Inscription, Diagnosis, Deception and the Mental Health Industry

How Psy Governs Us All

Craig Newnes

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To Fred

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Contents

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Abbreviations and Acronyms

AACAP	American Academy of Child and Adolescent Psychiatry
ACT	Acceptance and Commitment Therapy
ADHD (or AD/HD)	attention deficit and hyperactivity disorder
ADI-R	Autism Diagnostic Interview–Revised
ADOS-2	Autism Diagnostic Observation Schedule, Second Edition
AHP	Association for Humanistic Psychology
APA	American Psychiatric Association
APA	American Psychological Association
ASD	autism spectrum disorder
BNF	*British National Formulary*
BPS	British Psychological Society
BSHG	Bundessozialhilfegesetz: Federal Social Welfare Law
CAT	cognitive analytic therapy
CBF	cerebral blood flow
CBT	cognitive behaviour therapy
CDC	Centers for Disease Control (US)
CHADD	The National Resource Center on AD/HD (US)
CHRUSP	Center for the Human Rights of Users and Survivors of Psychiatry
CIA	Corporate Integrity Agreement
CMHERA	Community and Mental Handicap Education and Research Association
CPS	Chinese Psychological Society
CQC	Care Quality Commission
CRC	UN Convention on the Rights of the Child
CRST	critical realist social constructionism
CT	computerized tomography
DBT	dialectical behaviour therapy
DCP	Division of Clinical Psychology (within the BPS)
DSM	*Diagnostic and Statistical Manual of Mental Disorders*

DTaP	diphtheria, tetanus and pertussis (vaccine)
EBM	evidence-based medicine
ECHR	European Convention on Human Rights
ECPT	European Convention for the Prevention of Torture
ECT	electroconvulsive therapy
ECTAS	ECT Accreditation Service
EEG	electroencephalogram
EMA	European Medicines Agency
EMDR	eye movement desensitization and reprocessing
FDA	Food and Drug Administration
FDCA	Federal Food, Drug, and Cosmetic Act
GAD	generalized anxiety disorder
GDC	Guidance Development Committee
GMDS	Griffiths Mental Development Scales
GP	general practitioner
HCPC	Health and Care Professions Council
HRSA	Health Resources and Services Administration
IACP	Indian Association of Clinical Psychology
IAPP	Indian Association of Private Psychiatry
IAPT	Improving Access to Psychological Therapies
ICD	*International Classification of Diseases*
ICD-11	*International Classification of Diseases-11*
IPN	Independent Practitioners' Network
IPS	Indian Psychiatric Society
ISEPP	International Society for Ethical Psychology and Psychiatry
KPI	key performance indicator
LILACS	Literatura Latino-Americana e do Caribe em Ciências da Saúde
MCBT	mindfulness-based cognitive behavioural therapy
PCSR	Psychotherapists and Counsellors for Social Responsibility
PICOS	Patient/Problem, Intervention, Comparison, Outcome, Setting
PMC	PubMed Central: United States National Library of Medicine
PMDD	premenstrual dysphoric disorder
POPAN	Prevention of Professional Abuse Network
POST	Parliamentary Office of Science and Technology
PRN	*pro re nata* (as required)
PsySR	Psychologists for Social Responsibility
PTSD	post-traumatic stress disorder

RCT	randomized controlled trial
SAD	seasonal affective disorder
SCI	Support Coalition International
SciELO	Scientific Electronic Library Online
SCQ	Social Communication Questionnaire
SEAN	Scottish ECT Accreditation Network
SOAD	second opinion appointed doctor
SRS-2	Social Responsiveness Scale, Second Edition
SRV	social role valorization
SSRI	selective serotonin reuptake inhibitor
STI	sexually transmitted infection
TAT	Thematic Apperception Test
TD	tardive dyskinesia
TLA	three-letter acronym
VA	Veterans Administration
VAT	value added tax
WNUSP	World Network of Users and Survivors of Psychiatry

Introduction

Many years ago lived a boy who believed in any number of stories: ghosts lurked in the nearby churchyard, mums and dads looked after each other and stayed together forever, and it was, more or less, impossible to go to the USA unless you were very rich indeed. Other stories were more wrapped up in the world of professions and politics, a world seemingly light years from where the boy lived. In this world, anyone called a doctor was good and politicians were fine examples of people doing their best for others. His parents were considerably less sanguine about politicians but, to them, doctors were good guys, best exemplified by the US TV programme *Dr Kildare*. In fact, after Charlton Heston and Rock Hudson, Richard Chamberlain was the first actor's name I knew.

This volume is also less sanguine about doctors and the majority of praxis associated with the psy industry, an endeavour that appears to be marked by self-interest no less than the vehicle industry, though, as Montaigne may have noted, the *hypocrisy* of psy is more obvious.

Various commentators have pointed to the ways in which the psy complex maintains the status quo. Ivan Illich, for example, sees any professions allied to medicine, and, indeed, medicine itself, as part of the problem rather than the solution to the ills of individuals.[1] His thesis is reinforced by Magaro, who says, in relation to the manifest failure of US psychiatry to alleviate misery: "because the mental health industry is financially dependent on 'mental illness' there is no real reason to treat effectively".[2] Thomas Szasz claimed that a key role overlooked by mental health professionals when explicating their function is that of distributing important state and insurance-based resources: time and money.[3] Psy professionals act as the point at which resources are allocated, in effect to check whether the poor are deserving or not.[4] Among their genuine efforts to help, heal or simply assess their patients, it is not a role that many would necessarily recognize.

Beyond the dual roles of resource distributors and preservers of the status quo, the lethal nature of many service interventions might offer some validity to the possibility that psy professionals are involved in death-making – the idea that treatment of distressed and "marked" individuals is designed to kill either the body or the spirit (or both) under the guise of aid. Wolfensberger saw this as a largely unconscious process; though there are practitioners who set out to harm, one should hope the majority espouse more charitable motivations.[5]

From this perspective, my own profession, clinical psychology, seems to play a part in death-making, a part its practitioners might vehemently deny. The profession is often, at best, a bystander in a medically dominated service world where experimentation (via the lack of acknowledgement, for example, that all drugs affect people in different ways and thus need to be systematically monitored) is the norm. Wolfensberger suggests that killing of the spirit is everyday practice for many psy professionals. His position echoes that of the sociologist, Gruenberg, who coined the term "the social breakdown syndrome" as a way of describing the institutional impact on psychiatric patients.[6]

Imagine you have a poorly paid job, live in a part of town where the streetlights often don't work, and worry about the two teenagers that now live alone with you and your elderly mother. You see a counsellor employed as an Improving Access to Psychological Therapies (IAPT) worker who reassures you (despite her own doubts) that you are a candidate for cognitive behaviour therapy (CBT). Better still, it won't take long. Although the counsellor appears kind, the office warm and the buses not too inconvenient, you don't feel a lot different after three visits. After two more you are told that your time is almost up and you seem to be "resisting". Your spirit dies a little. This is not the fault of the counsellor, nor a particular limitation of the therapy produced by the material context of the patient's life. Talking treatments are bound to kill a little of the spirit despite the best intentions of patient and counsellor; talk is neither going to change the context of the patient's life nor, necessarily, lead to the patient gaining the power essential to change – a dispiriting outcome.

The disciplines of counselling and clinical psychology, despite the tendency of some individuals to protest otherwise, are nested in the wider discipline of medicine; practitioners work alongside psychiatrists and other professions within the psy complex, for whom the discourse and associated power structures are medical.[7] Thus, in the scenario above, for many patients the next referral will be to a psychiatrist. On the way they will return to their general practitioner who will, entirely in keeping with his or her role, prescribe (more) medication to "help the person through" the period leading to the psychiatric appointment.

Among psy professions the claim to be acting in the best interests of others may ring hollow for those receiving their services. This volume is not an attempt to blame those working within the psy complex[8] for harm they may – inadvertently more often than deliberately – cause. Rather, it includes an attempt to delineate that harm using a specific analysis: the categorization of harm into "wounds".[9]

The volume will examine human service provision in its historic and social context. The focus will be on those aspects of the psy complex most frequently referred to as mental health or mental illness services. These draw from the language, praxis and historical precedent of services for those labelled disabled, or in receipt of a psy diagnosis or formulation. These aspects all play a part in this account. My focus on mental health services is motivated partly by some 30 years in the mental health industry (the last 18 as the director of a National Health Service (NHS) psychological therapies department employing over 80 staff) and partly by a desire to make sense of how it is that services harm people. I shall draw on the ideas of Wolfensberger and Szasz in this endeavour. The current *zeitgeist* seems to show many of the signs of a return to the tenets of anti-psychiatry elucidated by Laing, Cooper and others (Szasz never positioned himself as an anti-psychiatrist). This volume may be claimed as part of that tradition. The reader may find that it owes more to the analyses of Foucault, Rose and others.[10] The critique of psy is easily construed as criticism, but to criticize psy practitioners is to imply they might have been able to step beyond the *zeitgeist* in which they work – an impossibility. Instead the volume offers some examples of work that, at the very least, is likely to result in fewer wounds.

After the first chapter about the current service system, the second gives an overview of the "wounds". Subsequent chapters explore in more detail psy praxis: its language and societal position, and its role in shaping modern notions of the self. The volume has some similarities to an episode of *Dr Kildare* – an opening scene introducing the audience to new characters and giving the briefest kickstart to a plot, later scenes illustrating the actions of good and bad guys followed by the almost messianic efforts of Dr Kildare to save patients, often a child from a poor family. A relieved and grateful relative or patient appears just before the credits roll. Let's see . . .

Contextual note

This volume was mostly written in France and the UK, interspersed with gardening, child-minding and various beverages. The keying-in was accompanied by music from Ponce to Allan Holdsworth via Prokoviev and Bill Frisell. The plaudits, however, go – as ever – to Frank Zappa. Try "Make a Jazz Noise Here" and go from there.[11]

1

Thou Shalt Not Kill

On my desk sit some 30 or so textbooks,[1] two novels,[2] an autobiography[3] and 50 psy journals. The textbooks represent less than 1 per cent of my library, much of which rests in boxes elsewhere. These 30 are worth about US$500, which might be all a commentator needs to know about the psy industry, a global economic endeavour supporting researchers, universities, pharma, clinicians and publishers. The titles before me are revealing; sociological and critical analyses of psy compete with historical accounts. There is an absence of books that might be subsumed under variants of "A Guide to Curing X Using Y: An Evidence-Based Approach". Contemporary psy practitioners are likely to have shelves more populated by books of the latter type. Whether or not they read them is unknown and, to the publishing industry, unimportant. The barely read volumes on the shelf behind me attest to my own bias.[4]

The date of publication of these volumes has significance dependent on the reader. As noted by Marshall,[5] there is a tendency among psy practitioners to focus on work of recent origin. Thus the most contemporary book (as it happens, my own)[6] on my desk might be preferred to *The Asylum as Utopia*,[7] first published in 1837, and reprinted with an introduction by Andrew Scull in 1991. Yet *The Asylum* details many of the arguments still prevalent today between professionals claiming expertise and jurisdiction over the mad. A plea for asylums to embrace moral therapy, it maintains – in a familiar and contradictory fashion – the position that insanity lies within the realm of medicine for understanding and treatment. As now, the position was not without its critics. An editorial in the *Quarterly Review* from1816 opined: "the strict medical treatment of madness must be regarded . . . as empirical, and the most extensive experience proves that very little is to be done".[8]

Within a century, madness had fallen deeper within the embrace of medicine while psychology, via Freud, Watson and others, was laying claim to the territory. A further century on and the psy industry dominates a public discourse of distress, as its language and diagnostic terminology are used by everyone from teachers and concerned relatives to media pundits, including sports and music journalists.

For alienists of the early nineteenth century, the questions of nature versus nurture or character versus environment were as prominent as they are today. Partly due to the influence of phrenology, the brain featured in these disputes: "The brain, as a material organ, was liable to irritation and inflammation, and it was this that produced insanity."[9] Despite much claimed "advances" in the mind/brain conundrum, psy is no further forward in crossing the divide between metaphoric constructions such as love, guilt and avarice, and the specific workings of the brain. Concepts such as depression and disorder remain context-bound linguistic devices rather than testable or reliably measurable diseases of the brain. Neville's conclusion in the first half of the nineteenth century that he could find no "connection of the faculties of the mind with the brain"[10] still obtains. Philosophers have little difficulty with such a conclusion; for those dependent on research funding in the field of neuropsychology, it is an overlooked perspective.[11]

Contemporary observers would recognize the context in which *The Asylum as Utopia* appeared. Parliamentary inquiries of 1807, 1815–1816 and 1827–1828 had revealed "medical malfeasance, maltreatment and, even murder" as everyday barbarities within the hospital system.[12]

The psy professions

Professions evolve slowly. Although statements by professional bodies may move with the *zeitgeist*, the practice of individual members of psy remains invisible to public scrutiny and may not reflect the aspirations of any particular professional body. In an article from 1996, after a brief historical overview of clinical psychology's alignment with psychiatry and scientism, I suggested:

> We need to take both our history and the experiences of our trainees [newcomers yet to be drawn in to the professional rhetoric and aware of "the smell on the ward, the patients' fear of the effects of medication, the power of the responsible medical officer, the common sense of those deemed mad."][13] more seriously. We need to constantly review our place in maintaining power for some at the expense of

> others and find ways of helping our profession articulate some of this in ways which ordinary people could understand . . .

And I concluded: "If we don't, we are doomed to continue the boring trudge towards professional credibility and political neutrality at the expense of our humanity."[14] Some might suggest that, as a well-paid, white, professional male in a secure role as psychological therapies director, I was having my cake and eating it. The remarks were heartfelt and formed part of an anti-professional rhetoric traceable to at least the nineteenth century. The appeal for humanity above scientism (they need not be mutually exclusive) could be made again today with little change to the critique of the profession's public stance.

The British Psychological Society's (BPS's) position is a (stereo)typically professional one. The society regularly makes public statements in the fields of psychology and health policy. As in many similar statements by other professional bodies, however, a close analysis reveals contradictions – an inherent difficulty when claiming to respect psy recipients' dignity and individuality while simultaneously, as human science, categorizing those individuals. This inherent difficulty obtains in the practice and research of psy professionals where their own supposed individuality is disguised by means of appeal to expert status, a status that tends to exclude the presence of psy professional-as-actor within the published discourse. To some extent, this is less the case in psychoanalytic praxis where the examination of countertransference is routine. Here, obscurantism dominates by reference to unconscious processes that only the analyst can divine (through an equally abstruse language and untestable theories).

A further challenge faced by the BPS is that members are people too. They are as likely to be as distressed and oppressed as their patients and research subjects. Claims to expertise in living can be questioned via simple enquiries about a particular psychologist's experience in, say, parenthood, religion or sexuality.

It has been claimed that some people are so odd, challenging or downright obnoxious to be around that their only chance of human contact is with people paid to attend them. For Wolfensberger, in a moralizing account of the service response, staff–patient or client–carer interactions are likely to add to the distress of service recipients.[15] For all his directness, however, he does not detail the challenges faced by staff and carers. Even John Bailey, in his otherwise brutally honest account of living with the Alzheimic Iris Murdoch, does not dwell on the minutiae of necessary physical procedures.[16] An unflinching account of the indignities and physical unpleasantness of bowel cancer is to be found in *Unexpected Lessons in Love*. Written by a retired psychoanalyst, the novel is striking in its plainly autobiographical scenes featuring shit and other bodily matters. Like *The Iris Trilogy* it has the advantage of being transparently honest and should perhaps be required reading for anyone considering a career in nursing.[17]

Much publicized scandals in the UK in relation to the hospital care of older people have used terms indicating disgust at a "failure of care" among paid staff, failure that frequently involves assaulting and neglecting patients. Bailey comes closest in describing a possible reaction to the presence of someone who is ill and docile, yet immensely demanding: aggression. He describes with great candour his murderous emotional responses to the woman he had been married to for 47 years.

In exposing the abuse of patients by staff, there seems little room for any discussion of the fact that *pace* Wolfensberger being paid to care does not remove a professional's human response. I have discussed elsewhere how little is known about the interactions between trained clinical psychologists and patients in the consulting room.[18] Similarly, little is known about the daily interactions of care and nursing staff with their patients. Patients, however, may be aggressive, repetitively demanding, frustratingly docile and themselves frustrated. This can be the consequence of the ward environment, medication or aspects of the patient's way of coping that pre-date service involvement. Staff reactions to such conduct can be contextualized in terms of the unrealistic expectations placed on them by professional bodies, their public image (nurses as "saints"), relatives and the patients themselves.

