well-documented problems with labelling people according to their problems (ibid.:7-8). Nevertheless, in a concession that might well be termed "discounting" by Comerford, though is more similar to Peyton's idea of a framework within which we can work with clients, she maintains that it is still helpful to have a language that generalises about individual differences and their implications for treatment, especially for trainee therapists: "Once one has learned to see clinical patterns that have been observed for decades, one can throw away the book and savour individual differences" (ibid.:7).

McWilliams writes "I am unconvinced by the argument that simply allowing a relationship to develop will create a climate of trust in which all pertinent material will eventually surface" (ibid.:8). Is this a criticism of the kind of Rogerian approach advocated by Comerford, an approach that Sterling and Hellewell refer to as "idiopathic" (1999:11)? Hers is a stance that sees opposition to psychotherapeutic diagnosis in terms of the potential for the misuse of such diagnosis; Comerford's point is not that it is prone to misuse, but that it should have no role in therapy (i.e., CCT) in the first instance. Could it then equally be a criticism of CCT that it disregards the potential for character patterning (or, to use Johnson's term, "character styles" (Johnson 1994)) to reveal tendencies in the way certain life situations can be addressed? Of course, this is something entirely different to the enterprise of a nosology of disorders like the *DSM* (and thus demonstrates how a discussion of diagnosis centred around the *DSM* can miss the therapeutic point). Moreover, it is also both entirely separate and inherently relevant to the dilemma posed by Brouillette's example. It is separate

because, in his example, the life circumstances that are causing the problem are presented as being *objectively* unfair – they are the sort of circumstances that anyone, whether they be considered mentally healthy or ill, emotionally resilient or vulnerable, would have a problem with. As such, this "problem" is not a matter of mental disorder, though emotional distress will obviously be a symptom. Yet it is also inherently relevant to Brouillette's example because the person's character style may reveal not just how they will manage the stress of the job, but also how they found themselves *in* the job in the first place. Herein lies the hope that is essential for therapy – if the client's character has both granted and moulded their agency in finding themselves in *that* job, then that same character and the skills it enables will equally be integral to addressing the problems in that job, or to seeking out an alternative, perhaps finding a different job. Resilience and hope are key here, and this is where therapy can help.

Yet what if the external life circumstances respond to this with the sucker punch of depriving the client of those possibilities, of alternatives, of that external hope? For example, what if we are not talking about Brouillette's New York, but a small town during a time of recession where few sources of alternative employment exist, when our client is in negative equity on her mortgage, is perhaps raising a number of children on her own, perhaps one of whom has special needs.[5] She may come to therapy suicidal, and yet there is a strong case for saying that there is nothing wrong *with* her, in spite of so many things being wrong in her life.

The issue mentioned earlier of the distinction between assessment and diagnosis seems very pertinent here: we assess the client, let them tell us about their life circumstances and their symptoms. The needs that we saw with Mullen – that we identified as pusillanimous in her argumentation – are nevertheless present in a palpable way in the therapist's own search for a diagnosis, though "diagnosis" here may be cloaking a deeper search for hope – a

[5] In my own experience, this scenario is no less improbable than Brouillette's.

hope that is necessary for the therapist to find if she or he is to be of any benefit to the client. Aside from the Rogerian distaste for diagnostics, this urge could of course be countered by asking, why should we look to a manual like the *DSM* when the problem so clearly seems *not* to be in the client, but in the world in which they live? Is there a temptation to pathologise an inability to deal with life that is harder to resist than the realisation that life at certain times and in certain circumstances cannot be dealt with? If so, how does this manifest in the therapist and in the counter-transference?

Earlier we referred to the distinction between assessment and diagnosis and there is a sense in McWilliams's discussion that she is very much referring to the act of assessment rather than anything that could run the risk of labelling:

> For those of us who associate a diagnostic session with images of authoritarianism and holier-than-thou attachment, let me stress that there is no reason an in-depth interview cannot be conducted in an atmosphere of sincere respect and egalitarianism. [...] Patients are usually grateful for professional thoroughness. One woman I interviewed who has seen several previous therapists remarked 'No one has ever been this interested in me!' (McWilliams ibid.:8-9)

McWilliams here is eager to distinguish between what she calls "descriptive psychiatric diagnosis" with her own mode of "inferential / contextual / dimensional subjectively attuned diagnosis." The *DSM*, she contends, lacks an implicit definition of emotional health or wellness. Bearing in mind Insel's and Andreasen's comments referred to earlier, it is also worth noting that McWilliams criticises it[6] for both validity *and* reliability. She concedes that earlier editions of the *DSM* (specifically the second) were excessively

[6] It should be noted that as McWilliams is writing in 2011, her references are to the DSM-IV-TR.

psychoanalytic, failing to take stock of other powerful ways to conceptualise psychopathology, yet attempts to redress this imbalance led to a "deemphasis on the client's subjective experience of symptoms" (ibid.:9) and it is this *experience* of symptoms that psychotherapy is in a unique position to address.

On the appellation of the term "medical model" to the mode of diagnosis espoused by the *DSM*, she queries the focus on symptoms: "[N]o physician would equate remission of symptoms with the cure of the disease" (ibid.:10) and thus the traditional suspicion with which psychoanalysis has viewed a therapeutic focus on the symptom (in contrast with a modality such as Cognitive Behavioural Therapy) is seen to be not so far removed from the medical conceptualisation of treatment. Yet, in considering the nature of psychopathological symptoms, McWilliams goes further in also critiquing the reification of categories of "disorder" leading to a tendency to see psychological problems as discrete symptom syndromes.

There, she contends, two problematic effects of this: firstly there is the creation of the possibility for insurance companies to specify the lowest common denominator of change, even though this may be the tip of the psychopathological iceberg. This is obviously as much a critique of insurance assessment as it is psychopathological, though it can also be seen to exert an obvious potential influence on the course of therapy. Secondly, however, this atomisation of symptoms that results from the categorical approach is obviously one that benefits pharmaceutical companies, who can market specific treatments for particular new conditions – Allen Frances notes that the arrival of Prozac coincided with the publication of the *DSM-III* in 1987 and that sales of the drug took off at least partly because of the manual's very loose definition of "major depressive disorder" (Frances 2013:69). Somewhat alarming support for the interconnectedness of Prozac with nosological categorization is provided by Cosgrove (2010), who notes how, when pharmaceutical giant Eli Lilly's patent expired on

Prozac, the company put the same ingredients into a pink pill called Serafem, and created a new illness – "premenstrual dysphoric disorder (PMDD)" – which it was claimed the "new" drug could treat. As McWilliams notes: "Many women become irritable when premenstrual, but it is one thing to say 'I'm sorry I'm kind of cranky today; my period is due' and another to announce 'I *have* PMDD'" (McWilliams 2011:11, emphasis in original).

It is easy to be critical about this, as indeed Cosgrove is regarding the conflict of interest it reveals in the professions of psychiatry and psychopharmacology. Yet is there not also an argument against this, positing that to regard PMS fatalistically as a "norm" is disempowering? One response to this is the generally problematic nature of psychopharmacology that has been extensively documented (Kramer 1993). Yet, McWilliams provides a separate argument which addresses directly the matters of (dis)empowerment this topic raises: categorical diagnosis leads to a "reification of self-states for which one implicitly disowns responsibility. 'I have social phobia' is a more alienated, less self-inhabited way of saying 'I am a painfully shy person'" (McWilliams 2011:11). Introducing the notion of responsibility here may be contentious – we are hardly to *blame* PMS or shyness on those who suffer from their effects. Yet responsibility too implies that one can take action about a particular problem. This is important in considering the criticism of the fatalism or norms noted above – pharmacological solutions appear empowering only when they are presented as the *only* effective solution, and only when removal of symptoms really means removal of the problem. If there is an argument for this in the case of PMS, it still does not mean that there are no other approaches to the problem; yet the example of a drug being used to "treat" shyness is another matter altogether.

In relation to the kind of interaction with real-world concerns that Brouillette describes, the categorical diagnosis of the *DSM* or *ICD* again proves problematic. For example, from 1980 it was specified that a criterion for the inclusion of a mental disorder in

the *DSM* was that there had to be empirical research to support the disorder's inclusion. In some ways this sounds eminently responsible as a matter of scientific procedure. At another level, however, it was problematic. In 1980 there was enough empirical research to justify the inclusion of multiple personality disorder (later termed "dissociative identity disorder") in the *DSM*, yet very little research had been conducted into childhood dissociation. As such, in spite of the general agreement among clinicians that dissociative identity disorder in adulthood is generally preceded by dissociation in childhood, the *DSM-IV* included no diagnosis for childhood dissociation (McWilliams 2011:10). While testable hypothesis formation in science follows on from naturalistic observation, the reality of psychopathologies mean that they are observed by clinicians before they can be studied (McWilliams 2011:10).

If the traditional rationale of the planning of treatment is adopted for diagnosis, then this alone is sufficient to conceptualise in a medical sense, generating a distinction in treatment between idiopathic and nomothetic approaches. This is not to lay a claim to idiopathic approaches (exemplified by the position adopted by Comerford) being universally desirable, or at least not in the psychoanalytic tradition; on the contrary, for characterological issues psychoanalysis will favour certain approaches for certain personality types: "Even the most classical analyst will be more careful of boundaries with a hysterical patient, more pursuant of effect with an obsessive person, more tolerant of silence with a schizoid patient" (McWilliams 2011:11). While it is worth considering the potential loss inhering in a stance that would jettison this level of characterological awareness, it is also worth bearing in mind whether such a focus on character styles, their tendencies in reaction and their potential for resilience might again distract a therapist's attention away from the intractability of real-world challenges in the manner suggested by Brouillette.

Indeed, returning to Brouillette and the client whose problem was her stressful lifestyle, McWilliams makes the point that a major advantage of psychoanalytic diagnosis is that it is (now) good at distinguishing between symptoms that are related to stress in life, and those that originate in a problem intrinsic to the client's personality (McWilliams 2011:13). There is a big difference between a woman with symptoms of bulimia who is alarmed by the relatively sudden development of her disorder in first year of college and a woman who has had binge-purge cycles since primary school to the point that they have become normalised. While the prognosis for treatment for both women would be very different, as far as *DSM* classification is concerned, both women would simply be diagnosed with "bulimia."

This matter of nuance is significant, and perhaps in that very notion of "nuance" lies the key to the positive potential of the kind of psychoanalytic psychopathology that McWilliams is advocating. It is less a question of detail in terms of "labelling" (the reified atomisation that would appear to be the inevitable destiny of a system underlying the *DSM*) than in a sensitivity to the client's condition determined by therapeutic considerations – those attendant to the possibility of treatment or healing, even if they are not fatalistically determined by it. McWilliams writes: "Once I have a good feel for the person and the work is going well, I stop thinking diagnostically and simply immerse myself in the unique relationship that unfolds between me and the client" (2011:18). While the distinction between diagnosis and assessment remains a moot point in McWilliams's model, the general evolution of the therapeutic relationship is that of the therapeutic alliance, traditionally conceived.

2.3. Conclusion

One matter that has not been addressed extensively in the above discussion – either with regard to the *DSM* or to psychotherapeutic psychopathology – is that of client expectations. It may sound obvious to state that a client who goes to therapy is expecting a therapeutic solution to her or his problem, and yet this is a significant factor influencing the diagnostic scenario presented by Brouillette. The client experiencing real-world difficulties needs help, and while it may not exclusively be help at an emotional level that is being sought (other agencies such as legal aid, social workers etc. may also be involved), the therapist is presented a case for psychotherapeutic treatment. Thus, as treatment – and arguably diagnosis – are in some way pre-determined by the client's choice to present in therapy.

What is the deciding factor in choosing therapy, in the client's own perception that their 'problem' is one of mental (ill-)health? When does sadness, sorrow, anxiety, exceed the quotidian level which we can be expected to deal with on our own, and when does it reach the threshold where professional help is required? This will be the topic of the next chapter, in particular the nature of emotional "normality" and disorder, and the question of sanity in the individual and in society.

Chapter 3

Normality and Disorder in Psychopathology and in Society

3.1. The Vexed Question of Normality

3.1.1 "The Normal Are Not Detectably Sane": The Rosenhan Experiment, and Robert Spitzer

The last chapter concluded with some remarks on the influence exerted on considerations of psychopathology by the client's presentation, in and of itself, to therapy. Regarding psychotherapeutic assessment and diagnosis, much is typically made not just of the way a client describes her or his symptoms, but also *how* the client presents, in terms of appearance (complexion, clothing, posture, gait, demeanour etc.) While these factors are important, here we mean something separate to this – that which is communicated by *the fact that* a client presents in therapy.

In considering this issue, it is worth recounting a famous experiment in the history of psychopathology. In the early 1970s a research team led by David Rosenhan were admitted as in-patients to psychiatric hospitals on the grounds of complaining of auditory hallucinations (Rosenhan 1973). As in-patients, they returned to acting "normally" – as will be seen, the issue of what "normally" means in this context is a moot point, but in practical terms they ceased to report the auditory hallucinations. Nevertheless, they found that during their periods in hospital, the slightest things that they did tended to be interpreted as symptoms – a patient waiting for dinner, for example, was reported as displaying behaviour "characteristic of the oral-acquisitive nature of the syndrome" of schizophrenia (Rosenhan

1973:256) – though some of the other patients realised there was nothing wrong with them. All participants were released after a certain period (on average, 19 days) on condition that they acknowledged that they had a mental illness (all but one were diagnosed with schizophrenia "in remission") and that they agreed to taking antipsychotic medication.