Wolfensberger is loath to concede that facing patients who shout, smear faeces or lash out on a daily basis is too much to ask of paid staff. His position can be seen as contradictory in that he offers frequent examples of elderly parents who have killed their disabled adult children due to concern that the services will not be able to cope when the parents can no longer do so. There are now regular reported incidences of carers who kill in the context of the exhausting demands of their charges. John Knott, for example, was "devoted to his terminally-ill wife Anne" yet shot her and himself. Anne was diagnosed with Alzheimer's disease.[19] If parents or others who claim to love people placed in care cannot cope to the extent that they have placed them in the hands of strangers, it seems unlikely that those strangers – even when described as caring professionals – will do much better (for a discussion of a psychodynamic understanding of the carer's predicament, see Chapter 4).

The above discussion focuses on the physical challenges faced by care staff. My intention has not been to reduce the import of other challenges. For example, miserable people, notwithstanding the imprimateur of a depression diagnosis, are miserable to be around – one reason why therapy sessions are only an hour long. Similarly, someone responding to voices telling them to shout at strangers is frightening, with or without a label of schizophrenia. A woman who refuses to eat on a daily basis will irritate and upset nursing staff in a similar way to the effect her conduct has had on relatives or lovers. Self-harm through cutting requires a degree of patience (and tolerance of blood) few people regularly display – staff or members of the public.

John Bailey, for example, has no hesitation in using the tranquillizing neuroleptic promazine to give himself peace from his wife's restlessness: "Carers . . . soon become experts at reading the physical symptoms and choosing the remedy from among the sedatives prescribed. When Iris has a wandering fit at two in the morning promazine syrup seems the best bet."[20] Bailey doesn't require the myth that promazine is an "antipsychotic" chemical agent. Like thousands of care staff concerned to keep their patients as docile as possible, the drug is used as a tranquillizer. Listed as an antipsychotic in the *British National Formulary* (BNF), promazine is recommended for agitation and restlessness in older people. Due to contact sensitization, staff are warned to handle the tablets with care, yet the drug is taken *orally* by patients. Almost 50 adverse effects are noted, including agitation. Potential drowsiness, nightmares and insomnia are noted, all effects seen by staff and Bailey himself as features of dementia rather than the results of medication.[21] Throughout the BNF, adverse effects are listed as "side-effects", a linguistic device implying that drugs target particular behaviours and symptoms. In fact, medication acts in poorly understood ways on individuals with unique metabolisms who are frequently already affected by other medications, coffee, alcohol and similar psychoactive substances.

It seems too simple to me to place at the door of care staff the responsibility for the indignities and assaults foisted on patients. This recourse to proximal and individualized explanations and accusation may suit organizations, professional bodies and relatives but it is acontextual. Relatives are in a double-bind. Unable or unwilling to take on the task of meeting the daily demands of being a full-time carer, many – it would seem quite reasonably – turn to services. There are regular media accounts of the "sacrifices" made by relatives, though these seem outnumbered by the more newsworthy treatment of hospital or care-home scandals. Similarly, increasing numbers of people describe in the media their adverse reactions to psychotropic medication, promoting instead the benefits of professional counselling. For millions more, the simple experience of being helped by friend or neighbour goes unrecorded. This is, in part, due to the promotional efforts of therapists and counsellors, but also due to the ordinariness of neighbourly conduct and friendship: the media have little interest in discussing the everyday.

For those trusting professional services, who agree to their relatives being labelled, medicated or moved elsewhere, it is a commonplace that their anger at the mistreatment of patients is fuelled by guilt following the act of rejecting their parents or children, or a sense that they should have known what might happen. The hierarchical context of institutional care is such that proximal explanations for mistreatment, along the lines of "The nurse/psychiatrist/paid carer was wicked", become a focus wherein one factor – the peculiar nature of institutional response – is ignored. Further, the places where people are congregated bear little relation to ordinary homes. The necessary rules around safety make, for example, fire doors ubiquitous, and for many older, more frail people, pushing open a heavy fire door is impossible; they are trapped for the best of intentions. As one ex-patient and carer at Shelton Hospital remarked, "there is nothing normal about these places".[22]

Designed in 1843 to accommodate 60 mad people, Shelton Hospital, then the Salop County Lunatic Asylum, welcomed 120 patients. As in most other similar asylums, overcrowding led to the necessity of calming the residents. Bromides were introduced in 1857 and paraldehyde in 1882. Three years later the population stood at 800.[23] Perhaps, for some, the smell of paraldehyde or the locked oak ward doors became familiar, but for the majority and visiting relatives the atmosphere in institutions, however clean and modern, remains alien. Institutions require efficiency. The price that care homes, hospital wards and similar environments pay for such efficiency can be a lessening of their humanity. Ironically, advertisements for care homes for older residents stress their "homeliness" rather than their efficiency.

Harm in context

Decontextualizing figures in the history of psy and related disciplines combined with the individualism inherent in the reductionist approach can, paradoxically, leave us in both a finger-pointing culture and a moral vacuum. In the field of medicine, for example, Harold Shipman seems clearly to blame for the murder of a (yet to be fully determined) number of his patients. Working in a context wherein, as a doctor, he was a trusted figure in the community, Shipman was able to kill with impunity for some years, and it was only when a *financial* conflict of interest with the beneficiaries of one of his victims appeared that his crimes came to light. For Josef Mengele the experiments on his concentration camp subjects are, rightly, seen as crimes against humanity, yet they occurred in the context of Nazism, the eugenics movement and the apparently irresistible urge (for a scientist) to experiment on living subjects. Those subjects had already been declared subhuman and, via the simple process of being shaved, positioned as interchangeable *non*-individuals. Further, the experiments led to the production of various physical *treatments* enjoyed by subsequent generations and profits for manufacturing drug companies.[24]

Another example is Egan Moniz, who despite *not* being the surgeon responsible for lobotomy (the operations were performed by Lima) was awarded the Nobel Prize in 1947 for developing a procedure that killed many while rendering many more shadows of their former, frequently agitated, selves. Similarly, Walter Freeman, inventor of the transorbital leucotomy, was first hailed as a saviour who might reduce the population of incarcerated psychiatric patients only to be virtually forgotten by the 1970s. To his credit and unlike numerous other members of psy, Freeman spent many years post-retirement on extraordinarily exhausting peregrinations (he was suffering from rectal cancer) following up ex-patients.[25] Moniz and Freeman developed procedures now regarded as barbaric (though a form of lobotomy, via electrodes, is still practised today), but these arose in a context of interprofessional competition between neurologists and psychiatrists, and institutional alternatives that seemed worse than the risks of psychosurgery. Further, Freeman used the comparative costs of his procedure to sell it to state-employed hospital superintendents keen to use less public money than would be necessary for the continued hospitalization of patients.

The economic argument obtains today in all publically funded services and is the main factor in the UK Government-funded promotion of CBT delivered by IAPT workers. These workers are paid less than professionals with more training (e.g. counsellors and clinical psychologists) and their aim is to get patients into paid employment, thus saving in disability payments. The fact the scheme does not work is glossed over by the media and IAPT workers alike.[26]

Within the psychological nexus schools, theories and individuals compete for recognition and status by means of publication. A kind of immortality, in addition to the more proximal benefits of money or the reward of doing a job well, may be the aim. In Dorothy Rowe's terms they, like all of us, are trying to be good.[27] Seeking respect in this and future generations may be construed as a form of hubris. It is an ambition that is rarely fulfilled. In a volume dedicated exclusively to dates and anniversaries, thousands of entries can be found for people who are deemed to have made a difference. Psy professional entries are limited to William James, Jung, Freud, Jones (Freud's biographer), Pavlov and – slightly stretching the definition of psy – Anton Mesmer. Skinner, Watson, Szasz and Eysenck are absent. To give some perspective, the majority of other entries cannot be regarded as panegyrics to the famous: Nepos (d. 25 BCE), Comyn (d. 1306), Queen Elizabeth of Roumania (d. 1916) and Granville Bantock (d. 1946), for example, are recorded. Scientists (e.g. Pasteur, Hertz, Newton, Boyle, Priestley, Edison, Einstein, Jenner, Faraday, Darwin, Galileo, Fleming, Fahrenheit and Curie) are present in large numbers. Tellingly, the volume lists 27 chemists, including Jacob Bell (d. 1859), founder of the Pharmaceutical Society.[28]

The catalogue puts psy in its place – as influence and as a field in which individuals gain recognition in the wider world. Contemporary recognition is now made easier by the Internet and mass media – fame that is likely to be short-lived. It has been argued that the impact of psychoanalytic ideas is best seen in advertising through the praxis of appealing to unconscious drives for power and possessions. This may be an accurate interpretation but one that doesn't require the acknowledgment of Klein, Freud, Winnicott or Horney as theorists (though Freud's nephew, Edward Bernays, was a founder of the US Public Relations industry).

The presence of so many chemists may have much to say about their importance in the wider picture, whether it be through penicillin, electricity or – in the case of Bell – recognition that chemistry is a substrate to modernity. Any suggestion that the lower numbers of psy professionals reflect their lower numbers in the population might be countered by reference to the inclusion of numerous popes and Danish monarchs.

In a system as bureaucratic and vast as the NHS, the diffusion of responsibility makes difficult the individual attribution of blame. Although in recent cases, such as the Staffordshire scandal over deaths of elderly patients, certain individuals at a number of organizational levels have lost their jobs and face criminal charges, this is rare. Imagine you are seeking help from a therapist who specializes in a particular method. The therapist is accredited, a member of the relevant professional bodies and supervised by a similarly qualified senior colleague. Despite the more or less correct application of the particular therapy, you feel no better. Indeed, for a time you feel worse and, rather than returning to employment and a valued position among your family and local community, you are now haunted by the belief that you have failed as a therapy patient. A minority of therapists research their own therapeutic results.[29] If your therapist follows up the treatment, he or she is likely to also conclude that the therapy has failed. This conclusion can be the beginning of a career as a mental patient which progresses down a familiar route of more therapies, medication or other treatments. Most of the professionals involved will follow procedures recommended by the psy literature, their employers or their supervisors. An attempt to sue the therapists for failure to help, or for harm incurred, will be defended on the basis that the procedures are widely acknowledged as appropriate, and supported by academic research and published accounts of success rates of at least 66 per cent. It is unlikely that the therapists will join you in suing either the published researchers or the journal publishers. If you have received medication, the prescribing physicians, in following best practice, will not join you in taking legal redress against the drug manufacturers.

In the 1990s, Jim Goodwin, a clinical psychologist in the USA, was suspended for offering all his patients his, admittedly idiosyncratic, version of CBT after first diagnosing them all as depressed. A local prescriber had aided him in prescribing those same patients Prozac.[30] A few years later, Goodwin would have been able to claim that such practice was recommended by numerous published CBT-plus-drug trials and was, indeed, best practice. Had he so wished he could have simultaneously defended his diagnostic regime on the basis that psychiatric diagnoses were, in any case, notoriously unreliable, and "depression" was as good a label as any to justify his interventions.

Goodwin's exposure takes no account of how little is known about what happens within the consulting rooms of hundreds of thousands of therapists. Claims to be practising CBT, psychoanalysis and so on are not corroborated via access to observation of therapists at work. A BBC documentary presents Goodwin as a wild card and positions him as a zealout against the more considered perspective of the psychiatrist Peter Breggin and local sages in a barber's shop. The documentary, however, is an exemplar of a culture wherein criticism of psy and its experts continues to develop.[31] The origins of this culture might be traced to antiquity (see Chapter 5). The ubiquity of the Internet and mass media makes easier access to critique by patients who experience psy as toxic, expert commentators who decry fellow professionals and measured sociological analysis. A focus on individual malfeasance is common.

John Rosen, for example, was the progenitor of "direct analysis". The latter consisted of deliberately scatological and extremely unpleasant "interpretations" to those he diagnosed as schizophrenic. Shocked into a state of liveliness, previously sedate patients would be jolted into activity for a few days. Rosen neither followed up these "successes" nor suggested that their lethargy had been medication-induced.[32] Masson's *Against Therapy* devotes a chapter to Rosen and many pages to Perls and Rogers.[33] Masson also dwells on Jung's willingness to change his theories to fit a paradigm enhancing the Teutonic myth. In his autobiography, Jung deals with this period in a few pages devoted to his views about the nature of evil rather than any strictly biographical data, a position consistent with the rest of *Memories, Dreams, Reflections*, where dreams and reflections hold greater sway than memories.[34]

In summary, the themes outlined above include:

1. The psy enterprise is one element of a broad economic endeavour.
2. Within the psy system, arguments concerning the causes and amelioration of distress have continued for over 200 years (and outside the system for millennia).
3. The impact of psy theories and praxis has not been sufficient, with few exceptions, to gain lasting fame for the progenitors of those theories and praxis. Critiques focus on individuals rather than the psy system *per se*.
4. The role of expert for psy professionals is undermined by factors including the human fallibility of the professionals themselves and a lack of validity or reliability in procedures common to professional praxis.
5. Such praxis involves harm to those whom professionals attempt to help.
6. Care systems employ professionals and procedures that harm those in their care, particularly those who enter the system because their conduct or characteristics cannot be tolerated by other community members or relatives.

These themes are explored in more detail in subsequent chapters. The next section will explore possible avenues for psy that may lead to less harmful practice.

Psy as a means of helping others

Many volumes of the type noted above ("A Guide to Curing X Using Y: An Evidence-Based Approach") follow a similar format. This includes early chapters on alternative approaches detailing their failings, followed by claims for the benefits of the proposed therapeutic or research direction. It is a format well known within the advertising industry; selling psy parallels selling any other product, from cars to shampoo.[35] This volume uses a different approach. In the final section of this chapter I shall propose some tentative avenues for psy, the arguments for which can be made by the reader through close attention to the critical analyses in subsequent chapters.

My aim in promoting new praxis is modest. Change and homeostasis occur in context. Thus, in the absence of wider professional and public movement, service praxis will continue to evolve gradually, that evolution being dependent on the wider system. A systems theorist might suggest that changes suggested here will be met by moves in the opposite direction – a further entrenchment in existing policies and professional behaviour. The presence of numberless advice and similar volumes in remainder bookshops supports the idea that suggestions, including those by experts, are difficult to act on. Although subsequent chapters might seem a basis for widespread change within the psy system, here I shall offer only two suggestions.

The first is that psy should concentrate on abandoning one procedure known to harm far more people than it helps – electroconvulsive therapy (ECT).

The second is that psy professionals should limit themselves to the possibility of making minor inroads into the distress of others – a recognition that the context-bound lives of people in services, families, particular cultures and linguistic frames of reference make the hour-by-hour conduct of practitioners more important than their ambition for the future.

These suggestions should not be construed as a version of "Abandon hope all ye who enter here." Rather, they recognize that hope, as a mainstay of existence, should be tempered with caution and modesty.

The rationale underlying the first suggestion can be found in Chapter 5. The rationale underlying a plea for modest ambition can be found in the majority of the other chapters. Chapter 5 specifically examines the history and contemporary state of a praxis causing harm to service recipients. One possible reading of the majority of the remaining chapters is that psy practitioners can *only* hope to provide a degree of comfort for patients rather than transforming lives of distress inextricably bound up in factors beyond the control of either the psy practitioner *or* the patient.

Contextual note

This chapter emerged with a good deal of John Coltrane but was edited in almost total silence, except for the muffled sounds of children getting ready for school.

2

The "Service Wounds"

Before I qualified as a clinical psychologist – a profession that guaranteed intellectual stimulation, incremental pay increases and, crucially, was far easier than my previous occupations as a ceiling-tiler, extruder operative in a rope factory and "grease monkey" on a monstrous conveyer belt and freezer in a frozen-food factory – my grandmother was briefly incarcerated in St Nicholas psychiatric hospital in Great Yarmouth. The "bin", as it was none-too-affectionately known to local residents, held a particular terror for her. A brother-in-law had already died in a strait-jacket in Thorpe Asylum near Norwich and she had heard, via neighbours and friends, of terrible goings on behind the doors of St Nicholas. As a child I had spent countless hours combing her long black hair (that she invariably curled into a "bun") and enjoyed many memorable times with her playing cards after eating enormous meals. She was renowned for her hospitality – during the Second World War her husband had happily brought numerous naval companions home on shore leave to share their rations and her largesse as a hostess. In the family and for many others besides, she was a beloved matriarch. One night in late 1976, her elderly lodger found her wandering around the garden after a bout of debilitating shingles. She was confused, so he had asked the neighbour, a social worker, to help; hence the admission to St Nicholas. She was unfortunate: she was admitted on a Thursday night and Friday was the day the hairdresser visited. By the time my mother arrived on Monday to speed her discharge, the long, black hair was gone. My grandmother had neglected her hair for a time and the hospital had concluded it should be shaved off "in her best interests" for "health and hygiene" reasons.