Rosenhan's study proved controversial in the psychiatric community, eliciting a scathing response from Robert Spitzer (Spitzer 1975), who would subsequently go on to compile the *DSM-III*. Looking at Spitzer's rejoinder, it becomes clear that Rosenhan's experiment was more multifaceted than merely revealing inadequacies in psychiatric diagnosis. Rather than investigating all of the experiment's implications – along with those of Spitzer's responses – let us limit our consideration to what both Rosenhan's and Spitzer's positions reveal about attitudes to "normality."

It is clear from both that once the pseudopatients reported their hallucinations, different standards of normality applied. Rosenhan challenged the diagnosis of schizophrenia, saying that they should have been diagnosed as having hallucinations of unknown origin, i.e., a diagnosis effectively based on a description of symptoms; for Spitzer, the symptoms betokened schizophrenia – a syndrome of which the symptoms are merely the external manifestation (Spitzer 1975:449). On admission to hospital, however, pseudopatients' behaviour returned to "normal," though Rosenhan and Spitzer disagree about what this is: for Rosenhan it is merely the absence of the symptom. Spitzer, however, challenges the designation of pseudopatients' behaviour as normal, citing another commentator who noted that

> the pseudopatients did *not* behave normally in the hospital. Had their behavior been normal, they would have walked to the nurses' station and said 'Look, I am a normal

person who tried to see if I could get into hospital by behaving in a crazy way or saying crazy things.'

(Hunter 1973:361, cited in Spitzer 1975:443, emphasis in original).

If, for Spitzer, absence (or remission) of symptoms alone was not sufficient to denote normality, this then raises the question: what else had happened for schizophrenia, rather than hallucinations, to be considered the diagnosis? There are two factors worth bearing in mind here: firstly the patients' decision to report, and secondly their decision to report these symptoms to a psychiatrist, rather than, for example, a psychotherapist, counsellor, social worker, religious minister, or friend.

Taking the first factor – the act of reporting – it is worth considering this alone as an act of communication. In communication theory – and specifically relevance theory – the decision to communicate, separate from the content communicated, is regarded as "ostensive behaviour" (Sperber & Wilson 1995:46-53). Thus what Sperber and Wilson refer to as the "ostensive inferential" nature of the reporting of the pseudopatients' symptoms in the Rosenhan Experiment itself partly communicated the response that was expected – that of a psychiatric diagnosis. Reporting the experience of auditory hallucinations is one thing, but aside from communicating the nature of the symptoms the subject experiences, the subject's *decision* (in ostensive-inferential terms) to report this itself communicates a desire for her or his condition to be addressed.[1] This is a significant point and one which this reader has not encountered in the extensive literature on the case – Spitzer's frustrations in his response ("One hardly knows where to begin," (ibid.:443)) can be seen as comparable to those of Comerford, referred to in the last chapter, in spite of the fact that both reflect entirely

[1] This is often referred to as the decision "to reach out," and is particularly significant in addiction therapy, where it constitutes an important stage in recovery. Identifying it as ostensive-inferential serves merely to grant it a more general currency, extending its relevance to other psychopathological environments.

opposite attitudes to diagnosis. The ostensive-inferential act of *reporting* a symptom, for Spitzer, is sufficient for one conception of normality (non-pathological) to be replaced by an entirely different pathological normality, according to which symptoms are not perceived in isolation (as Rosenhan would wish) but are understood as signifying a different mental state. Moreover, on being discharged, the pseudopatients' injunction to acknowledge the fact that they had a psychiatric condition (albeit one that was currently "in remission") – what Rosenhan refers to as the "stickiness" of psychodiagnostic labels (Rosenhan 1973:252-254) – shows how difficult this new psychiatric/pathological normality is to leave behind.

This final detail is significant in relation to the more general theme of this work – the consideration of the external lifestyle factors that Brouillette mentions. While the pseudopatients on discharge were hardly labelled for life, the fact that the absence of their symptoms could only be seen in terms of remission serves to show how their diagnosis sealed their fate regardless not only of external circumstances (they were urged to continue taking their medication rather than to make lifestyle changes or engage in therapy) but also of their own reporting of their symptoms. They would carry with them their psychiatric history and normality, conceived in whatever way, would be hard to return to. Thus the kind of injustices reported by Brouillette, which can obviously exert severe psychological trauma, might be more likely to be played down as their reporting in itself could be seen through the lens of the client's past psychiatric history.

Regarding the second factor – the choice of a *medical* specialist to present to – inhering in this is the acknowledgement of a power structure: hospitals are where you go for all illnesses physical or mental, and are thus ultimately trustworthy. Nevertheless, there is very much a sense that the pseudopatients were *submitting* to this power: once in hospital, they had to play by hospital rules – rules that redefined their normal behaviour as "symptoms." Indeed, the submission was so total that one even gets the impression that a

different standard of normality applied within the hospital. This is further evidenced in the fact that, on discharge, the new "normal" persisted – the pseudopatients could only leave by agreeing with the hospital authorities that they had a mental illness. This will seem particularly relevant when we discuss the power structures attendant to David Smail's idea of social materialism and psychopathology in Chapter 4.

3.1.2. Psychiatry Forty Years On: Allen Frances and Normality

> "Defining *normal* should be easy and being normal should be a modest ambition. Not so. Normality has been badly besieged and is already sadly diminished."
>
> Allen Frances, *Saving normal* (2013:3)

Historically, the Rosenhan Experiment can be seen as part of a larger debate in the 1960s and early '70s in which many of the precepts of psychiatry began to be challenged by the anti-psychiatry movement referred to in Chapter 1. An account provided forty years on by one of Spitzer's colleagues – and chair of the *DSM-IV* Task Force – Allen Frances will be examined for the different perspective it provides on both psychopathology and mental good health.

While Frances's book *Saving normal* is a searing critique of the *DSM-5* (the work of Frances's successors) for its role in pathologising many "normal" mental states, it is also interesting for his bleak view on the uses his own work and that of his colleagues in the 1970s and '80s had been put to, and his admission that his *DSM-IV* "had probably resulted in more

harm than good" (Frances 2013: xiv).[2] Failings of the *DSM* are chronicled for many of the reasons we have seen already – arbitrary diagnostic standards, atomisation of symptoms resulting in (and indeed inviting) an over-reliance on psychopharmacology, etc. – yet the matter of normality that was so central to the Rosenhan/Spitzer debate, remains centre stage four decades on. It is presented, however, in more diffident and circumspect terms at least partly because of the challenges posed by the successive editions of the *DSM* to considering what is normal and what is pathological.

That abnormality is critical to our discussion of psychopathology may be seen in its centrality not only to the Rosenhan/Spitzer debate, but also to Brouillette's scenario, where the client does not appear to question the (ab)normality of her life/work conditions, or at least not before working to develop her own resilience to them. Yet if we are to understand abnormality, we much also understand normality and, after the defensive dogmatism of Spitzer's critique of Rosenhan, it is refreshing to read his former colleague's doomed attempts to define what is ostensibly a simple concept. The dictionary, Frances reports, is unhelpfully tautological: normal is not abnormal (ibid.:4). If we look to philosophy, then utilitarianism – "the greatest good for the greatest number" – might appear promising in providing an idea of what that good might be in terms of health or ill-health. Yet its ill-suitedness may be shown by the fact that it was used in this way in Nazi Germany to provide a *highly* restrictive notion of "normality" to determine not only sanity and insanity, but also life and death (see Fuller Torrey & Yolken 2010). It is thus not without irony that Frances concludes that it was this utilitarian principle that determined the approach adopted in the *DSM* (Frances 2013:5).

What about statistics? The idea of normality that can be arrived at via bell curves and standard deviations may appear beguiling, but it is ultimately unsatisfactory when it comes to

[2] This admission was also echoed by Spitzer when he was interviewed by Adam Curtis for "The Lonely Robot," the second episode of Curtis's BBC documentary *The Trap: What Happened to Our Dream of Freedom?* (Curtis 2007).

the human psyche. It might be tempting to attempt to define a set of criteria according to which an individual experiences mental distress, accord each criterion a scale, use a series of assessment tests to mark people on the scale for the various criteria, determine greater or lesser degrees of normality using standard deviation, and then decide (but how?) on percentile thresholds between mental health and ill health. Yet even if all this could be done, it would still not provide a workable definition of what it means to be mentally healthy. To deem someone in the 19th percentile ill and someone else in the 20th percentile healthy is absurd – mental illness manifests in different people in different ways and these two people may display similar levels of incapacity. Even a sceptic reading Brouillette's dilemma would still have to admit that we are mentally healthy or ill according to the life challenges we may encounter and in our interactions with the world. It is not inconceivable that someone suffering a social phobia, but happy enough with their own company, might well live a perfectly fulfilled solitary life – a life that might prove difficult for more social people. Such variables – and many others – are resistant to statistical measurement.

Medicine too provides no enlightenment as to what is normal. It is likely that very few people are healthy if we are to adopt the World Health Organisation's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of infirmity" (WHO 1946, cited in Frances 2013:9). Am I sick if my body aches after strenuous exercise or if I feel sad after a bereavement? Again, the problems with thresholds that we saw with statistical solutions are present here too: if I become forgetful as I get older, at what stage does it become pathological?

The difficulty in defining "normal" is, for Frances, matched only by the difficulty in saying what is abnormal: "I have reviewed dozens of definitions of mental disorder (and have written one myself in *DSM-IV*) and find none of them the slightest bit helpful either in determining which conditions should be considered mental disorders and which not"

(ibid.:16-17). Nonetheless, in drawing attention to this definitional difficulty, Frances is not entirely siding with the anti-psychiatry camp and saying that mental disorders do not exist. He has sympathy here with the motives of one of the most famous exponents of anti-psychiatry Thomas Szasz[3] – mental illness is used as justification for the incarceration of numerous "problematic" groups, from troublesome misfits to political dissidents. While it is important to guard against this abuse of psychopathology, there are also reasons to suspect that Szasz's "myth of mental illness" may itself be mythical (Wakefield 1992:374). There are, after all, patterns to the kinds of issues clients present with. While it may be hard to characterise a condition like schizophrenia as a discrete pathological entity (like a tumour or a heart attack), it is nonetheless recognizable through a series of symptoms, and brain correlates. Moreover, it is possible to predict the course of the disorder and also to recommend certain treatments.

Disorders are recognizable. The problems come when they are to be described at an aetiological level, which is why editions of the *DSM* from the third onwards made no attempt to provide aetiologies, relying instead on the description of symptoms. The advantages to developing a rigorous descriptive nosology must have appeared tantalizing in the early 1970s, given the crisis faced by psychiatry from opponents such as Szasz, Rosenhan and Laing, and Spitzer's efforts, as presented by Frances, appear heroic. And yet the consequences of characterising disorders without aetiologies has been, as we saw in the last chapter, that all manner of human discomfort can be pathologised.

The solution to defining disorders for psychiatrists, as proposed by Frances, is "utilitarian pragmatism" – to call mental disorders as they are seen (ibid:21). And yet given the fluidity with which they appear to be manifest, a fluidity that has grown extensively over

[3] It is interesting to note that Szasz, who had died in 2012, is mentioned in the acknowledgements to Frances's book: "[A]lthough I strongly disagreed with [his] extremist views … I very much liked him personally and always admired his willingness to fight for what he thought was right" (Frances 2013:287). It is hard to imagine such bonhomie in the defensiveness of someone like Spitzer in the post-Rosenhan days of the mid-1970s, or indeed from Jerome Wakefield in the early 1990s (see Wakefield 1992).

the past five decades with overdiagnosis and the increasing involvement of pharma in the treatment of mental distress, as disorders have become more atomised and targetable, is the middle-ground option of calling mental disorders as they are seen really so viable? Psychiatry does not view mental disorders in society at a remove – rather it very much influences the object it is observing, and nowhere is this more visible than in the growth in influence of the *DSM* that Frances is writing about.

So far, much of our attention has been on psychiatry. What of psychotherapy? In some ways, many of the more severe psychoses that concern psychiatrists are of little concern to psychotherapists as they may not be suitable for psychotherapy in the first instance. However, another comment that Frances makes in discussing the limitations of the *DSM* is of relevance to psychotherapy: "A great deal is lost in the translation between the rich diversity of different individual experiences of depression and the bland five-of-nine criteria set used to describe it" (ibid.:25). While Frances makes the case for psychiatrists to be sensitive to the diversity of individual experience, this is where it is easier for psychotherapy to come into its own.

It is this recounting of the experience of societal and cultural factors that leads Brouillette to his dilemma, a dilemma which marks a very significant point of departure from Frances's account. For Frances, normality is something to be trusted – a common-sense position that allows us, as he says, to adopt the pragmatic approach of calling mental disorders as they are seen. Given the context of the well chronicled escalation of diagnoses attendant to the growth in use of the *DSM*, this is understandable. Yet this position does not allow for the questioning of normality itself as a yardstick for mental health and this is a significant factor attendant to Brouillette's dilemma – what if the "normal" world itself is the problem? In the next section, another perspective will be offered that locates the pathology not (solely) in the client, but (also) in normality.