The hairdresser's concern and action might be construed as kindness or "just doing her job". A Foucauldian perspective might be that her role was part of the disciplining process wherein the rules of the institution are upheld via praxis that nullifies *resistance*.[1]

Delineating the "wounds"

Wolfensberger may not have regarded the haircut as a "wound" as such but the incarceration, lack of control and *indignity* experienced that Friday can all be seen as typical of what happens to people in human services. These so-called wounds involve being "marked" (labelled in ways not valued by wider society and thus more likely to be confused with others with similar, frequently poorly defined and stigmatizing, labels), rejection and exclusion, being moved within and between services, being associated with devaluing imagery, losing relationships with valued others, isolation and congregation with people similarly devalued, lacking security and control, becoming poor, being blamed, being subjected to case conferences, being invaded without consent (e.g. with *pro re nata* (PRN)/as required medication), being referred without consent, being *denied* help, being given aversive or useless "treatments" (a historical perspective would include opium, bromides, chloral, cannabis, cocaine, sulphonamides, paraldehyde, electroshock, insulin, coma, ECT lobotomy, lithium, chlorpromazine and other neuroleptics, barbiturates and more recent drugs such as diazepam (Valium) and zopiclone) and being verbally abused or physically assaulted in institutions. For Wolfensberger the loss of personhood and potential for bodily harm in this, by no means exhaustive, list makes the service recipient "dead".[2] This position is echoed by Thomas Szasz. In a footnote in *Cruel Compassion* he writes: "Unlike Nazi psychiatrists, democratic psychiatrists do not literally kill their patients. They kill them metaphorically, by incarcerating, shocking and drugging them."[3]

Wolfensberger uses the term "devalued" to describe the majority of service recipients. Other authors have argued that service recipients are valued as consumers of a variety of medical and psy commodities.[4] One recent analysis suggests that consumers are themselves *consumed*.[5]

With a – perhaps unconscious – inverse nod to Foucault, Wolfensberger sees the process of devaluation as analysable in terms of attributes that society values. Foucault sees descriptions of abnormality as, by default, defining normality. Thus a child's disruptive conduct in the classroom, rather than being seen as understandable boredom, is described as symptomatic of some form of hyperactivity and diagnosed accordingly; society maintains discipline via the processes of diagnosis and psy intervention. Similarly, preferring public transport to privately owned vehicles, having more than three children (or none at all), enjoying discordant music or feeling unhappy despite being surrounded by family and material goods will be seen as abnormal; private cars, a couple of kids, loving families and a desire for wealth through possession become some of the signifiers of normality. For Wolfensberger, a catalogue of what is valued in post-industrial culture can infer what will be devalued and lead to the wounds of those who embody that devaluation.

Thus if wealth, certain kinds of physical health and beauty, youth, competence, independence, intelligence, productivity and individualism are valued, then those who are poor, not stereotypically healthy or beautiful, incompetent, dependent on others, less intelligent or less productive are devalued. These characteristics further lead to the possibility of negatively valued individualism, and such individualism is likely to lead to the wounds outlined above.[6]

For Schiller, writing in 1794, civilization itself, via modern divisions of labour and ideas (the basis of the cult of technical "expertise"), is an all-pervasive wound severing the "inner unity of human nature" leading to disharmony between and within individuals.[7]

For Wolfensberger, personal "wounds" begin with rejection or exclusion by those closest to the identified patient. In general medicine such exclusion might be life-saving – for example, if the person is moved to a highly sterile place of safety due to vulnerability to infection. But for many the rejection occurs because the person is different in some way from expected physical or social norms. Clinical psychologists may assess people and agree they need to go to a "specialist unit" for those with learning disabilities or suggest a diagnosis of anorexia nervosa for those not eating much. In the markedly psychometric phase of the profession's development, such assessments were a predominant feature of daily clinical work. The closure of large psychiatric hospitals has resulted in the development of smaller, specialized units where assessments leading to exclusion from mainstream society are maintained. Though these units are generally less isolated than in the past (many nineteenth-century psychiatric asylums were built many miles from centres of urban population), individuals still find themselves congregated with strangers whose main similarity is that they are also unwanted, unpopular, difficult to live with or marked (diagnosed) by a psy professional, sometimes a clinical psychologist but increasingly by everyone from teachers to patients themselves.

Elsewhere I have described psychologists as "entrepreneurs of identity".[8] In effect they sell new versions of the self (more "confident" and less likely to be rejected or diagnosed) to people. That same self (a concept barely considered until the seventeenth century) can, through the auspices of psychological therapists, become, variously, “more integrated”, “congruent” and so on. The identities proffered within the psy complex are generally less benign and frequently involve a diagnostic label (or “mark”) that may well lead to advantages such as Social Security benefits but is otherwise not societally valued. Although individuals and families may utilize the diagnosis in various ways (e.g. in gaining access to benefits payments), the devaluation of the person’s status is evidenced by the ways in which diagnostic terminology rapidly becomes pejorative, a phenomenon accompanied by campaigns to counter prejudice or “normalize” madness. Hence describing someone as a “mongol” or “cretin” entered the vernacular to be replaced in the formal lexicon by “subnormal” or “learning disabled”. Already in the UK, “spesh” – as a diminutive of “special educational needs” – has become a term of abuse.[9]

Critics of incarceration included Defoe, Swift and Chekhov.[10] Criticism ranged from the treatment of incarcerated people, to overcrowding via economic arguments against supporting the indigent. Dorothea Dix, a Boston schoolmistress, devoted herself to improving the lot of the incarcerated after conducting a Sunday School service for female convicts. After addressing the state legislature in Massachusetts in 1843, then Congress in 1848, she visited the York Retreat and toured asylums in Scotland. By the time she retired in 1880, the number of US institutions for retarded or mentally ill people had increased from 13 to 123. Of these, 32 had been founded directly by her. To an extent this reduced – at least temporarily – the overcrowding but failed to allay suspicions that psychiatrists had no *methods* for treating the insane, only experimentation via the latest physical treatments. These included lethal drugs, electricity and spinning chairs.[11]

Institutions are not immune to the tendency to being cast as places of ill-renown, a tendency countered via a name change. Szasz notes how Sonoya Colony (an epileptic colony opened in upstate New York in 1894) changed its name to Craig Colony, then the Craig Colony for Epileptics; then, in 1951, the Craig Colony and Hospital; in 1966, the Craig Colony School and Hospital; in 1968, the Craig State School; and in 1969, the Craig Development Centre. Despite the name changes it remained a venue for “storing epileptics”.[12] This praxis still obtains. Residential facilities for older people are more likely to be promoted as “homely” with names such as “The Gables” than advertised as “Storage facility – old people”. A 2014 report launching an inspection regime for the 25,000-plus care homes in the UK proposed assessment predicated on the notion that such places should create "a real sense of an individual's home". This "civilizing" practice was to involve using prospective residents' own furnishings and curtains to make environments less alien. The move was supported by the charity Age UK and highlighted the importance of familiar objects for those diagnosed with dementia.[13]

The economic context for services for older people is reflected in events and exhibitions such as the Alzheimer Show, held at large venues in London (Olympia) and Manchester (EventCity) in May and July 2014. These were put on for "Public, carers, relatives and professionals" who would find "Information, products, services and practical help".[14]

Devaluation writ small

Subsequent chapters will examine the wounds in more detail. Here I shall concentrate on the everyday indignities for people at risk of devaluation.

Labelling is necessary. We cannot, for example, cross a road safely unless we have grasped that "vehicles" can be "dangerous". The discourse of services, despite the continuous revision of terms, focuses on labels for individuals that those individuals may not choose. An absence of validity for labels promoted by psy makes such praxis particularly pernicious. Chapter 3 examines this in more detail. The arbitrary grouping of individuals can be seen as serving the interests of those promulgating these sociolinguistic divisions. For example, *The Daily Telegraph,* a newspaper read by 500,000 people in the UK and many more online, frequently makes distinctions between "taxpayers", "pensioners" and "the unemployed". This nomenclature renders invisible unemployed, taxpaying pensioners (a significant proportion of the readership). The letters page attests to the irritation of those who reject this editorial policy – a policy that remains unaltered. For service recipients a publishing preference for technical terms such as "dementing" or "disordered" positions their identity as within the purview of psy and neglects equally apposite terms such as "experienced" or "charming". I can be described as a father, guitarist, psy critic, middle-aged white man, author, gardener and so on. My service experiences included labels such as brain-damaged, atypical service user, accident victim and survivor. This last referred to recovery from a road accident rather than service-survivor, though some of my experiences, particularly when being interviewed by medical and psychological experts, might be classed under the latter rubric.

To some extent the survivor movement continues to challenge demeaning nomenclature. "Challenging behaviour", for example, is a term that can be seen as neutral. Is the challenge to create more appropriate services, to develop tolerance or to adjust our understanding?

As noted above, deindividualizing labels add to a societal response of rejection and exclusion. This can involve incarceration (see Chapter 4), and in some cases, for example, the urgent transfer to specialized medical facilities can be life-saving. For psy recipients, displacement (in Wolfensberger's terms "distantiation") is likely to involve movement to establishments exclusively reserved for other devalued people. This is termed "congregation" and can be seen in psychiatric units or specialist clinics for those diagnosed with devaluing psy terms – for example, eating-disordered or "psychotic". Again, there have been moves away from this practice in services for those labelled "learning disabled" but, even here, economics of scale still lead charitable and public endeavours to provide accommodation for a minimum of six people. The same economic imperative results in regimented living conditions or "days out" for groups made conspicuous by socially unacceptable appearance or conduct. The days out are facilitated by service vehicles emblazoned with logos and text relating to the charity involved. The promulgation of non-normative living spaces for service recipients can be compared with the provision of desirable state-funded apartments in Scandinavia (see Chapter 4) or, on a smaller scale, with the "landladies" scheme in Shropshire in the 1980s and 1990s. Here, local residents were paid to offer bed and breakfast accommodation to a maximum of two long-term psychiatric inpatients as part of an initiative to allow patients accommodation that might promote greater integration with the community. This scheme had its detractors and critics, some of whom pointed out that the landladies were frequently located a considerable distance from patients' communities of origin. As monies were diverted to the establishment of new inpatient services, however, the scheme ended despite its popularity among patients and its obvious geosocial advantages over the inpatient unit.

In promoting the advantages of low-key – indeed inconspicuous – accommodation for those at risk of distantiation, I don't wish to downplay the impact of communities where this accommodation may be located. "The community" is an amorphous construction that can be applied to grouped persons ("men", "women", "service users", "the public") as well as neighbourhoods. The smaller the neighbouring physical community, the greater the possibility of *both* rejection and integration. For example, I spend up to six months of the year in a French village.

The population of 108 includes powerful local families, a convivial and "community-spirited" mayor, several cliques and people who only speak to each other waiting for the bread van. One 90-year-old man speaks nothing but Occitan, several octogenarians were born in the homes they still occupy and foreigners like me stay on the cusp of integration despite almost a decade of sharing pastis, bus journeys (the bus to Lezignan market is twice monthly), and a love of the language and countryside. One young man described as "handicapée" lived in the village with his mother until recently, but when she moved away, so did he. His was a well-known presence in the village square, as is a friend's daughter who has more conspicuous difficulties in walking and talking. Neither individual was obviously rejected by the community but it is possible that, just as in a smaller Lincolnshire village I lived in some 30-odd years ago, there are individuals who are hidden from view by embarrassed parents. The wider societal context of medicalization is evidenced with reference to the use of antidepressants. As elsewhere in France, their use exceeds anywhere else in the Northern Hemisphere.

"Control" in the majority of institutional care is in the hands of staff. Thus outings or activities within the institution are dictated by factors that may include competing institutional praxis (ward rounds, case conferences, staff shifts, etc.), availability of transport, patient discharge or admission, treatment requiring ward observation, and the disabling effects of drug and other treatments. The patient is positioned in the role of a child, with choices made by paternalistic others.

It requires fortitude to survive these in-roads into autonomy and personhood. In constraining circumstances as outlined above, survival – via vociferous or violent objections to the passive role – may be construed as further proof of psychiatric illness and treated accordingly, perhaps with medication. The smooth running of inpatient environments requires less tolerance of challenging conduct (whether seen as protest or not) than ordinary homes. The use of PRN medication might therefore be a simple need to prevent disruption to the regime in a poorly staffed facility and needs no justification beyond the institutional imperative.

Towards care

The context of institutionalized care – within or outside the confines of bricks and mortar – is, by definition, ordered according to the broad requirements of the institution. As a professionalizing endeavour, psy needs technoterminology, particular praxis and an explicit promotion of psy practitioners as expert in human affairs. This volume presents no illusions about the intractability of psy in its claims to expertise and jurisdiction over devalued people, and the remaining chapters present only tentative suggestions for change. A number of psy practitioners and researchers already support these ideas and praxis. Services can, perhaps, move in directions implied by the previous section, as follows.

As described in Chapter 3, there is a continuing debate around the nomenclature for those in receipt of services. The debate frequently centres on how best to delineate the deserving poor (see Chapter 8) and diagnostic nosologies. For individual practitioners rather than the psy system itself, it might be possible to accept a more parsimonious labelling practice first suggested (in print) over 200 years ago. In 1810, John Haslam, apothecary (physician) to Bethlem Hospital, believed that "comprehensive taxonomies of madness were quite worthless. Insanity was better seen as a single basic disorder, visible in a variety of phases and manifestations."[15] This move has the advantage – to non-professionals – of leaving the discourse of madness in the public domain. Some people are just odd. They may, of course, be odd in culturally specific ways difficult to comprehend, or conduct themselves antisocially, but their oddness does not necessitate psy involvement, and antisocial behaviour already brings with it the possibility of legal sanction. The generic description – "just odd" – could be applied to revered artists (van Gogh, Picasso, Banksy), acclaimed authors (Balzac, Proust, the reclusive Salinger), poets (Keats, Wilde, Auden), musicians (Mozart, Ives, Zappa) and people in fields from architecture to nuclear physics. These others are feted more for their power to influence and sell than, frequently self-proclaimed, oddity, but to many observers they would be regarded as unusual. Typically perhaps for the gaze of psy, many similarly creative individuals have been diagnosed retrospectively.[16] Given the neutrality of "oddness" there is a possibility that the non-stigmatizing aspects of people's conduct can be emphasized. This move might enable an active search for a person's strengths rather than weaknesses, a praxis encouraged by organizations such as Values in Action.[17]

I recognize that "oddness" is a culturally embedded notion and, like any judgement, is determined by proximal and distal power. The use of oddness as the criterion would not prevent those with vested interests claiming that a relative, neighbour or stranger in the street is odd in order to stigmatize or persecute an individual – a tactic used by paternalistic alienists in the nineteenth century to incarcerate women who, for example, wanted to become independent through education. The communal oppression of homosexuality throughout the twentieth century gained its foothold through appeals to the inherent oddness of not preferring a heterosexual relationship. If psy involvement were limited to emphasizing the culturally pertinent strengths of individuals, however, the industry would not be used as a pseudoscientific prop to these and other forces of ostracization as it has been in the field of psychometrics, notably "intelligence".

Objections to the dehumanizing scale of institutional care might be met by systematic provision of homes reflecting more mundane realities. Homes can be unkempt, chaotic, noisy and distressingly shared with family members. Arguments and claims over living space are as frequent as times when family members share a joke or discussion about the latest TV series. Shared mealtimes are likely to be battles over who gets what – one reason why meals (more often snacks) are taken in isolation in front of a personal computer or X-box. The chaos and familial divisions reflect a form of individuality less available to those in institutional care.

For families or adults sharing apartments, these challenges present an immediate problem that can be met, in part, by an appeal for tolerance. The strain of sustaining employment, however, with a concomitant desire for relaxation when not at work stretches to the limit such tolerance in households including employed people. Add to this the strain of caring for a person with physical difficulties and the tension leads to the rejection described above.