3.2. Critiquing Mental Health and Normality: Erich Fromm and *The Sane Society*

Returning to Brouillette's example, what if we were to conceive the problems faced by Brouillette's client not just in socio-political terms, but in a pathological light? What if we consider the pathology to be in society rather than (or, perhaps, as well as) in the individual?

This was a possibility that Freud considered in *Civilisation and its discontents*, where he tentatively proposed a research project "upon a pathology of cultural communities"[4] (1930/2001:144), though he acknowledged that the methodological hurdles in such a study would be considerable. It was a challenge taken up by Erich Fromm in *The sane society* (1956).

In Chapter 1 we mentioned that a significant current of Critical Psychotherapy emerged from the work of the Frankfurt School, whose theorists had embarked on an ambitious project from the late 1920s onwards of exploring the potentials of synthesising the work of Marx and Freud, believing in Fromm's case that "psychoanalysis could supplement Marx's oversimplified notions of human psychology … by explaining why the victims of irrational authority and exploitation so readily acquiesced to their fate" (Ingleby 1991: xxi). Fromm had started out among such theorists as Siegfried Bernfeld, Otto Fenichel, Paul Federn and Wilhelm Reich and like them trained and practised as a psychoanalyst, though unlike them, he lacked medical training – a fact which ultimately led to his expulsion from the International Psychoanalytic Association in the 1950s. For years before that he had disagreed with many of Freud's central psychoanalytic premises, in particular that "the basic

[4] This is from the Vintage edition based on the 1930 Joan Riviere translation. Interestingly, Fromm (whom one presumes would have read Freud in German) quotes the line as "into the pathology of civilized communities" – probably his own translation, giving a greater insight into his own interpretation of Freud's proposed programme.

passions of man are not rooted in his instinctive needs, but in the specific conditions of human existence, in the need to find a new relatedness to human nature having lost the primary relatedness of the pre-human stage" (Fromm 1956/1991:xi). Fromm came in for harsh criticism from his former Frankfurt School colleagues – particularly Herbert Marcuse – and even his present-day supporters acknowledge failures in his thinking (David Ingleby, devotes a large section of his introduction to *The sane society* to a discussion of the book's shortcomings (1991:xxxviii-l)). Nevertheless, while even his exponents such as Petteri Pietikainen acknowledge that he "is a 'forgotten intellectual' … as a 'revisionist psychoanalyst' he has a relatively secure status" (Pietikainen 2007:168) and the idea of "the pathology of normalcy" developed in *The sane society* – the idea that societies, as well as individuals, can be ill – continues to prove influential (Pietikainen 2007:177-182; Burston 1991:133-158; Ingleby xxiv-xxxviii, l-liii).

In elaborating the pathology of normalcy, Fromm is attempting the outline an aetiology of alienation. In this context, he attacked the view associated with Adolf Meyer which had dominated in the USA for at least two decades previously, that return to mental health involved socialisation, and in particular the individual's return to citizenship. There was much in common between Meyer and Fromm – Meyer's own break from Kraepelinian diagnostics and the characterisation of patients into pre-existing nosological categories was consonant with many of Fromm's ideas (Lee and Irwin 2018:43). For Meyer, mental disorder was characterised as a functional deficit manifesting in maladaptation and his standpoint can be seen as the opposite of what we saw in both the Rosenhan Experiment and in Spitzer's reaction to it: "The Meyerian model conceptualised psychiatrists' task in terms of resocialization and it also gave them a new social role as counsellors of right living" (Pietikainen 2007:178). What was being proposed was conformism-as-therapy, which was critiqued by Fromm on the grounds that society needed to adjust to the needs of its citizens

rather than vice versa – "normalcy" in society is a symptom of social pathology. The relevance to the situation described by Brouillette over sixty years later is immediately apparent, though here the enemy is not the psychiatrist wishing to re-socialise the client, but the psychotherapist who sees the solution as within the client in terms of developing resilience to address "pathological normalcy,"

> From the standpoint of normative humanism we must arrive at a different concept of mental health; the very person who is considered healthy in the categories of an alienated world, from the humanistic standpoint, appears as the sickest one – although not in terms of individual sickness, but of the socially patterned defect.
>
> (Fromm 1956/1991:197)

Both Brouillette and Fromm are critiquing redemption in the psychology of adjustment, and just as Brouillette is questioning of his own role as psychotherapist, Fromm is critical of conformist psychoanalysis throughout his career. As early as 1947 he had criticised psychoanalysis for not "augmenting our knowledge of how man ought to live and what he ought to do" (1947:6) and he maintained this critical stance to the end of his life, in his final book bemoaning the fact that psychoanalysis had been transformed "from a radical into a liberal theory of adjustment" while psychoanalysts "adopted the philosophy of their [bourgeois] class and for all practical purposes became supporters of consumerism" (1982:137-38).

Fromm's remedy was to re-cast the notion of mental health humanistically, not in terms of the individual's ability to adjust, but in terms of developing the ability to become "authentic" in one's relations to self and others. For Fromm, mental disorders were existential, psychological reactions to the pathology of normality and were typified by the

general symptom of "alienation," variously conceived. Alienation is significant here as the term had not only earlier been used to refer to mental disorders in the nineteenth century, but had also been used by Hegel and Marx to illustrate "self-estrangement" – interesting when related not just to what McWilliams noted about our relationship to "having" symptoms noted in the previous chapter, but also in connection to David Smail's social materialist account of the commodification of disorders, discussed in Chapter 4. Fromm sees the blame for alienation lying with capitalism, and his observations are made with particular reference to mental health in the USA, the capitalist model he sees being emulated by other Western societies (Fromm 1956/1991:117-147).

Fromm's proposals offer an interesting theoretical light on the matter of psychopathology and society, but how practicable are they in relation to the actual work of the therapist? Certainly his proposal that "Humanistic Commutarian Socialism" is the only way out for mankind as a whole and that psychological healing can be effected by a client participating in therapeutic activities in small-scale artisanal communities in France has its appeal, particularly considering the Brouillette example. Nevertheless, there is the abiding problem throughout *The sane society* that Fromm is, as Ingleby notes, "first and foremost a moralist" (ibid.:lii). Here we return to the problems voiced by some of the commenters on the Brouillette article noted at the start of this work: is it possible to be a psychotherapist and to have a political agenda at the same time? This is not to say that the work that psychotherapists do is apolitical – it is carried out within the same network of power structures as all other work in capitalist society. Yet Fromm's solution is one that involves explicit moral advocacy and, whatever about the feasibility of this in the modality of psychoanalysis, it would certainly appear to challenge the very nature of what we understand

by a more Rogerian mode of Client-Centred Therapy:[5] what if the client's moral outlook is distinct from that of the therapist?