One service solution to this has been embraced in Scandinavia (see Chapter 4). Another was first devised over 1,600 years ago: reduce the size of institutions. Between around 400 CE and 1300 CE about 100,000 hospices catering for up to 12 dependent people each were established in Europe.[18] Principally supported by religious orders, the hospices offered succour to the poor and others unable to live independently or within their families of origin. One of the first small insane asylums in the UK was the hospital of saints Anthony and Elegius in Cambridge. Founded in 1361 as a leper house (by which time leprosy had all but disappeared), by the sixteenth century it was a small asylum with two tenements.[19] The possibility of abuse remains in smaller residences, as evidenced by an inquiry into the treatment of six insane and three infirm people at St Mary Bethlehem in 1403.[20] The smaller the number of residents, however, the more likely that social relationships will develop among patients and any necessary support staff, and lessen the need for extensive rules governing daily activity. Establishing smaller facilities is not a panacea, but it normalizes the kind of environments in which people find themselves; chaos, noise and arguments become part of ordinary discourse rather than disruptions to a regimented day, and opportunities for psy to determine the consequences.

The Berlin Runaway House "Weglaufhaus", for example, opened in 1996 (see Chapter 4). Specifically anti-psychiatric in ethos, it caters for residents who can live there for up to six months. All have been inmates in psychiatric institutions and are homeless or threatened with losing their accommodation. It is small and staffed by volunteers (often themselves psychiatric survivors). House decisions are made by residents and it has helped numerous people re-enter society.[21]

Imagery associated with services is often devaluing and reinforces stereotypes marking service recipients as different – logos on vehicles and letterheads, roadsigns warning of an approach to buildings for distantiated persons, staff uniform and similar marks are ubiquitous. Within a short distance of a UK care home or psy facility, an approaching motorist is likely to see a red rimmed triangle within which appears a silhouette of two people walking bent-backed. The one in front leans on a walking stick and the one following represents a woman. There is an association with infirmity, an association which may be enquired about during the theory element of examinations for driving proficiency. It seems a small – yet immensely difficult and costly – step to replace signs that are as much part of the national consciousness as the logo for Coca-Cola. A few projects have successfully replaced these notifiers by recourse to the question: "What are we trying to achieve?" In consequence, an effective warning sign has been found to be prominent displays of the question: "Do your brakes work?" The result is that motorists brake and slow, often with no awareness of why they are doing so and no associated stigma for the care home.

Case conferences *as* case conferences would cease to exist in the circumstances outlined in the preceding paragraphs. People living together need to talk in order to get on. Some less able individuals need help in this regard – a role for advocates (see Chapter 9). The requirement for a degree of social cohesion further emphasizes the importance of scale; the smaller the number of people congregated together, the easier social integration will be. For Wolfensberger, one solution to the inherent problems of congregation is to ensure that in any domestic environment, individuals displaying socially valued conduct outnumber those who are made conspicuous by cultural oddness. An example here might involve an apartment where younger students live alongside someone who is less socially competent. Assault and drug-taking remain a possibility, but such conduct is embedded in a normative discourse rather than the oppressive praxis and debilitating drug regimens associated with psy (see Chapter 5).

Concluding remarks

In *Taking Care*, the clinical psychologist David Smail discusses psychological praxis less dominated by self-interest. His focus is the dehumanizing aspects of psychotherapy and the concomitant need for jargon and technical expertise. He suggests roles for psychotherapy in the domains of comfort and clarification, roles that can be fulfilled by friends or anyone who takes the time to listen to the experiences of others.[22] Critiques of Smail's position include a suggestion that he is naïve (and surprisingly optimistic) in believing that psy professionals can move away from the comfort of theory, technical praxis and the material rewards of power,[23] a failure to grasp the political context of psy, and a lack of insight into what psy professionals actually *do* in the privacy of the consulting room as opposed to what they *say* they do in supervision or print.[24] The criticisms emanate from psy itself and rarely from patients. If it is naïve to listen and collaboratively make sense of a person's distress, then it is also a mark of friendship. Professional bodies are, however, keen to reduce the possibility of friendship and companionship between their members and service recipients – a move that retains the power of "expert" status and distances professionals from both patients and their own interweaving roles of parent, oppressor, oppressed citizen, lover and so on.[25,26] The small steps towards revaluing distantiated citizens outlined above can similarly be branded naïve. The following chapters will examine the difficulties the psy industry faces in taking care.

3

Labelling and Languaging the Other

By the age of six I knew my dad aspired to a Rover. Too young to take responsibility for doing the family laundry, I still knew that there was a choice between Daz and Omo. Some time in my teens I developed, as if from nowhere, a hankering for a pair of Levis (especially the wildly patched pair to be found inside the gatefold sleeve of *After the Goldrush*)[1] and probably not long after that I began *thinking* about what shampoo to buy rather than taking the cheapest that came to hand. From automobiles to washing-up liquid via clothes and shampoo, branding is ubiquitous. The naming of things and actions is essential for everyday discourse. Labelling objects and conduct is inextricably bound up with the organization of society. In capitalist society, such labelling is transformed into branding. The "brand" of psychiatry and psychology is underpinned by the further branding of individuals and their (socially undesirable) conduct via diagnosis.

Many psy professionals work without diagnostic schema. For them, *some* construction of a person's difficulties is still necessary. The person seeking help may use terms such as fed up, crushed, miserable, fearful, lonely or any number of other descriptors for suffering. The psy professional may see him or herself as a healer, deliberately embracing the patient's vocabulary. Often, a subtle coconstruction takes place wherein "fear" becomes "anxiety", "miserable" is translated as "depressed" and so on. In an age when medical language (and *self*-diagnosis – see below) is the dominant discourse, many people will use technical labels to describe themselves and others. "I think he's autistic" or "I'm a typical bipolar" are as likely to be heard in the general practitioner's (GP's) office as "He's very closed-in" or "I go up and down, Doc." Away from the context of that same office, counsellors, psychologists and others may work in ways that are relatively jargon free. Psychotherapists working within a narrative frame are just as likely to question medicalized jargon used by the patient (a typical intervention might begin: "Who first called you depressed?").[2]

A major factor in any medical intervention is, however, the diagnosis. You can't, at the expense of the UK's NHS at least, have kidney dialysis because you like the idea. As an essentially medical endeavour, psychiatry and its allies – Big Pharma and psychology – have a vested interested in diagnosing as many people as possible. Within the NHS, some clinical psychologists have maintained praxis where a medical diagnosis is either ignored in favour of a patient's exposition of his or her difficulties or, favouring Goldie's "eclectic" position, an adjunctive therapy or psychological formulation approach is suggested.[3] Others, trained in the use of psychometric protocols, have confirmed or changed diagnoses. This is a more common approach in, for example, the preparation of court reports. For clinical psychologists dependent on the reimbursement of fees by insurance companies, diagnosis is ubiquitous. The insurance company standard manual for diagnosis is the *International Classification of Diseases-11* (ICD-11), a volume no less flawed than the much maligned DSM. American clinical psychologists are expected to use ICD-11, thereby marking patients with labels that have no validity or reliability.[4] Often for the best of intentions, clinical psychologists – even counsellors – will use diagnoses. In the USA, several states have now licensed psychologists to prescribe psychiatric drugs, a process that again makes diagnosis necessary. The outcome is that more and more people are diagnosed as mad.[5]

This chapter critiques the use of diagnosis within psy and its ubiquity in the wider world. Small changes are suggested for practitioners who will require considerable local and professional support to achieve limited success.

Classifying conduct

This section examines some of the history of attempts to classify human behaviour as different types of madness and explores the historical consistency of critiquing these attempts.

Plato and Aristotle regarded reason as the defining human characteristic, a characteristic vulnerable to the perturbations of the passions. Madness could easily be detected through observation, mental states only being occasionally referred to. Before the nineteenth century, though rich in detail, references to insanity were made in molar (all-or-none) terms. Behavioural criteria (signs) had been the basis for melancholia, mania and dementia, subjective experience barely figuring.

One of the first published accounts of madness – largely using the words of the patient and written in 1810 – was produced by John Haslam (see Chapter 2). He was apothecary (resident medical officer) to Bethlem Hospital, London, during its move from Moorfields to Lambeth.[6] Like his contemporaries, Haslam saw reason and insanity as opposites; "comprehensive taxonomies of madness were quite worthless. Insanity was better seen as a single basic disorder, visible in a variety of phases and manifestations."[7] Madness was "the opposite to reason and good sense, as light is to darkness, straight to crooked, &c".[8]

The establishment of a truly descriptive psychopathology took around 100 years, from the 1820s to the First World War. It wasn't until the 1830s that books about insanity came to regularly include clinical vignettes and reports of subjective experience: so-called "elementary" symptoms.[9] Berrios notes the marked difference over a period of barely 50 years between the work of Haslam, Rush and Pinel and that of Esquirol, Morel and Tuke. There were few diagnostic groupings prior to the 1830s; melancholia, mania, phrenitis, delirium, paranoia, lethargy, carus and dementia were the main ones. As new nosologies appeared, so did new categories; others, such as carus and phrenitis, disappeared.

The mid-nineteenth century is rich ground for historians attempting to chart the bewildering variation in psychiatric nomenclature. In Germany, first Krafft-Ebing in 1867 and then Westphal used a technical term – *Zwangsvorstellung* – to refer to irresistible thoughts (obsessions in contemporary discourse). In France, Falret in 1866 had already used the term "obsession" and Morel had written about emotion as contributing to obsessional aetiology. Later, Luys brought subjective experience to the fore by defining obsessions as private, individual events. By the end of the century, Esquirol, Ball, Magnan, Kahlbaum, Kraepelin and Maudsley were merely some of the more renowned nosologists to have produced extensive and competing classifications of psychiatric morbidity.

In 1906, the Joint College of the Royal College of Physicians of London drew up the fourth edition of the *Nomenclature of Diseases*, forerunner to the *International Classification of Diseases*, now in its eleventh edition.

The publication of yet another classificatory scheme was not universally welcomed: in his presidential address to the American Medico-Psychological Association, Charles Hill the following year observed the only diagnosis omitted was "the *classifying mania* of medical authors".[10] Over a hundred years later his wry comment found a sympathetic response in Levy's proposed category, pervasive labelling disorder.[11]

The origins of DSM

The first official, largely Kraepelinian, classificatory system in the USA was produced by the forerunner of the American Psychiatric Association – the American Medico-Psychological Association – in 1918. There were 22 principal groups of mental disorder. Two mood disorders – manic-depressive psychosis and involutional melancholia – were listed. "Affective disorders" were introduced by the Standard Veteran's Administration (VA) classification in 1951. The first DSM, produced the following year, was similar to the VA system: "affective disorders" became "affective reactions". In all, DSM-I described 112 different diagnostic categories.

The ontogenesis of DSM-I was a more fraught, contested and drawn-out process than the simple summary above might imply. Grob[12] notes that "classification systems are neither inherently self-evident nor given", and, "although nosological debates dealing with mental disorders were [and are] phrased in scientific and medical language, they were shaped by . . . the social origins and ideological, political and moral commitments of psychiatrists; their desire for legitimacy . . . [and] . . . the broader social and intellectual currents prevalent . . .".[13,14]

Nineteenth-century psychiatrists and alienists had long believed that mental illness was precipitated by a combination of psychological and environmental factors which might include improper living conditions. For many, the innumerable forms of human conduct were barely explicable and impossible to classify. Following Esquirol, for example, Ray, in 1838, had divided insanity into idiocy and imbecility for those with congenital defects and a second group where lesions were the probable cause of either mania or dementia. In the same volume he explicitly denied that any classification "could be rigorously correct, for such divisions have not been made by nature and cannot be observed in practice".[15]

Despite such doubts, by 1885 a group of American psychiatrists under the direction of Clark Bell, president of the New York Medico-legal Society, had followed their British counterparts in producing an eight-fold categorization of mental disorder, a slight increase on the seven-fold nosologies of the International Congress of Alienists (1867) and the Association of Medical Superintendents of American Institutions for the Insane (1869). Only a year later, Bell found himself rejected by Pliny Earle, a grand figure in US alienism, on approaching him for help with yet another classificatory system. Earle's discouraging response has been echoed by critics to the present day: "no classification of insanity can be erected on a pathological basis . . . for . . . the pathology of the disease is unknown . . . we are forced to fall back upon *the apparent mental condition,* as judged from the outward manifestations". Grob notes that, in the absence of a clear indication of organic injury or decay, psychiatrists had no hesitation in looking for environmental factors in insanity; sexual excess, diet, housing, misdirected education, and domestic, financial and occupational difficulties were cited in an ever-lengthening list. Predating, by over 150 years, the technique of "psychological formulation" embraced by UK clinical psychologists, and acknowledging the lack of utility of classificatory systems, Samuel B. Woodward, the first president of the Association of Medical Superintendents of American Institutions for the Insane (now the American Psychiatric Association) had already recognized that therapy was "independent of any nosological system, but, rather had to reflect the unique circumstances presented by each individual case".[16] In fact, as detailed by Valenstein,[17] an obsession with technologies of intervention led psychiatrists to attempt a host of deadly interventions based on putative theories of organic aetiology rather than an analysis of personal and environmental factors unique to the individual. For Smail,[18] similar, if less physically dangerous, technoprocedures are mistakenly pursued by clinical psychologists.

Of the 22 groups in the first *Statistical Manual for the Use of Institutions for the Insane,* 20 represented forms of disorder assumed to have biological foundations. These included psychosis with arterial sclerosis, general paralysis, Huntington's Chorea, and psychoses with brain tumour, cerebral syphilis, pellagra and epilepsy. The preference for somatic nosology might be explained by the fact that the overwhelming majority of psychiatrists dealt with hospitalized patients with severe physical impairments. Between 1918 and 1942 the *Statistical Manual* went through ten editions, the tenth making provision for *psychoneuroses* and *behaviour disorders* – almost certainly a response to the observation that soldiers could be returned to the battlefield of the Second World War within days of treatment involving little more than rest and companionship, an outcome that common sense suggested could not be achieved if their distress had an organic substrate.

Between 1948 and its publication in 1952 the APA Committee on Nomenclature and Statistics had circulated for comment a draft DSM-I to numerous organizations and individuals. The social, cultural and medicotechnological climate following the Second World War had been transformed from that immediately after the First World War when the first *Statistical Manual for the Use of Institutions for the Insane* had appeared. Mental disorders were now divided into two main categories: disturbance resulting from impairment of brain function (trauma, alcoholism, multiple sclerosis, etc.) and disorders resulting from an inability to adjust. The second group was further divided into psychotic and psychoneurotic disorders. Post-war, the psychiatric community, influenced by psychodynamic theory, moved towards a position whereby mental health and illness were on a continuum and sought to treat more individuals diagnosed as psychoneurotic. DSM-II was published in 1968. Its authors turned their sights to the wider community for corroboration and collaboration. Influenced by the eighth edition of the *International Classification of Diseases* (ICD-8), affective reactions became major affective disorders, now including involutional melancholia and listing psychotic depressive reaction separately. The overall number of disorders rose to 163. DSM-III, published in 1980, contained 265 disorders.

A new feature of DSM-III was its multiaxial orientation, Axis I describing symptom-based disorders and Axis II personality disorders. The remaining three axes specified medical conditions (an intriguing feature in a nosology, supposedly articulating all psychiatric disorders as medical phenomena), severity of stressors and the best level of psychological functioning during the preceding year. The all-encompassing nature of the new volume was commented on by Jay Katz, a professor of psychiatry at Yale: "If you look at DSM-III you can classify all of us under one rubric or another of mental disorder."[19] Freud, Marie Jahoda and Karl Menninger were among many psy professionals to already be on record as suggesting that we were all mentally ill at one time or another, to a greater or lesser degree. This position puts those frequently critical of the diagnostic endeavour – for example, clinical psychologists – in a paradoxical position from which they can escape via the Judeo-Christian tradition of charitableness. Distress can be normalized or placed on a continuum wherein it is the suffering of the individual (or others, such as the family) or the temporary apparent inability to function socially (so-called "problems in living") which dictates the need for professional intervention; suffering is the only justification needed for referral to a mental health professional. DSM-III-R, DSM-IV and DSM-IV-TR were published in 1987, 1994 and 2000, respectively. The 265 diagnoses in DSM-III increased to 292 for DSM-III-R and 365 for both the later editions. DSM-5, published in 2013, has a similar total.[20]

The centrality of embodied language

Aristotle first used the concept of habitus (his term hexis being translated as "habitus" by the Scholastics), later to be elaborated by Mauss and revised by Merleau-Ponty and Bourdieu. Bourdieu explained its dependency on history and human memory: a certain behaviour or belief becomes part of a society's structure when the original purpose of that behaviour or belief can no longer be recalled and becomes individually socialized. An example might be the way that, in English, the principal meats are called lamb, chicken, pork and beef. For centuries the poor could only afford the first two and as they usually raised the animals themselves the meat was simply named after the animal. "Mutton" from older animals and more frequently the dish of peasants is derived from "mouton", French for sheep. The rich, distinguishing their greater "sensibility" and wealth, described (or disguised) their meat via different terminology; pig became pork and cow became beef.

The term has been used by Elias, in Mauss' account of "body techniques" (*techniques du corps*) and in the work of Weber, Deleuze and Edmund Husserl.

Mauss defined habitus as those aspects of culture that are anchored in the body or daily practices of individuals, groups, societies and nations. It includes the totality of learned habits, bodily skills, styles, tastes and other non-discursive knowledges that might be said to "go without saying" for a specific group; it can be said to operate beneath the level of rational ideology.

According to Bourdieu, habitus is composed of

> systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organize practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of the operations necessary in order to attain them.[21]

An example might be "depression". Jackson notes depression as "a relative latecomer to the terminology for dejected states".[22] In 1725, Blakemore writes of "being depressed into deep Sadness and Melancholy", while in 1801, David Daniel Davis' translation of Pinel's *Treatise on Insanity* rendered l'abbattement as "depression of spirits".[23] This historical usage has been all but forgotten – being depressed is no longer something that is *done to* the person, it is an entirely internal affair. Nor is it a technical term for the majority of English speakers – it is the way we might describe our mood.

For psy the term is part of the cultural capital: a non-financial social asset that promotes social mobility beyond economic means. Education, intellect, style of speech, dress and physical appearance are all examples of cultural capital (*le capital culturel*). For Bourdieu, capital acts as a social relation within a system of exchange, including all the material and symbolic goods that present themselves as rare and worthy of being sought after in a particular societal context. Cultural capital acts as a social relation within a system of exchange that includes the accumulated cultural knowledge that confers power and status.[24] This is echoed in Wolfensferger's suggestion that devaluation ensues when a person cannot access material goods or socially valued modes of interacting. Thus psy uses cultural capital to further devalue individuals (or arbitrary groupings such as "schizophrenics") within a context where the devalued people will have no access to the historical underpinnings and social meaning of the language used to describe their conduct. Someone described as schizophrenic will not necessarily consider the use of the term as a way of emphasizing the professional's expertise, nor, in its derivation from Latin – the language of the elite – historical links with class and education. The labelled individual is likely to "realize" there is something "wrong" with him or her – something that only the person with greater cultural capital can fix.

In the absence of access to a sociological view of this kind of exchange, the labelled person may believe the "expert" is in some way showing off in using a technical term.[25] The *consequences* of being so described will still impact on the person's sense of personal worth and lead to further exchanges that leave the person confused and distressed – for example, in the adverse effects of equally mysterious medication, hospitalization or therapies conducted by those with obviously greater cultural capital.

Language is central to cultural capital. In his exposition of critical realist social constructionism (CRST), John Cromby discusses how, for social constructionists, "the world we experience and the people we find ourselves to be are first and foremost the product of social processes… It is primarily the societal reproduction and transformation of structures of meaning, morals and discursive practices that constitutes both relationships and subjectivity." Language (as the carrier of categories and meanings) is thus central. Discourses, shaping what can be said and done, "condition what is likely to be *thought*".

As discourses are the products of embodied beings in a material world, for CRST, "our embodied practices run alongside our discursive practices, shaping and constraining them."[26] At its simplest, a person with a cleft palate will have less cultural capital than someone with no such physical challenge, both because of a devalued physical appearance and due to the fact that the person's speech will be impaired – leading to discursive restraints on interaction *and* thought.

Cromby discusses the way in which the social transactional script (Helpless-Helpful, Powerless-Powerful and Worthy-Worthless)[27] of "helplessness" (for people diagnosable as depressed) comes to reinforce feelings of inadequacy. The script is a product of an interaction between the person and their impoverished environment. The "daily grind" of coping with limited resources leaves people unable to sensitively negotiate relationships.[28]

Mays and Albee note that ethnic minorities are more likely to be poor, live in substandard housing, and suffer educational disadvantages and other examples of discrimination. At the same time they are more likely to suffer a range of physical health problems from increased tooth decay to cirrhosis. Citing, among others, Flaskerud, they suggest that members of ethnic minorities more often seek help from traditional healers, root doctors, clergy, herbalists, and family and friends.[29] By contrast, and to an extent undermining Cromby's link between poverty and distress, there are more psychotherapists per capita in Washington DC than anywhere else in the world – the majority from the white area of Northwest Washington.[30]

On a reflexive note, this volume displays many features of cultural capital. Ostensibly written as a means of considering how psy maintains the "them and us" divide, it uses language and knowledges unavailable to the majority (the "them"). References follow a scientistic agenda, and some word usage and concepts will escape even those most likely to afford the purchase price. One goal, consistent with academic aims, is to garner more cultural capital (though not much financial reward; as a five-year endeavour, the publisher's payment equates to less US$1 per hour, while attempts to find a space to write without interruption – frequently in the garden shed – have their own costs in terms of family harmony). In addition, little between these covers is not already known to my fellow passengers on the 501 bus to Shrewsbury, though their philosophies are expounded in less esoteric language.

The next section examines in more detail one means by which psy maintains its cultural capital – obfuscating language or *lingua obscura*.

Lingua obscura

As part of their daily practice, clinical psychologists and therapists working in psychiatric and outpatient settings regularly use diagnostic labels. Although the BPS criticized the proposed increase in potential diagnoses in DSM-5, the BPS statement doesn't demand that members stop using diagnosis and the language of psychiatry.[31] To do so would be an explicit attempt to reduce psychologists' cultural capital. A cursory survey of the language used by clinical psychologists in the UK in their publications in various journals and newsletters would have revealed the impossibility of acceding to such a demand.[32] It should be noted that the practice journal and Division of Clinical Psychology's newsletter *Clinical Psychology Forum* does not escape the scientistic gloss of diagnosis. Recent papers include those of Devlin (2014), and Bullock, Judd and Murray (2014). For me at least both the contents of the articles and their titles merit a footnote (to be found in an autobiographical novel concerning the writer's translocation to France); "A team of linguistic scholars has studied this sentence for weeks and they are still split fifty/fifty as to whether it makes sense or not."[33]

Diagnoses change over time. During my clinical psychology training in the late 1970s I saw only one person diagnosed as depressed and many more diagnosed with agoraphobia. Although the topology of the neighbourhood (very flat) and the presence of numerous street markets may have accounted for the disparity, a simpler explanation is that depression wasn't a fashionable or, for drug manufacturers, a profitable diagnosis then. Diagnoses change, as does the language used to describe undesirable or confusing behaviour – usually some time after the diagnostic usage has fallen out of favour among psy professionals. Thus words like "moron" and "imbecile" have come into common parlance even though they have not been official categories of disability for over 80 years.

The growth in diagnoses suggests that the next edition of DSM (due within the next ten years) may contain 500 disorders. Whether the number of diagnoses rises or not, bears little relation to the diagnostic rate or the consequences for those diagnosed. Despite no change in the criteria, for example, of Attention Deficit Hyperactivity Disorder (ADHD), in the UK the number of children so diagnosed rose from 20,000 to 300,000 in the lifetime of DSM-III-R.[34]

The requirement by insurance companies in the USA and the UK for psychologists to use diagnoses in writing court reports is one factor in the persistence of psy jargon. Others include the need to present as "expert" and use of a code that can mark out authors and researchers as part of a particular scientific community. In the consultation room, that code acts as a distancing motif between therapist and patient.

Proximal influences include a *requirement* for university staff to publish research as part of a contract of employment. Research output is used as a means of distributing resources, status and power between individuals within schools/departments; between departments/schools; and between universities and higher education institutions. The best key performance indicator (KPI)-rated universities get the greatest financial rewards. A larger number of KPI "points" are won by publishing in the most KPI-prestigious journals. For psychologists, this implies mainstream acritical publication strategies, deploying mainstream acritical referees and publishing mainstream acritical manuscripts with the greatest degree of *scarcity*. The majority of the most prestigious journals are those supported by the American Psychological Association (APA). The APA publishes rejection rates from its journals every year in *The American Psychologist*.[35] Rejection rates are treated as measures of the quality of a journal and its publications: the higher the rejection rate, the better the quality. Rejection rates of about 80 per cent are considered a mark of editorial excellence. For undergraduate psychology students, being required to learn to do references in the way required for submission to APA journals is related to the politics of funding of the higher education sector and is the beginning of subjective reconstitution to reproduce the means of production of the psy-complex labour force in order to generate income for an entrepreneurial higher education institution.[36]

Avenues for publication are numerous: informal newsletters, professional newsletters, peer-reviewed journals, textbooks, websites and blogs are a few of the options. Peer-reviewed journals are the most prestigious and, for academic clinical psychologists assessed according to their publication output, they are a vital means of disseminating their work. Clinical psychologists can submit their research to well over a hundred journals devoted to psy and any number tangentially related. To do so means using the language of psy and, frequently, an all-too-predictable format displaying the author's familiarity with playing the publication game. The format can be described as an hourglass, beginning with a justification for the research in terms of contemporary (preferably global) relevance, via a description of what was tried out with whom in a particular locale, to the need for further research to confirm the (preferably global) implications of the findings. Such research, by necessity, uses anonymized subjects, frequently grouped by diagnostic categorization ("depressed", "autistic spectrum", etc.) or vague demographics ("elderly", "black", "adolescent", etc.) and describes technical procedures as if they are carried out without deviation from official manuals of treatment. Indeed, many research protocols use exclusively manualized treatment. Any variation, however gross, within the practitioner is denied by default; a manual was used so, by definition, all participants used it in the same way. Thus journal articles, sometimes with a bewilderingly large number of authors (again, a function of the academic demand to publish), will have titles using the format: Therapy X for condition Y: A comparison with therapy Z. The scientistic discourse of clinical psychology ensures that the unique characteristics of patients and researchers/practitioners disappear in these, largely quantitative, studies. Scientistic dogma insists that inductive methods of the natural sciences are the only source of factual knowledge; in particular, knowledge about human society. Further, only knowledge which is measurable can be "real" knowledge.[37] I should add that discursive attempts to bypass this difficulty through reflexively incorporating the position of the researcher tend to become reductionist exercises that position the researcher as both within *and* outside his or her own experience.[38]

Diagnoses and associated descriptors also change to incorporate other conduct, losing or gaining associated stigma in the process. "Manic depression", for example, has been replaced by "bipolar disorder", a label that some diagnosed individuals have no hesitation in using, especially if "coming out" adds to their celebrity; in turn, this will help an associated charity gain funds. Similarly, there are numerous Internet chat rooms for people with almost any psychiatric diagnosis (it is tempting to suggest that their contributors offer some support to the validity of at least one diagnosis – narcissism) where people offer each other support or, in a skilful inversion of the associated stigma, declare they are "mad and proud".

These discursive moves by patient group and diagnosed individuals, however, create a problem within the discourse of responsibility. To the majority, madness is positioned as a lack of responsibility for one's conduct – to whit, a person acting in non-socially sanctioned ways is either "mad" or "bad". A person diagnosed with schizophrenia partly as a result of hearing voices can receive state benefits in addition to – frequently – noxious professional interventions. The benefits received are a consequence of the person's position as one of the "deserving" poor. If that person then joins a group such as the Hearing Voices Network and later joins a MadPride march protesting about the treatment of psychiatric patients, it is unclear how the system and its representative professionals are to respond. If the person claims to be "proud" of his or her particular kind of madness, then, by implication, the person has worked hard to achieve something (voice hearing, say) and expects approbation. It is a rare diagnosed individual who will say he or she has aimed to hear voices – the majority find voices distressing and want to control them. If the voices are not within the power of the hearer to produce, then "pride" is an illogical response. A different reading of the term would be how it positions people in a way that is societally arresting, gaining valued media coverage for a protest voice. It might be that the person is claiming the right to control the voices in a particular way and is proud not of the ability to summon voices, but to overcome the experience. The person is not "proud" to be mad (a socially constructed and diagnostic praxis beyond the recipient's control) but proud to feel some control over the future response of professionals – as helpful adjuncts to self-directed healing rather than figures vested with authority and coercive power.

The Byzantine nature and sheer size of the psychiatric and social care system means that loss of notes, mistakes in note-keeping and data entry, or the tiredness of busy care staff may lead to patients being confused with others. If labelled via a psy assessment the labels themselves are likely to be confusing to both patients and staff; ignoring for a moment the lack of reliability and validity of psychiatric nomenclature, it is a rare member of psy who can adequately explain the difference between "schizophrenia", "schizotypy" and "schizoid personality disorder". Despite rhetoric from assessors that their assessments, and hence services, are "needs-led" the bestowal of such labels says little in terms of patient need. More psychotherapeutically inclined clinical psychologists might make clinical notes including assessments of "ego-strength" or "insight", but it is impossible to know what the patient or other professionals reading the notes make of such jargon. Further, as I have previously outlined, notes – frequently now a computerized record – will be kept for many years and there is no way of knowing what future readers might understand by terms such as "depressed" or "borderline".[39] This may seem an unduly cautious analysis but I should like to give the reader an idea of possible consequences of the longevity and power of patients' notes (which by definition reify terminology). In the early 1990s I agreed to attend a case conference for a female inpatient after her psychiatrist had suggested psychotherapy might be an avenue "worth exploring". As part of his introduction to the woman's case history the psychiatrist beamed as he said that he had found "the answer" in some old notes. Admitted as a 20 year old in the late 1950s, the woman had "responded" to ECT. Without further ado, the psychiatrist said that psychotherapy wouldn't be needed and referred the patient for a 12-session series of ECT. The woman was probably 35 years older than at the time of her previous admission, married *and* divorced, a mother and grandmother. The considerable change in her proximal circumstances and accelerating change in the wider context (in 1958 her home town had been a sixth of its current size, the US/USSR space race was yet to begin and personal computers were inconceivable) were seen as irrelevant to the woman's supposed internal, probably biological, disease, as evidenced by her fateful response to ECT so many years before.

A clinical psychologist or counsellor reflecting on his or her own professional development might like to review sets of notes on patients that he or she has taken at, say, two-year intervals. (I know of *no one* who does this; once the patient is discharged the clinical psychologist or counsellor may never wish to see the notes again.) Some may find little change; others may be surprised at the apparent ease with which they have adopted new jargon; others will observe how an early ease with medicalization of distress has changed to a focus on specific conduct. Recently qualified clinical psychologists should find extensive use of psychological formulation.[40] A further challenge might be to follow up the random sample and discover if the patients found the notes helpful. Notes are one way in which professionals place a distance between themselves and patients. They fulfil one aspect of "the gaze".[41]

Patients in the system, confused by forms or neglected by busy professionals who should be organizing state benefits on their behalf, soon become financially worse off. They can be blamed for "resisting" therapy and will be subject to case conferences, often attended by staff they have never seen before and won't see again. They can also become ciphers in case conferences or "case discussions" where they are not present. Instead, professionals offer different perspectives on the patient; a ritual that can resemble a competition for dominance of a particular theory or treatment approach; the patient is only required as a common reference point. Psy professionals are under pressure to see as many patients as possible; the idea that someone who is persistently late for appointments is "resisting" helps make it easier to discharge the patient. The nature of professional justification and the long life of the psychiatric record may mean that a reputation for "resistance" (no bad thing for liberation psychology)[42] will be one of the marks the patient receives.

Lingua franca

All descriptive pathology relies on everyday adjectives delineating specific aspects of pathological conduct. Kraepelin, for example, suggested that "morbid personality" (a forerunner of the general category personality disorder) could be divided into six types; " . . . excitable, unstable, eccentric, liar, swindler and quarrelsome."[43] All are context dependent and vary according to the values of the observer.

Viewers of parliamentary debates might conclude that modern politicians are morbid personalities. An historian using the suggested method might suggest that many celebrities are neurasthenic and an equal number of media presenters, hysterics. This view reverses the practice of ascribing recent diagnoses to historical figures. In a study of 291 "world-famous men", Felix Post suggests that 72 per cent of his sample of authors would be diagnosed as depressed. He posits that Balzac would be better seen as "hypomanic", a diagnosis not included in any psychiatric nosologies until long after the author's death.[44]

As coordinating editor of *Clinical Psychology Forum*, I ensured that the "notes to contributors" bucked the academic trend. On the inside cover of each (monthly) issue the following appeared:

> Contributors are asked to use language which is psychologically descriptive rather than medical and to avoid using devaluing terminology; i.e., avoid using clustering terminology like "the elderly" or medical jargon like "person with schizophrenia". If you find yourself using quotation marks around words of dubious meaning, please use a different word . . . we reserve the right to shorten, amend and hold back copy if needed.