In the final chapter, we will examine the issue of whether or not this issue can be obviated in a way that is commensurate with the precepts of humanistic Client-Centred Therapy.

[5] In response to Richard Evans's comment regarding the non-directive nature of Rogerian therapy – "the client-centred therapist becomes a sort of mirror to reflect the patient back to himself, rather than reinterpreting his behaviour for him" – Fromm replied "This is quite right. But … I don't agree with Dr. Rogers in this respect, either. I think his expression 'client-centred therapy' is rather strange, because every therapy has to be client-centred. If the analyst is such a narcissist that he cannot center around the patient, he really shouldn't do the job he's doing" (Evans 1966:34).

Chapter 4

Psychosocial and Social Materialist Perspectives on Psychopathology

4.1. From a Psychiatric to a Psychosocial Perspective for Psychotherapy

A lot of attention so far in this analysis has been devoted to psychiatry. This is deliberate – obviously there is an overlap between the interests of psychiatry and psychotherapy, and the testimonies of Mullen and McHugh discussed in Chapter 2 demonstrate the abiding relevance of psychiatric tools like the *DSM* for some psychotherapists for better or for worse. Even Fromm's critique of Meyer demonstrates psychotherapy's tendency to use psychiatry as something to distinguish itself from, and these distinctions also come to the fore in *Saving normal* with Frances's worries about psychiatry's concern with the worried well: "Only a very few people have severe mental illness, many more have mild mental illness, but the real mother lode of market share is the worried well" (Frances 2013:93).

Is psychiatry's difficulty, psychotherapy's opportunity in this respect? It is not that psychotherapists regard the "worried well" designation any more or any less oxymoronically than do psychiatrists – yes, worries may pose problems for wellness in a way that a therapy focussed more exclusively on the emotions must take stock of, but in psychopathological terms this does not mean that these people are "ill." Rather psychotherapy's distinctiveness from psychiatry – and indeed its strength – is its fundamentally non-diagnostic nature and the non-medical orientation of its praxis that can treat the concerns of those who are worried, though otherwise healthy, therapeutically.

Ultimately the implications of this distinction are parallel to those obtaining between psychosocial and psychopathological perspectives on distress. Indeed, if we are to consider a client's life/work context as a significant factor in her or his presentation – in the manner necessitated by Brouillette's dilemma – then a psychosocial approach may not only be more appropriate to psychotherapy, but also more beneficial to the client (Boyle 2011).

Allan Horwitz (2002) has discussed the nature of distress arising from external life circumstances, and which disappears when these circumstances are removed. The risks for the therapist of conflating the symptoms of such distress with those of a psychiatric disorder will be apparent from our discussion in the earlier chapters, though Horwitz's exhortation that distress that is disproportionate in severity or longevity to the context in which it arises should be classified as a disorder, may give rise to the concerns we have already seen of what constitutes "disproportionate."[1] Of course even stress that is entirely resultant from external circumstances can be self-perpetuating and generate other problems for a client, but rather than returning to the impasse of questioning at what point stress arising from environmental factors ceases to be normal and becomes pathological, could conceiving of the situation as a whole in *psychosocial* (rather than psychopathological) terms provide a viable psychotherapeutic alternative?

4.2. The Vulnerability-Stress Hypothesis

In this respect it is worth considering Zubin and Spring's vulnerability-stress hypothesis (1977), which conceptualises the trajectory of psychological distress. The hypothesis proposes that distress results from the activation of an individual's latent vulnerabilities by

[1] Horwitz and Wakefield's (2007) discussion of the rise in diagnoses of depressive disorder also generates similar concerns.

social and environmental factors. It is possible to characterise the relationship between vulnerability and stress factors in various ways: additive versions of the hypothesis focus on the combinatory effect of the stressors producing distress, while ipsative interpretations focus on the ratio of vulnerabilities to stressors, suggesting that the more there is of one, the less is needed of the other for problems to arise (Ingram and Luxton 2005).

It has been suggested that one reason for the popularity of the vulnerability-stress hypothesis is the latitude with which vulnerabilities can be characterised – Lee and Irwin (2018:130) note how the hypothesis makes a welcome change from the frequent equation in the literature of vulnerabilities with supposed biochemical or genetic factors. Because it acknowledges that environmental factors (of the kind Brouillette refers to) play a role in the aetiology of distress, it can avoid criticisms of neglecting context. Nonetheless Mary Boyle raises an important criticism of the hypothesis in this respect – it may *minimise* the effect of life factors by implying that negative life events only prove detrimental to mental health when suffered by those with pre-existing vulnerabilities (Boyle 2011). Once again, the issue of normality arises, with the implication that "normal" people are able to cope with these stressors.

Recent refinements of the hypothesis distinguish between distal and proximal vulnerability factors, with individual variation in distal factors (e.g., early childhood trauma) resulting in more proximal factors determining the way in which individuals process experience (Kinderman 2005). This can be seen as moving closer to the kind of psychoanalytic conceptualisation of character styles mentioned in connection with McWilliams in Chapter 2. Ultimately, however, it does not necessarily make Brouillette's dilemma any less intractable: as Lee and Irwin note "the notion of vulnerability factors is arguably superfluous in circumstances where environmental insults are of sufficient severity or duration to cause misery or distress" (2018:131).

For a psychotherapist, it is not only often hard to assess whether an individual's emotional distress arising from difficult life circumstances is compounded by a pre-existing "vulnerability," but it may also be a challenge to understand what Hammen (2005) refers to as the idiographic nature of stress in the context of a client's life – why will certain individuals react more negatively to certain stressors? In some ways this might be considered what Brouillette's example is trying to get away from in positing "unfair" life circumstances that will invariably be emotionally taxing for *anyone*, but nonetheless it cannot be pretended that all socio-environmental challenges will prove equally challenging for all. Inventories of life experiences and their emotional impact, such as Holmes and Rahe's Schedule of Real Experiences (Holmes and Rahe 1967), are prone to numerous subjective inconsistencies and it is interesting that attempts to remedy these – such as the Life Events and Difficulties Schedule (Brown and Harris 1978) – have adopted techniques more often associated with psychotherapeutic practice: semi-structured interviews to ascertain not only the life events that the individuals have experienced, but also the *personal significance* of these events – an idiopathic variable that checklist inventories like that of Holmes and Rahe did not consider.

4.3. Social Materialism and Psychosocial Perspectives on Distress

If we are to focus on what is central to Brouillette's example – the fact that, without denying that responses to life stress are subject to individual variation, nobody could tolerate the stress that his client was under without experiencing negative emotional consequences – it is worth considering a more political viewpoint that has been adopted by several theorists associated with Critical Psychotherapy, that of social materialism.

The premise of this approach is that if we are to acknowledge the centrality of context to all thinking around psychopathology in the client's presentation to therapy, then the huge role played by social disadvantage must be acknowledged (Fryers et al. 2003; Patel and Kleinman 2003). Disempowerment can be manifest in poor education, unemployment, low income, general lack of material assets, homelessness or poor housing etc., though it is equally manifest in Brouillette's example of someone who may be trapped in a job and, as such, is subject to exploitation. An aggravating factor may also be social inequality and the co-existence of extreme and ostentatious privilege alongside poverty and disempowerment (Wilkinson and Pickett 2010). It is easy to pay lip service to the role paid by social inequality in generating mental distress – one frequently finds references to it in the literature; what is rarer, however, is to see psychotherapeutic accounts of psychopathology into which social materialist factors are integrated. One such account was mentioned in Chapter 1 – that of Michael White and narrative therapy, which takes its lead from the work of Michel Foucault. Here we shall examine the work of another likeminded theorist, David Smail.

Similar to White and others associated with Critical Psychotherapy, Smail considered an understanding of power structures to be integral to thinking on mental health (Smail 1995, 2005, 2017; Midlands Psychology Group 2012). While power here can often be equated with money, it can also include education and other elements which can enable an individual or group to gain social and material advantage. The "embodied experience" of the individual (i.e., feelings, physical feedback), in Smail's understanding, is subject to proximal influences such as housing, education, employment etc. through which distal influences (e.g., politics, economics, culture) are expressed. As such, mental stress is *enabled* by our biology rather than being directly caused by it, with our bodies being enmeshed in a network of social power structures (Smail 2005). As psychotherapists, we see the emotional and psychological consequences of this power, though it is not transmitted through psychological channels but

rather through materialist ones, channels which Smail proposed could be mapped (Hagan and Smail 1997).

Lee and Irwin comment on how exceptional and innovative Smail's theories were for psychologists:

> Psychological models of distress are predominantly predicated upon individualistic psychological concepts, such as self-esteem or cognitive bias, that are, in turn, often labelled proximal vulnerability factors. In locating the origins of distress so immovably within the interior world of the individual, attention is deflected from the workings of material power. What is more, in such individualistic accounts of distress, 'victim blaming' hovers like a spectre, although this is not necessarily implied. (2018:144)

For both psychotherapy and (excepting behaviourism) psychology, the emphasis in the historical development of research has tended to be on what goes on inside our heads. In proposing that psychological research need not retreat to the "psychological black box," Smail is not dismissing the importance of examining subjective experience; rather he is appealing for factors in the subject's environment to be included in theoretical modelling so as to make distress meaningful. Certainly we may examine the role of proximal factors (relationships, etc.) in generating distress, though it is also important to examine the distal influences of power structures that may be impeding the individual's ability to do anything about the proximal factors in the first place (Smail 2017:18-20).

There is a natural continuation here from our discussion of Fromm – Smail saw himself as working in the same tradition as Fromm and other "apostates from orthodox psychoanalysis" such as Alfred Adler, Karen Horney and Harry S. Sullivan in emphasising

"the ways in which we are social products whose distress can neither be understood nor fully dealt with if divorced from its social context" (2017:20). Moreover, he identifies R.D. Laing as a key figure in linking this earlier psychoanalytic tradition with his own approach, though he believes that all of these thinkers have tended to be sidelined in the history of psychotherapy (ibid.). It is a fate that may be endemic to the intellectual current itself – at the time of his death in 2014, while Smail himself was well known in Critical Psychotherapy circles, he remained a somewhat marginal figure in mainstream psychotherapy.

This in itself may be significant. While the nature of psychotherapeutic research has certainly focussed on providing individualistic rather than psychosocial accounts of psychopathology, Smail himself highlights another reason for the neglect of the critical tradition which he represented:

> At an even broader conceptual level have been the critiques such as those of Michel Foucault (1979) and Christopher Lasch (1985) of the whole apparatus of 'treatment' seeing them as the result of an essentially *disciplinary* exercise. This kind of critique has laid the foundations for a widespread awareness of the social consequences – indeed the whole socio-economic and socio-political aims – of an ideology of 'therapy' which is closely allied to the interests of corporate capitalism.
>
> (Smail 2017: 22, emphasis in original)

The link between "treatment" and "discipline" that is identified here brings to mind our discussion of the Rosenhan Experiment, in particular the significance of *submitting* not just to an authority, but to an entirely different system of "normality." If Smail is right, then the very notion of treatment in the psychotherapeutic context, as well as implying a medical understanding of the therapeutic process, is itself a symptom of the commodification of

therapy. Yet is this surprising when we remember McWilliams's comments in Chapter 2 regarding the reification of disorder categories resulting in psychological problems being conceived as discrete symptom syndromes. Not only does this benefit insurance and pharmaceutical companies, but it also implies a different relationship between the subject and her or his psyche – the difference between *being* painfully shy and *having* a social phobia – something that can be *treated*. The desire on the part of both clients *and* therapists (if we think of the defences of the *DSM* voiced by Mullen and McHugh in Chapter 2) is to have things that can be treated, yet this atomisation is far less a characteristic of the nature of emotional distress than it is of capitalist commodification.

Conclusion

Analyses like those of Frances, Fromm, and Smail are perceptive and useful in providing the kind of conceptualization of psychopathology that can take stock of the external, societal factors that Brouillette's dilemma raises, and such a conceptualization has been the aim of the present work. Where they are less successful, however, are in responding to Brouillette's appeal for practical guidance on how to conduct therapy in ways that will address the real-world difficulties faced by his client.

This would be an interesting challenge to be taken up by future research initiatives in this field. While a working theoretical model, along the lines proposed by Smail, is useful theoretically, it is no substitute for practical how-to guidelines. Such initiatives could do worse than look to some of the psychotherapeutic projects that have emerged from the Liberation Psychology movement in the past thirty years.

Very much in keeping with what Smail advocated, Liberation Psychology was developed by Fr. Ignacio Martín-Baró as an approach to psychology that attempts to grasp the specific mental and emotional challenges faced by impoverished or oppressed communities, in particular by confronting directly the oppressive power structures in which they live (Martín-Baró 1996). A detailed account of Liberation Psychology is beyond the parameters of the present work, but since its emergence in Latin America in the 1970s it has come to be characterised by a social orientation marked in particular by "*concientización*" – a term coined by the Brazilian educator Paolo Friere which in this context refers to the act of consciousness-raising, acknowledging the intrinsic interconnectedness between a person's psychology and the socio-political structure in which they live.