This was an attempt to clarify and demedicalize the language of the profession. The final subclause, however, legitimizes censorship. At the proofreading stage, some terminology favoured by authors was changed. For example, "schizophrenic" would become "person diagnosed with schizophrenia". This practice was itself undermined because many of the people described as schizophrenic had not, in fact, been diagnosed. The outcome was a journal that rarely reflected the language commonly used by clinical psychologists. The aim (made explicit in a 1995 paper)[45] of shaping praxis via language was unfulfilled. Any desire to increase the number of articles with a more personal and less scientistic writing style was equally frustrated: in a review of over 1,500 articles published in the journal between 1990 and 2001, only 25 *non*-scientistic unsolicited papers were identified.[46]

The two most recent coordinating editors accepted these notes to contributors without demur[47] but, as noted above, the use of medical jargon in the journal has *increased*.

The ubiquity of diagnostic terminology, its popularity in mass media, and the presence of thousands of websites and easily accessible psy-based questionnaires means that non-psy professionals too have no hesitation in diagnosing others, sometimes describing a friend's child as "autistic" or a friend as "Aspergic". Journalists in the sports or music industry will call particular subjects "depressed" whether or not they have the official imprimateur. It is common to see actions or the actors described as "schizophrenic" (meaning contrary) in the media, and there has been a recent increase in journalists "coming out" as obsessive or depressed. Self-diagnosis via the Internet is now the norm for many.[48] This places professionals in the curious position of potentially arguing with patients about which label to use in a context where the labels are invalid and the *right* to diagnose disputed. A libertarian would suggest this represents a more democratic use of the psy lexicon.

In a French village I shuddered as a DJ increased the volume of the reggae he was playing to ear-shredding intensity. When asked to decrease the volume he ranted into the microphone that the audience just didn't comprehend the need for body-shaking bass in true Rasta music. One of the audience, familiar with the individual's ways, explained to me that the DJ had described himself as autistic and thus only able to work in a routine way – a routine that included insulting a room full of deafened paying customers.

Non-technical nomenclature is, however, readily available and used as part of common speech. When discussing why Jérôme Espinas, founder of the famous gypsy band Tekameli, hadn't gone on to personal fame and fortune, for example, Fernanda Eberstadt was informed by an illiterate Romany that Espinas was "completely insane", and this only moments after witnessing his genius in performing flamenco *cante jondo*.[49] In 200 years we have come full circle, with people who can neither read nor write agreeing with Haslam's black-and-white conclusions regarding sanity and insanity.

This simple sane/insane divide is popular in commentary and "public opinion". Notoriously, Vincent van Gogh was seen as "mad", and Picasso endured a prolonged artistic block as the result of tensions created in his love life. Kandinsky and Malevich's abstraction early in the twentieth century ensured both were also derided as "mad". Munich art critics saw the former as a madman while Malevich, and his colleagues Matiushin and Mansurov, were described as "three crazy monks."[50] Malevich is sometimes seen instead as a mystic. Peter Chadwick pursues the alternative interpretation of politically directed art through reference to Kandinsky (who thought art might increase spiritual awareness), Breton (who hoped for a Marxist revolution through art) and the Dadaists (who aimed for a deeper poetic reality than science could attain). "But none of these aims materialised. The art remains but the ideology is expendable."[51]

Unreason as diametrically opposed to reason has been used as the basis of a call to women to integrate their darker sides – anger, violence and passion – as a way of asserting themselves in a Western world where the call to gentility and reasonableness is ever-present[52] A return to the sane/insane dichotomy might *seem* possible for psy professionals. Distantiation, however, as a technical praxis requires more than the fear seen as motivating the establishment of late medieval leper and epileptic colonies. Removal to a place of potential help may only require a parent's concern that the child is experiencing more than the usual degree of, say, stomach pain. Such judgements are wholly subjective and based on forces beyond the parent's comprehension: why the pain was so difficult to tolerate at that particular moment may be not be easily understood, and unrelated to the child's experience. Once the child arrives at the GP's surgery or accident and emergency department, other factors come into play. The discourse of diagnosis will in part determine what happens next. Formal distantiation thus requires several related processes: concern about a form of distress or abnormality; removal to a place of assessment or diagnosis; and treatment, which may involve incarceration. Chapter 4 will examine the history and current practice of institutionalization.

4

Rejection: Exclusion and Incarceration

The places where people are congregated, subsequent to labelling, bear little relation to ordinary homes. As Olive Bucknall, an ex-patient and carer at Shelton Hospital, has remarked, "there is nothing normal about these places".[1] There are numerous psychological theories of human development that psychologists are exposed to both in their first psychology degree and in postdoctoral work. From a perspective of proximal power, the idea of "peer pressure" is well established in public and professional discourse. If the notion is valid then congregating people with other people who act in ways seen as mad or self-destructive should not be condoned by members of the psy professions. Advertisements in publications such as the BPS Appointments, however, continue to promote the "excellence" and exclusivity of unitary diagnostic units.

Once so distantiated, the person is likely to be moved again, frequently as a result of changes in local circumstances (something as simple as redecoration of the unit or something more dramatic such as unit closure due to financial pressures). The person, having already suffered disruption to relationships that are frequently valued (close relatives, local friends, etc.) now loses relationships with new-found companions. In seeing rejection and exclusion as the first phase in social devaluation, Wolfensberger tends to downplay the often aversive nature of local and family relationships in peoples' lives, especially those who are already implicated in the patient's distress. It is, however, a common feature of institutional life that people do find some degree of solidarity with others who are institutionalized – moves within the institution or hurried discharge break up these new alliances. Any person finding themselves in the hands of the social or health care system soon lacks control and the concomitant sense of security.[2]

This chapter will examine two aspects of the institution: first those characteristics related to physical and geographic factors, and second the institution as an embodiment of institutional praxis.

Bricks and mortar, concrete, glass and steel

Between around 400 CE and 1300 CE about 100,000 hospices catering for up to 12 dependent people each were established in Europe.[3] These were used as places of refuge for those without the resources to look after themselves, often due to physical difficulties. Foucault, among others, has written extensively about the rise of the convent as a place of healing and a place to hide the unruly.[4] Some religious houses – for example, Fontevrault Abbey in the Loire, were, by later standards, liberal with equality of gender and a laissez-faire approach to the more dependent novitiates, some of whom were battered women.[5] In Belgium the town of Gheel became a "refuge for the insane" following the establishment of the Church of St Nympha in the twelfth century. Some 500 years earlier, Nympha had escaped the incestuous advances of her father and after joining a religious order had cured two demonically possessed mad people. By the eighteenth century the townspeople of Gheel were offering refuge to the mad in their own homes, a practice which continues today as a potential model for community care.[6]

The root meaning of the word "hospital" is to give shelter. Of the 1,100-plus hospitals founded in England in the four centuries following the Norman invasion, 31 per cent were devoted wholly or in part to lepers. Holy Innocents, Lincoln, was refounded in 1461 as an almshouse with accommodation for three lepers. By then the majority of leper hospitals had become redundant. Those that had not fallen into disrepair became almshouses; some 67 per cent of the total population were paupers and few hospitals catered for the non-leprous sick poor.[7] Others gradually became dominated by medical staff who preferred physical intervention over simple labour and prayer. Elsewhere, workhouses started incarcerating a large proportion of mad inmates.

Maisons Dieu in France and hospitals in England, supported by donations and attached to monasteries, proliferated. The reigns of Henry VIII and Elizabeth I saw the establishment of 800 hospitals in England. Their aim was to provide shelter for travellers, most frequently the poor. It has been estimated that by the time of the Poor Laws at the turn of the sixteenth and seventeenth centuries, more than 10 per cent of the population of England and Wales were dependent on the parish. Two hospitals (St Mary Bethlehem (Bedlam) and St John the Baptist, Chester, founded in 1232) catered for the insane. Treatment consisted of bed rest, warmth, cleanliness and an adequate diet. Religious needs were attended to by monks and assistance provided by women. Medical care, as we might now describe it, was absent.[8] The infiltration of medicine didn't begin until the rise of the larger general hospital in the eighteenth century. The beginnings of the specialist hospital in England had to wait until 1804 with the establishment of Moorfields Eye and Ear Hospital.[9] A series of acts of parliament in the UK in the nineteenth century had seen medical domination reach its apogee in the creation of public lunatic asylums. The 1845 Lunacy and County Asylums Acts mandated the construction of county asylums, to be regulated by the National Lunacy Commission. Economic necessity soon led to savings based on scale rather than efficiency or cure. The West Riding Asylum, for example, had opened in 1818 to 150 patients; 80 years later it held 1,469.[10]

In the middle of the nineteenth century, Bellevue Asylum in New York held over a thousand *children* under the age of 16.[11] By the end of the nineteenth century, English workhouses and asylums held over 50,000 children. Abandoned or orphaned children of the poor were housed alongside adults.[12] English has estimated that hundreds of thousands of children were "stored" in nearly 800 public US institutions from the middle of the nineteenth century to the first quarter of the twentieth.[13] As noted in Chapter 3, some of these institutions were epileptic colonies disguising their principal function – that of incarcerating the unwanted – by regularly changing the colony's name. In the USA, child-specific psychiatric institutions were founded in the 1950s; the 1970s saw a massive increase. By 1993, hundreds of thousands of American children were held in these institutions, the majority receiving psychotropic drugs despite showing "no psychotic symptoms".[14]

In France, Louis XIV had ordered the grand incarceration in 1656. It was a police roundup of the odd and the mad. The reasons for incarceration in the Salpêtrière and Bicêtre (part of the Paris General Hospital) were social (disruption to society) and ethical (potential self-harm); the aim of the edict was to prevent "mendicancy and idleness as the source of all disorders".[15] The responsibility for deciding on those to be hospitalized lay with the chief of police. Pinel was appointed as physician of Bicêtre in 1793 and Salpêtrière in 1795. In 1838 he classed some as aliénés (insane) to be treated in hospital – hence, "aliénistes", the precursors of psychiatrists. As noted above, 150 years later there were many huge hospitals for the mad in the USA and Europe, a practice soon mirrored around the world.[16]

A common view of institutions built as asylums in the nineteenth century is that they were overcrowded and unkempt; "asylum" was a misnomer. Some private hospitals (e.g. Ticehurst House Asylum in Sussex) were considered places of refuge for the rich.[17] Those built as public lunatic asylums in the middle of the century were overcrowded and rapidly became places for the medical profession to experiment on the inmates using drugs of varying toxicity, spinning cures, strait-jackets and the like.[18] A modernist reading would suggest that we have progressed in the last century and a half. We now offer so-called community and primary health care, smaller residential centres for those deemed mad and dangerous, and specialist units for those inscribed with eating disorders, dementia and other psy labels. Allderidge has noted, however, that the provision of small, purpose-built specialist centres for those deemed mad is actually something of a return to much earlier practice. Henry Maudsley's proposal, in 1907, for a small facility was, "in fact recycling a model which had previously been used at the end of the 14th century". Bethel Hospital in Norwich, for example, built in 1713, still only housed 27 inmates 17 years later.[19]

Private madhouses, increasingly run by medical superintendents, were built in England in the late seventeenth and eighteenth centuries. Why the asylum movement began then is hard to establish. Andrew Scull's contention that the expansion was one consequence of industrial capitalism is difficult to support given that the social effects of capitalism (displaced families, disrupted family life, increasing employment for women and unemployment for men, the obnoxiousness of polluted cities, etc.) were not felt until the mid-nineteenth century.[20] County asylums proliferated in the years 1800–1900. Lincoln, Warwick, Leavesden and Lancashire were typical – imposing, built well away from centres of commerce or residential areas, and with adjacent agricultural holdings to allow a regime of work and fresh air. By the 1880s, near London there were "vast, utilitarian pauper lunatic asylums at Hanwell and Colney Hatch". Banstead and Claybury hospitals were soon added and by 1894 the five asylums managed by London County Council's Commissioners in Lunacy provided 11,668 beds, a figure that had risen to over 19,000 by 1910.[21]

A century ago the USA had close to 150 equally large institutions. Italy had many, some based in fourteenth-century buildings. Two, Macerata and Turin, were directed by the reformer Morselli, progenitor of the term "clinical" psychiatry and a firm advocate of physical work over the common praxis of blood-letting, coercion and restraint.[22]

Then, as now, potential disruption due to incarcerating problematic individuals together was a concern for administrators and clinical staff. Mechanical restraint for madness became a centre of controversy for alienists and psychiatrists in the USA and the Great Britain in the nineteenth century.[23] In part this was due to the successes at the York Retreat, successes based principally on a non-medical model of cure; insanity was to be held at bay via "moral treatment". Instead of being faced with purgatives and straitjackets, it was claimed that inmates at the retreat were given work (frequently in the gardens), varied amusements and discipline.[24] The Quaker origins of the retreat encouraged the formation of regular discussion groups wherein patients reflected on the reasons for being incarcerated, effectively a forerunner of group psychotherapy. Although Foucault has criticized the regime at the Retreat for the way in which the treatment emphasized internal discipline (in effect, the patients became their own gaolers), the system seemed to show that a medical ethos was unnecessary in treating the insane. One outcome was the way in which medical superintendents began to champion non-restraint and hard work for patients.

Opening on 28 March 1845 and designed to accommodate 60 mad people, Shelton Hospital, then the Salop County Lunatic Asylum, welcomed 120 patients. As in most other similar asylums, overcrowding led to the necessity of calming the residents. Bromides were introduced in 1857 and paraldehyde in 1882. Three years later the population stood at 800. Patients worked on the local farm, many leading productive lives, notwithstanding the risks inherent in being housed with so many others. Between 1905 and 1915, for example, the close proximity of so many people resulted in the deaths of 167 inmates from tuberculosis, 27 from dysentery and 28 from an outbreak of influenza at the end of the First World War. By 1938 there were 1,000 patients, the population peaking in 1946 at 1,100. Overcrowding was already a major factor when considering a patient's discharge. The hospital had been one of the first in the UK to use ECT and insulin coma therapy (in 1942), and when chlorpromazine was declared a breakthrough for those diagnosed with schizophrenia, this new technology was embraced. Chlorpromazine, as a major tranquillizer, had the effect of reducing any protest from patients at the overcrowded conditions – an effect to be valued whatever the therapeutic intent behind the prescription. In 1965 a fire on Beech Ward killed 24 women patients, an event still remembered by some senior staff (at least in the form of myth) and one which continued to be offered as evidence of the need for extensive fire-prevention procedures until the hospital's closure in 2013.[25]

I have visited dozens of psychiatric hospitals, specialist units, and "homes" for older people and those termed learning disabled. The hospitals, some still admitting patients, are all Victorian-era buildings. Recalling differences between them, whether in the USA or Europe, is difficult. Hospitals in Massachusetts (Worcester), Wales (Cardiff and Denbigh) and England (including Morpeth, Hellingly, Friern Barnet, Great Yarmouth, St Johns in Lincoln, the Warneford near Oxford, Prestwich near Manchester, Rauceby near Sleaford, Bury, and Shelton, Shrewsbury) all featured long corridors with polished floors, heavy oak doors, and notices indicating times for "recreational" activities, availability of the on-call psychiatrist, and various health and safety notices.

The specialist units, though smaller, are still alien to a casual observer – they may smell of disinfectant or polish and will have similar notices and imagery associating the patients with charitable status. In both types of institution, patients may be conspicuously drugged, agitated (or asleep) or invisible. For those patients who are simply chatting or engaging in other ways, there is nothing, in the absence of staff uniform, to distinguish them from the staff – one justification for staff to wear name badges.

Rampton Special Hospital (for "dangerous" learning disabled people) and Ashworth Hospital (for offenders deemed mentally ill) are distinguished by extensive security which may involve body searches of visitors and a large number of physical barriers – high walls, electronic surveillance, multiple locked doors and so on.

Smaller units have included those for both children and adults designated learning disabled. Here the imagery (toys, crayons, notices featuring colourful animals) can imply the residents are children, whatever their age. For most visitors, the presence of vehicles in the car park carrying charity logos makes it clear that the residence is a human services establishment. Apartments or terraced housing may have little or no associated devaluing imagery. A visitor would need to enter in order to discern the nature of the establishment. He or she may find a routine consistent with the hustle and bustle of ordinary life or a more ordered regime signalling institutional mores. The next section explores the ordering of the institution in more detail.

Institutional life

James Thompson regarded organizational procedures and protocols within the institution as one way of reducing anxiety-provoking uncertainty.[26] Hospital staff will become as institutionalized as their patients. One difference between staff and patients is power, whether it be the physical power bestowed by relative youth or the simple power of being able to go home after 12 hours on the premises – a power symbolized by access to door keys or cars in the staff car park (where some places will be reserved for "emergency" vehicles or medical staff).[27]

Menzies Lyth suggests we unconsciously defend against the fear of growing old ourselves by sending elderly people away to places where staff – sharing similar fears – develop routines around meal times or medication to protect themselves from the obvious misery all around. These routines are justified in terms of "patient care" or "safety" but, for bored staff, they also comprise the working day; relief from the suffocating presence of people whom society doesn't want.[28] Here, Wolfensberger's concept of death-making – perhaps too uncomfortable for many – does have the merit of making sense of why it is that older people are hidden from view in the name of care.

In a special section of *Le Monde* devoted to older people, Laurence Rossignol, French secretary of state for the family, describes her "vision" for older people as one which will preserve their right to autonomy. The vision includes the promotion of technology within the "Silver Economie". The lower half of the page is devoted to an advertisement for the French company Domitys, an organization currently responsible for housing 3,500 elderly people in 40 residences. Depending on the degree of support offered, the charge ranges from €900 to €2,700 per week. The director of marketing, Guillaume Lelong, predicts a population in France of more than 8 million people aged over 75 by the year 2028 and in addition to the 16 new projects under way in France he hopes to see development of his company in Belgium and Italy within the next two years.[29] Thus notions of "support," "autonomy" and "homeliness" are used to attract people to "homes" averaging over 80 residents in each. These residents will be strangers to each other with a range of ages (to the state or a private health care provider there is no difference between a 60-year-old and a 96-year-old – both are "elderly").

Elderly residents or patients are generally surrounded by trained nurses; the profession of psychiatric (or "mental health") nursing has grown exponentially since the mid-twentieth century when few psychiatric attendants were qualified. Recent reviews of staff in nursing homes in the UK have shown low rates of training of any type among staff, although enquiries into abusive regimes at numerous hospitals and care homes there reveal both the role of trained nurses in patient assault and the complicity of managers and consultants.

The history of Shelton Hospital (closed in 2013 and re-opened amidst much fanfare as Redlands on a site in the original grounds) is similar to that of many psychiatric institutions in the UK and the USA, some of which continue to expand the number of residents. Others in the UK, using as justification the requirement for "providers" to make profits in an ostensibly public and "national" health service, are divided into specialist "units" and services transferred to community centres. Rules and regulations continue to create a gulf between institutional care and what might be understood by the term "home". The extensive bureaucracy involved in even smaller, publically funded places led one German activist to propose a new diagnosis –"folia officialis" – to describe the completion of institutional forms disguising a denial of responsibility and lack of accessibility for residents.[30]

The closed nature of institutions, despite regular visits from official reviewers such as mental health commissioners, can make examination of the day-to-day life of patients difficult for the outside observer. The introduction of Patients' Councils in the 1990s and government schemes for greater transparency or institutionalized advocacy such as the Patient Advice and Liaison Service (PALS) have had limited success in opening up the institution to a more public gaze.[31]

The diffuse nature of responsibility in institutions may lead those responsible for reviews of institutional care to recommend further training for staff. For psy professionals the dominance of academic input to courses gives training an undeserved priority in the response of psy professionals to abuse within their own profession and the professions of others. Thus, in a recent response to the abuse of people with learning disabilities at Winterbourne View care home, a paper by two clinical psychologists assesses staff training as poor. The authors quote Rob Greig, responsible for producing the Department of Health strategy *Valuing People*.[32] In a letter to the prime minister in June 2011, on behalf of individuals and organizations in the field, Greig maintains there is "no place for hospitals such as Winterbourne View [in the provision of service for those deemed learning disabled]". The letter continues: "the provision of hospitals for the learning disabled is wrong". The two clinical psychologists suggest a "pragmatic approach" that does not support the "abandonment of facilities that we would judge 'at risk' ", including a contract for any input of psychological support.[33] The contract involves three key areas to be agreed before a psychologist's involvement. After clarifying the parties involved, the psychologist's requirements and commitment are delineated. The former prioritize the involvement of all relevant staff at appointments *despite* identifying low staff levels and morale as well as high staff turnover as risk factors in institutions. The section on the psychologist's commitment reveals the relative autonomy of the psychologist – someone who will be "on time", exclusive to the patient, and available to agree plans of action and reviews. The psychologist also commits to keeping the GP informed of progress. In similar disciplinary vein, the authors note that the psychologist will inform commissioners if the service cannot support interventions.[34]

A combination of ideology and fear has defined the treatment of the mad for millennia. In the third year of the French Revolution, prisons including Salpêtrière (which held the insane deemed "aliènes" by supervising physicians) were stormed by the Parisian mob and hundreds killed. Supposedly a swelling of a populist feeling against the monarchy, many of the first to die were already incarcerated: "Children as young as eight died, being found strangely hard to finish off."[35] The process was repeated – far more systematically – in the 1930s with the rise of Nazism, an ideology embraced by German psychiatrists to the extent that the first people to be killed – frequently by injection administered by nurses – were those seen as degenerate, the mad and the handicapped.[36] Whatever the justification for the incarceration of these people, the mob in the Paris of the eighteenth century and the medical superintendents charged with their care in Germany, unchallenged by the majority, saw to their extermination.

These events cast a bleak light on attempts by UK governments over the past 40 years to prevent similar "death-making" in residential centres for those with learning disabilities and homes for older people. It might be further argued that, despite the recent debates about euthanasia, the process is always present in the form of institutional abuse.

A combination of cost and policies encouraging societal inclusion of diagnosed individuals has led to a new generation of psychiatric inpatient facilities, generally more liberal in approach while, in the main, still requiring diagnosis before admission. Some environments eschew diagnosis and encourage a less formal atmosphere where residents can escape the pressures of their ordinary lives. The emphasis here is on safety and companionship rather than treatment. The Wokingham MIND Crisis House and the Soteria House in Bradford, for example, have support from local statutory services. The Berlin Runaway House enjoys a similar degree of freedom. With some exceptions, then, for many at risk of societal devaluation, a range of "wounds" may result from treatment by human services in their present form.

For a troublesome minority, the deinstitutionalization of the 1960s and 1970s has become a reinstitutionalization of people supposedly sharing similar characteristics (and diagnoses) – "eating disorder" units or "low-secure" establishments. In something of a return to the hospice movement of the half millennium before the 1600s, there are also now a few (formal and funded) retreats for those deemed mad in the UK and Europe. Essentially asylum from the excesses of modern life, the schemes tend to be short-lived, dependent on one or two energetic individuals and well-placed allies, and, to a lesser extent, deeply suspicious of the psy complex. The Wokingham MIND Crisis House, for example, survived for over 20 years. Run by a radical separatist, the house took in up to three "guests" who found life overwhelming. Some were referred by psychiatrists or social workers and "escaped" to the house rather than spend time in psychiatric hospital. This was despite the fact that the house kept only the barest details of the guests and banned visits from psy professionals. The sitting room resembled nothing less than a lower-middle class living room circa 1960, countless small porcelain knick-knacks on display, bottles of alcohol freely available (sherry appeared at 11.00 each morning), several cats and, apart from a fairly antagonistic poster about social workers, no obvious signs of any connection with statutory services. There may have been a notice with information concerning what to do in the event of a fire, but I didn't notice it on visits with clinical psychology trainees exploring alternatives to psychiatry. The house had been an "independent" branch of the local MIND; on the organizer's retirement, the house was subsumed under the local social services.[37]

Adopting a model similar to that of the original Soteria houses in the USA, there is a proposed further Soteria-style retreat in the UK. Like the Wokingham project, there is no particular view of medication, and potential residents will be expected to self-monitor its use. Funding is haphazard and dependent on a few committed individuals.[38]

The Berlin Runaway House has similar funding challenges. Explicitly opened for those rejecting psychiatric hospitalization, for 20 years it has continued to take in psychiatric "runaways".[39] The Weglaufhaus was the first anti-psychiatric facility to be officially funded as a crisis centre for homeless survivors of psychiatry.[40] Here they can "recover" and redirect their energies to talking about their experiences and developing plans for the future; medicalized perspectives using an illness metaphor don't necessarily colour discussions about feelings and social difficulties.

The Runaway House originates from the survivor movement in Germany.[41] A self-help group for survivors, the Association for Protection against Psychiatric Violence (Verein zum Schutz vor Psychiatrischer Gewalt e.V.) was founded in 1989 as a mixed group of survivors and other activists. In 1990 a private donor bought the villa in north Berlin that became the Runaway House. After a further six years of negotiation with government agencies, a day-rate remuneration for people's stay in the house was agreed using §72 BSHG (Bundessozialhilfegesetz: Federal Social Welfare Law) "Help in special social difficulties". As a consequence, potential residents were restricted to those who were homeless or in danger of losing their homes – an example, perhaps, of the limited chances of success for those promoting new praxis invariably constrained by a wider context of homeostasis rather than radicalism.

Proximal influences proved to be important. For example, court action was required against prospective neighbours who tried to prevent the house from opening. This kind of local resistance is encountered in the UK for projects as diverse as creating new motorways and opening (or closing) accident and emergency hospital departments.

For up to six months as many as 13 residents share the villa and organize the household (i.e. cooking, cleaning, shopping, working in the garden and looking after the house). All have been inmates in psychiatric institutions and are homeless or threatened with homelessness. Ten part-time and two honorary workers act as support staff. Half are psychiatric survivors and all are selected for perceived tolerance, sensitivity, openness and an ability to deal with conflict rather than professional qualifications. They share an anti-psychiatric stance. The majority of people in the Runaway House have long histories of psychiatric treatment; most have been institutionalized, forcibly treated and heavily drugged.

Residents are free to leave at any time and are offered support to withdraw from psychiatric drugs (neuroleptics, antidepressants, tranquillizers, lithium, carbamazepine, etc.).[42]

The preferred approach (to formal therapies) among volunteers and residents is to discuss questions like: "What helps you, if you get crazy? Which kind of support do you want or need? What experiences do you have with withdrawal?" Support workers also help residents dealing with the employment office and training centres, job applications and filling in forms. Clarifying the financial situation of the residents is important: some need debt advice or may be under guardianship orders. Most live on social welfare aid; some get pensions or unemployment benefits. To find out which benefits they are entitled to, which authorities are responsible and to make the claims correctly is another volunteer role. Ex-government workers are, for this reason, particularly valued.

Coverage of costs comes for each individual resident by one of the 23 different social welfare offices in Berlin. In 1992 the day rate for residency was DM200 per day (as compared to the day rate in psychiatric wards of DM300–700).[43] As in the Wokingham Crisis House, the costs are considerably reduced via the use of volunteers.

There is a contrast here with various small "crisis" projects, monitored by social services and only open to those marked with a psychiatric diagnosis. Beyond these projects there are numerous – unheralded – schemes that offer refuge to distressed people, the majority entirely informal; people are, indeed, being "good neighbours". It is in these local schemes that professional psychologists (clinical and community) may be found, frequently working voluntarily. It might be added that these volunteer professionals are not using psychological theory to justify their input.

In the majority of psychiatric facilities, care homes and residences for incarcerated children, treatments offered to patients remain under the direction of a member of psy – usually a psychiatrist. For those hoping to practise psy via the tenets of social role valorization, the history of institutional response to those that society finds disturbing forms the context for further "wounds" suffered by stigmatized individuals and groups. It is a context where the wounds are suffered (and hidden) behind the doors of the psychiatric clinic. The clinic has now expanded to include everything from housing estates to schools via GP surgeries. Chapters 5 and 6 will look in more detail at wounding physical treatments in psy, specifically ECT and drugs.

5
Assault as Treatment

For Wolfensberger, "invasion" without consent constitutes a service wound. The possibility of informed consent in a context where patients may have little access to information beyond that provided by psy professionals renders invasion *with* consent something of a *non sequitur*. This chapter examines this notion using a legal term – "assault" – for such conduct. It is a position that would have found sympathy with Thomas Szasz; he opens *Coercion as Cure* thus:

> the reality of psychiatric coercion and dehumanization is camouflaged by . . . a lexicon of euphemisms concealing the exploitation and injury of so called mental patients as "treatments".[1]

Two-and-a-half thousand years ago, Sushruta, a Hindu physician, claimed that madness was caused by "strong emotions and passions".[2] Plato, over a hundred years later, suggested madness occurred when the rational soul (located in the brain) was separated from the irrational soul (located in the chest, close to the heart). By 100 BCE, Soranus was using these ideas to recommend service rather than control, and the use of a tranquil ground-floor lighted room.[3] He argued against restraint and recommended talking to patients about what interested them.

From antiquity, physicians intent on changing mood recommended a mixture of more gentle praxis (especially for the rich) and more dramatic treatments. Soranus, in addition to a light diet, exercise and music, suggested blood-letting, leeches and poultices to counteract the black bile of melancholia. The regime was derived from Celsus, a follower of Hippocrates.[4]

The incarceration of so many people deemed mad during the nineteenth century necessitated the development of means to control unruly inmates. Except for the more resistant patients, straitjackets were rapidly superseded by a technopharmacopoeia, including bromides, cocaine, caffeine, paraldehyde and the sulphonamides. By the mid-twentieth century, psychiatric inmates were being assaulted with electroshock, insulin, psychosurgery, major tranquillizers such as lithium and chlorpromazine (marketed as drugs to combat supposed conditions such as manic depression and schizophrenia), and ECT (marketed as a specific treatment for schizophrenia and depression for an age range of 4–104).[5]

By comparison with the catalogue of somatic treatments, the total of 500 or so present-day psychotherapies attempted with people seen as mad seems positively modest. Trepanning – far from disappearing with the ancient Egyptians – re-emerged with Roger of Salerno in the twelfth century and again in 1899 with Claye Shaw at Banstead Asylum. Rather than freeing spirits, Shaw was attempting to relieve intercranial pressure, a presumed cause of general paresis.[6]

The site of intercranial pressure was the brain, an organ so little known and so complex that psychiatry has not hesitated to claim jurisdiction over its workings and modification. During the decades of the mid-twentieth century, neurologists vied with neurosurgeons and psychiatrists for dominance in the field. The first group saw neurosurgeons as useful partners in the enterprise. Psychiatrists were regarded as a profession that should limit themselves to functional disorders of conduct and an ill-defined "mind." For psychiatry, however, the brain seemed to show some promise in demonstrating that functional disorders were physically based.[7]

Lobotomy became a preferred treatment for those labelled as obsessive or psychotic. Valenstein, however, has shown that early claims for the cure of patients undergoing frontal lobotomy were exaggerated. Moniz, for example, was unable to demonstrate that any of his patients were enabled to live outside the hospital, and death or apathy were common outcomes.[8]

Freeman and Watts had been responsible for a new surgical procedure in 1937, the severing of nerve connections between the frontal lobes and the rest of the cortex. This was the standard lobotomy until Freeman pioneered the transorbital lobotomy in 1945. The modified procedure involved inserting an ice pick through the eye socket in order to sever nerve connections. Between 1936 and 1951, over 18,000 lobotomies were performed in the USA. In December 1940, Golla, at Bristol's Burden Neurological Unit, performed the UK's first lobotomy. Less than 15 years later over 12,000 similar operations had been carried out in England and Wales.[9]

Neuroleptic drugs (see Chapter 6) were introduced in the early 1950s, and leucotomy fell from favour as the drugs were shown to more efficiently produce the desired apathy and docility. Fennell has remarked that before 1950 a patient might first receive insulin coma, then ECT and finally lobotomy several times, a tribute to the survival of the spirit if not the brain.[10]

The majority of medical terms used in the late nineteenth century implied a knowledge of aetiology of disorder when, in reality, physicians were in the dark – notwithstanding Kraepelin's extraordinary efforts to demarcate human distress through psychiatric diagnosis (see Chapter 3). Terminology included "nervous breakdown", "shell-shock" and "nervous prostration." The popularity of the term "neurasthenia" (promoted by George Beard) led Erb, a German neurologist, via a form of inverted deductive reasoning, to conclude that stimulation of the nervous system would cure the disordered nerves. He pioneered electrotherapy, a descendant of the ancient Egyptian practice of plunging epilepsy sufferers' arms into a tank of electric rays, and a forebear of ECT. In the USA, Beard went on to co-author a volume of eventually some 600 pages entitled *Medical and Surgical Uses of Electricity*.[11] Beard's treatment (electrical stimulation, rest cure and friendly moral exhortation) was entirely in keeping with his theory that symptoms were, essentially, a result of exhaustion brought on by excessive "brain work" in bourgeois patients. These individuals suffered depletion in their bodily energies that were a natural part of human efforts to work and achieve – an optimistic view of humanity Cushman notes as "very American".[12]

Numerous physical treatments were developed between the two world wars. It has been estimated that in the 1920s thousands of thyroidectomies, ovariectomies, castrations and removal of all or parts of various other glands were attempted. Via opiates and barbiturates, patients were kept asleep (narcosis therapy) for weeks on end. Likewise, patients were treated with X-rays, with injection of toxins into the cerebrospinal fluid, and with shock induced by the injection of horse serum and other agents.