Of course this alone does not constitute a psychotherapeutic modality, but psychotherapeutic approaches have begun to evolve out of Liberation Psychology. An account of one such initiative has been provided by Russell and Bohan (2007), who describe their attempt to reframe the psychological issues of people from the LGBT communities "as resulting from an understandable incorporation of the homonegative attitudes characteristic of the social structures within which gay and transgender people live" (2007:60). As such, the possibility of (self)-victim blaming that Lee and Irwin identified – and that may well also be present in Brouillette's example – is confronted at the outset, and acknowledged in a way that the client can see that the onus of responsibility for injustice (in this case, homonegative attitudes) is placed on the socio-political power structures in which the individual lives. This then frees the client to consider their *own* issues, distinct from (though intertwined with) prevailing attitudes and conditions in society as a whole.

Future research may identify other possible applications of Liberation Psychology in psychotherapy, though the necessity of acknowledging the pathology as being at least partly within society remains. That the efforts of thinkers like Martín-Baró, Smail, Fromm and others may be seen as elaborations of Freud's original research proposal in *Civilization and its discontents*, demonstrates that such an agenda may be eminently feasible.

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Appendix A

Why Therapists Should Talk Politics

BY RICHARD BROUILLETTE
March 15, 2016 3:21 am

"I'm meeting my boss later," my patient said. "I'm worried she's going to tell me I'm not pulling my weight, and that I should volunteer to work more hours to show my commitment."

This tension had been building at her job for months, and she feared that there would be a tacit threat in this meeting: *work longer hours, uncompensated, or we will push you out*. She was already finding it hard to spend so much time away from home. But she couldn't afford to risk unemployment.

"What am I supposed to tell my children?" she asked, breaking down.

My stomach knotted. Such worries among my patients are becoming so common, so persistent, that I find myself focusing less and less on problems and neuroses that are specific to individual patients, and more and more on what is happening to the fabric of daily life.

As a psychotherapist with a private practice in Manhattan, I see a lot of early- and mid-career professionals coping with relentless email and social media obligations, the erasing of work/life boundaries, starting salaries that remain unchanged since the late 1990s. I see "aging" employees (30 and up) anxiously trying to adjust to a job market in which people have to change jobs repeatedly and cultivate their "personal brand." No one uses all her vacation days. Everyone works longer hours than he would have a generation ago.

Typically, therapists avoid discussing social and political issues in sessions. If the patient raises them, the therapist will direct the conversation toward a discussion of symptoms, coping skills, the relevant issues in a patient's childhood and family life. But I am growing more and more convinced that this is inadequate. Psychotherapy, as a field, is not prepared to respond to the major social issues affecting our patients' lives.

When people can't live up to the increasingly taxing demands of the economy, they often blame themselves and then struggle to live with the guilt. You see this same tendency, of course, in a variety of contexts, from children of divorce who feel responsible for their parents' separation to the "survivor guilt" of those who live through disasters. In situations that may seem impossible or unacceptable, guilt becomes a shield for the anger you otherwise would feel: The child may be angry with her parents for divorcing, the survivor may be angry with those who perished.

This is no different at the social level. When an economic system or government is responsible for personal harm, those affected can feel profoundly helpless, and cover

that helplessness with self-criticism. Today, if you can't become what the market wants, it can feel as if you are flawed and have no recourse except to be depressed.

Over the last 30 years, I believe, these changes in the workplace have been slowly taking a psychological toll, though in a more diffuse, less detectable way than with any one traumatic event. To a degree that they may not be aware of, people feel less hope and more stress; their self-regard is damaged; they believe they are fated to take what they can get; they exist in a state approaching learned helplessness.

There comes a time when people can't take it anymore, when too much is being demanded of them. How much blame can people tolerate directing at themselves? When do they turn it outward?

My sense is that psychotherapists are playing a significant role in directing this blame inward. Unfortunately, many therapists, because they have been trained not to discuss political issues in the consulting room, are part of the problem, implicitly reinforcing false assumptions about personal responsibility, isolation and the social status quo.

If the patient describes a nearly unbearable work situation, the therapist will tend to focus on the nature of the patient's response to the situation, implicitly treating the situation itself as unchangeable, a fact of life. But an untenable or unjust environment is not always just a fact of life, and therapists need to consider how to talk about that explicitly.

This is, in ways, an old quandary in psychotherapy. Should therapy strive to help a patient adjust, or to help prepare him to change the world around him? Is the patient's internal world skewed? Or is it the so-called real world that has gone awry? Usually, it's some combination of the two, and a good psychotherapist, I think, will help the patient navigate between those two extremes.

When therapists make the dialogue only about their patient's life narrative, without including a frank discussion of social and economic hardships, they risk reducing psychotherapy to a tool of social control. That might sound overly polemical, but consider a government proposal in Britain last year to put psychotherapists in jobs centers to offer counseling for the unemployed, with the unemployed possibly facing a reduction in benefits if they declined treatment. In such a situation, therapy could easily become an arm of the state, seeking to "cure" listlessness or a reluctance to work, potentially limiting social and political awareness among those it is intended to serve.

Too often, when the world is messed up for political reasons, therapists are silent. Instead, the therapist should acknowledge that fact, be supportive of the patient, and discuss the problem. It is inherently therapeutic to help a person understand the injustice of his predicament, reflect on the question of his own agency, and take whatever action he sees fit.

When I am in this situation with a patient, I will introduce into our dialogue the idea that what is happening is unfair. This opens an opportunity for us to explore how my patient reacts to the notion that he is being mistreated, which can be revelatory and vital to the therapy.

I once had a patient who had reached a breaking point with the situation in the startup where she was employed. In her therapy, she had been struggling for two years with the idea that it was possible to have authentic communication in relationships. Our therapy helped her hone her anger into a courageous, well-considered and pointed group email that resulted in nearly half of her co-workers supporting her and prompting direct labor negotiations with the chief executive.

The supportive role therapy plays in such events may strike some people more as social work or organizing than as mental health treatment. But that would be wrong. Therapists need to consider such political interaction in the consulting room as inherent to the therapeutic process. Patients become motivated to change the world around them as a solution to what had become internal stressors. This is an experience of not just of external but internal change, bringing new confidence and a sense of engagement that becomes a part of the patient's character.

You would be surprised how seldom it occurs to people that their problems are not their fault. By focusing on fairness and justice, a patient may have a chance to find what has so frequently been lost: an ability to care for and stand up for herself. Guilt can be replaced with a clarifying anger, one that liberates a desire — and a demand — to thrive, to turn outward toward others rather than inward, one that draws her forward to make change.

Richard Brouillette, a former community organizer, is a psychotherapist in New York