Julius von Wagner-Jauregg (the only psychiatrist to receive the Nobel Prize – Moniz was a neurologist) injected patients with malaria as a cure (fever therapy) for shell-shock and general paresis. Despite claims of success rates approaching 80 per cent, the treatment had fallen out of fashion by the late 1940s. It had been known since the turn of the century that general paresis was caused by a spirochaete found in syphilitic patients and, despite the similarities to popular conceptions of schizophrenia, it was eventually acknowledged that its aetiology differed. The idea that schizophrenia was caused by possible pathogenic mechanisms had by then taken root.

Insulin-coma therapy for schizophrenia was first attempted at the Lichterfeld Hospital in Berlin by Manfred Sakel in 1927, then later in Vienna.[13] He suggested that the rationale was to "overstimulate the vagus system", adding that psychotherapy might continue as part of the treatment.[14] He reported an initial recovery rate of 87 per cent, to be amended to 12–14 per cent in the USA by 1939.[15] In his account of directing the "insulin room" at Warlingham Park Hospital in Surrey, England, between 1948 and 1953, Ronald Sandison discusses the outcome of insulin therapy for two patients undergoing 45 and 52 induced comas in a context where "no one said, 'This is what you should be doing, this is where you should look.' "[16] The experimental nature of the treatment seemed of little concern to the author, a Jungian analyst by inclination. Although insulin treatment was on the wane in the USA, Mayer-Gross and colleagues could write, in 1960, that it "is still recognised as one of the most effective methods of treating early schizophrenia".[17] It was unmentioned in psychiatric textbooks within ten years and does not appear at all in the index of Stone's history of psychiatric treatment, *Healing the Mind*.[18]

For many people the change came too late. Jerome Frank, a US-based activist, speaks eloquently of his experience of the treatment: "I was forced to undergo combined insulin-electroshock, a total of 85 shock 'treatments' . . . My father had signed the consent form."[19] Walter Freeman (see above) might have argued that Frank's recovery and spirited fight against psychiatry over some 50 years was evidence that electroshock had not harmed him, despite Frank's assertions to the contrary and the fact he lost his memory for the two years preceding the first shock.

Although many of these medicalized assaults had a short life, some – for example, electronarcosis – were still in use in the German Democratic Republic in the 1960s in contrast with the numerous psychotherapies emerging in the USA in the same decade. An economic and intellectual context binds clinicians and researchers in maintaining the praxis, so increasing their cultural capital. A negative public and recipient reaction to what is seen as harmful praxis further requires a remarketing of physical assault by psy practitioners and the associated publishing industry. The next section addresses these marketing endeavours.

Marketing assault

There is a discernible "evolution" in physical treatments for the mad. Underlying the change, a pattern can be detected whereby new approaches are heralded as "breakthroughs". As in the marketing of any product, the faults of the previous product are emphasized and the (frequently well-known) adverse effects of the newest procedure downplayed. The fundamental problem that all so-called psychiatric conditions are linguistic constructions is ignored in marketing campaigns – rather like ignoring the carbon footprint in the manufacturing process of "green" automobiles (or the fact it is greener to walk, cycle or take the bus).

I have twice been electrocuted. The first time, on a building site in my teens, I touched the bare live cable on a faulty electric drill. Earthed via rubber soles on a pair of sturdy boots, I felt a powerful jolt to my arm – and nothing more. It was painful for a few seconds, and I remained alert enough to employ at least one Anglo-Saxon expletive. Some 30 years later I managed to prod a screwdriver into a live electric socket. This time, minus any rubber soles, my body jerked backwards and I awoke after a few seconds of unconsciousness having hit the edge of the kitchen table with some force. Electrocution is not something to take lightly. In between the two incidents I met numerous individuals who had been electrocuted under the auspices of psy. The treatment receives bad press among recipients and only occasional press coverage by the media. In the days when I regularly received phone calls from journalists asking for quotes about the state of psy, I would usually say: "You're asking the wrong questions. You should be writing about ECT." Invariably the response would come: "They don't still do that do they?"

Campaigns against most psy treatments, however, have existed for well over a century – from the Alleged Lunatics Friends Society of the mid-nineteenth century to the Prevention of Professional Abuse Network (POPAN) today. There are several websites devoted to critiquing ECT.[20] Facebook and related media are a source of information from ECT survivors.[21] Campaigners aim to make the practice more *visible*.

ECT might be viewed as representative of much that occurs within the psy complex: the technique has harmed millions; it is based on suspect and ever-changing theoretical assumptions; research is scientistic and carried out exclusively by those with vested interests in the results; it is most commonly used on those with little power who have been marked, frequently via psychometric assessment, in the context of coercion and lack of consent; and – importantly – health professionals are largely silent on the topic. For Erwin Staub, they would be classed as "bystanders" in the face of harm perpetrated on patients in the same system within which they work.[22]

During ECT an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalized seizure activity. The person receiving the treatment is anaesthetized and muscle relaxants are given to prevent spasms. Melinda James, an ECT survivor, notes:

> The drug they give to avoid bones breaking is NOT a muscle relaxant. It is a muscle paralyser. It paralyses all the muscles. You cannot blink your eyes, you cannot breathe. I know because one time or maybe more (I only remember one) they did not give me enough of the anaesthetic, and I was not asleep. I could not tell them I was fully conscious – could not move, could not blink my eyes. I saw the doctor leaning over me with the electrodes. Then I was knocked out by the shock. Fully conscious, but paralysed, it felt like someone had bashed my head in with a hammer.[23]

ECT is recommended to be given twice a week for up to a maximum of six weeks. Repeated treatments induce molecular and cellular changes in the brain, characterized by psychiatrist Peter Breggin as "brain damage" and an "electrical lobotomy".[24,25] Weiner agrees that it is possible via an electroencephalogram (EEG) to detect brain injury following unilateral ECT.[26] Quite independently, neurologists Symonds and Sament compared the resulting cerebral damage of the practice to head injury.[27,28] Some 20 years later, in 1988, McClelland suggested post-ECT changes were identical to classic signs of frontal lobe damage.[29]

The studies cited in the previous paragraph might suggest why ECT is repackaged. A treatment designed to cause brain damage requires a marketing approach that ignores adverse effects while offering a convincing rationale. Similar rhetoric is used concerning air-strikes in Iraq or other besieged countries: the procedure is claimed to be specifically targeted and any unintended damage "collateral." For the human brain, however, signs of damage are frequently functional. Few psychiatrists or psychiatric nurses will have seen a patient post-ECT without disturbances in vision, balance or coordination.[30] Many will have witnessed in ECT survivors post-treatment memory loss in excess of six months. The loss of memory is of less concern to clinicians when recipients are elderly: symptoms may be interpreted as features of normal ageing. Thus age as well as the supposed psychiatric disorder can be used to distract relatives, carers and patients from recognizing iatrogenic sequaelae.

The next section will explore the service context and rational for assaulting, via electrocution, people marked with labels as diverse as schizophrenia and epilepsy. The praxis, popular in services for older people (particularly women), is also promoted for child recipients. One argument presented for this is that children are being "denied" the right to a treatment with proven efficacy among the adult population.[31]

The service imperative

At the local level it is immediately apparent that praxis is governed by economic imperatives. Some psy professionals working in the UK's NHS may receive referrals advocating a therapy with the greatest evidence base (as supported by randomized controlled trials [RCTs] and National Institute for Health and Care Excellence [NICE] guidelines). The referring agent – a teacher, social worker or GP – is, however, also a busy professional concerned with other pupils, clients or patients. The referred person is "processed" via assessment in a similar way to any consumer product on a factory conveyor-belt. Thus the busy referring agent directs the recipient into the psy system where waiting lists and the pressures of institutional praxis, such as staff meetings, case conferences, patient registration and note-keeping, take precedence over the stereotypical therapy hour. Meetings between service recipients and psy staff inevitably comprise a professional discourse boundaried by concerns on the professional's part about other patients waiting to be seen and concerns on the part of the recipient about how much to reveal to a professional who is clearly busy and part of a broader institutional response.

With few exceptions – for example, therapeutic communities – management within health systems is predicated on industrial models. Industry uses people as the means of production. The product – a car, chocolate bar or electric white good – is made in the most efficient way presently available in order to be sold at a profit to consumers. In the absence of being able to convincingly transfer the "product" analogy into health systems (in this case the product is a changed person), management instead focuses on efficient praxis. Thus people are moved as quickly as possible through the system, and workers – GPs, psychiatrists, nurses, psychologists – are managed in terms of targets, face-to-face contacts and the looming ubiquity of waiting lists.

The demands of the economic imperative (efficiency and productivity) within health systems fall within a broader economic context.

Paraphrasing Warner,[32] Johnstone notes: "At times of labour shortage, the emphasis [of treatment] turns to rehabilitation and social causes of distress … whereas in economic downturns there is a swing towards biological theories and treatments, with correspondingly negative prognoses."[33] Nor should the economic imperative of the psy publishing industry be ignored (see Chapter 2). The recent *Oxford Handbook of Child Psychological Assessment*, for example, retails at £150, a sum only available to wealthy individuals or institutional libraries. It is not likely to be much read but the benefits to the *authors'* individual cultural capital and institutional profile are considerable.[34]

It should be of little surprise in this context that theorists such as Lewontin take the opportunity during periods of economic decline to suggest genes for unemployment, domestic and social violence and homelessness. Lewontin does not suggest genes for drawing conclusions like these; perhaps there is no place for ironic reflexivity during economic downturns.[35]

ECT, promoted as "safe and effective", can be regarded by services as an efficient means of processing recipients if waiting lists for psychological therapies are extensive, resources (e.g. hospital beds) at a premium and pharmacology (usually the first recommended treatment) has failed. The next section reviews the history of ECT.

An overview of ECT

Some noted figures have received ECT, among them authors Linda Andre, director of the Committee for Truth in Psychiatry, Janet Frame, Sylvia Plath and Ernest Hemingway. Hemingway claimed that his subsequent memory loss robbed him of the ability to write, and he killed himself. Actors Judy Garland, Vivien Leigh, Gene Tierney and Carrie Fisher were recipients, as were musicians Bud Powell, Vladimir Horowitz, Michelle Shocked, Tammy Wynette, Townes van Zandt, Peter Green and Lou Reed. Ted Chabasinski, an American attorney and psychiatric survivor activist, first received ECT aged six.[36]

In the 1930s a Hungarian psychiatrist, Julius Nyirö, promoted a theory that schizophrenia could not coexist with epilepsy. Ergo, if epilepsy could be induced in someone diagnosed with schizophrenia, the schizophrenia would be cured. László Meduna claimed dramatic success with a catatonic schizophrenic after injecting camphor (used as a stimulant for centuries in China and Japan) to induce convulsions. Meduna instigated shock treatment using the synthetic metrazol.[37] Bini and Cerletti, two Italian psychiatrists, are credited with the move from chemically to electrically induced convulsions. They first diagnosed and then electrocuted a vagrant who quickly declared himself "cured". In similar vein, at a local seminar over 60 years later, Viv Lindow, an ECT survivor and researcher, explained to a group of psychiatrists that the way to avoid further shocks and get out of psychiatric hospital is to say you feel better *however you feel*.[38]

ECT remains a core treatment in psychiatry, especially for people over 60. Its reputation as alternatively "life-saving" and "barbaric" ensures that the public remain largely ignorant of its popularity with psychiatrists. It is a treatment hidden behind the closed doors of the clinic, one well known to the staff and rarely publicized, despite at least one psychiatric journal being entirely devoted to the practice. The medical superintendent and his colleagues at Shelton Hospital in the late 1950s had sufficient faith in ECT to give each other shocks, and there is a – possibly – apocryphal tale of a local farmer who bypassed the need for psychiatric authority by giving himself rather haphazard electric shocks via the battery of his tractor.[39]

Electroshock – as it was then known – was introduced into the USA soon after Meduna's first publication on the topic in 1935. By 1940, ECT was the preferred way to create the desired seizures, and 43 per cent of US mental institutions were using it. Between 100,000 and 200,000 patients now undergo ECT in the USA annually. This is only an estimate, however, as only four states (Colorado, California, Texas and Massachusetts) require reporting on ECT statistics. The American Psychiatric Association claims that one in 200 ECT patients suffers memory loss. Figures from California suggest a proportion closer to one in five. Reporting of adverse effects ("complications") is limited to non-fatal cardiac arrests or arrhythmias requiring resuscitation, fractures, apnoea persisting 20 minutes or more after initiation of treatment, memory loss reported by the patient extending more than three months following the completed course and deaths which occur during or within the first 24 hours after a treatment. Between 1989 and 1994 (1993 figures were unavailable) over 12,000 people received ECT, 445 (3.6 per cent) of whom were involuntary patients and 364 (3 per cent) were treated without consent. Half were over 65 years old, 21 (1.7 per cent) were under 18, and 68 per cent were female. More than a fifth of all patients had serious complications. The most often reported complication (19.7 per cent of all patients and 93.6 per cent of all complications) was memory loss lasting longer than three months.[40]

Between September 1993 and April 1995, 15,240 ECT administrations in Texas hospitals were subjected to a review. Almost all of the patients (88.1 per cent) were white, five were less than 18 years of age and 70.3 per cent were women. Eight patients died within 14 days of a treatment, three of whom committed suicide. The researchers conclude: "Our data support the common finding that ECT is generally safe and effective."[41] As noted below, the claim that ECT is "safe and effective" is used in all official literature from psychiatric organizations. The claim is untrue for many recipients but so ingrained as part of the psychiatric lexicon it is repeated *ad nauseam*, and it is one way of ensuring publication: only critical texts or scrupulously honest psy researchers admit that the procedure is flawed and dangerous, sometimes lethally so.

Use of ECT at the Father Muller Medical College Hospital, Mangalore, over the period 2002–2011, peaked at 2.14 per cent of inpatients in 2006. Usage returned to an average of 1 per cent. About half the patients were being treated for schizophrenia, a much higher proportion than in Western countries. A major difference between use of ECT in India and elsewhere is the number of treatments patients receive. During the Mangalore study, 189 patients received just 638 treatments, a mean of between 3 or 4 treatments per patient as opposed to 12 in the UK and the USA.[42]

In some African countries, practice is limited by anaesthetic resources, so that unmodified ECT is used in Nigeria; the risks to the patient of broken bones or dislocation are considerably heightened.

Effectively banned in Italy, Austria, Germany and Switzerland for some years, ECT is now returning throughout these countries. In his *Dictionary of Psychiatry and Medical Psychology*, Uwe Peters defines ECT as "Production of a generalised epileptic seizure as treatment procedure. Technology: With the help of a convulsor an alternating current from 70 to 100V and about 150mA is passed through the head of the anaesthetised and muscle relaxed patient for 1 to 9 seconds. With the release of seizure the treatment is finished."[43] Peter Lehmann, an activist and survivor, has suggested that Peters has been instrumental in the revival of ECT in Germany.[44]

ECT is forbidden in Slovenia; a small number of patients are, instead, sent to Zagreb, Croatia, where the procedure obtains. The Slovenian authorities claim only 3–12 patients are referred each year. In Greece a 2007 survey found 137 people were given ECT (Greece has a population of about 11.3 million), a rate of 0.001 per cent of the population. Schizophrenia was the most common diagnosis. In Turkey, one hospital (Bakirkoy Research and Training Hospital for Psychiatric and Neurological Diseases in Istanbul) accounted for 3,490 ECT patients from 2008 to 2010, the majority with a diagnosis of mania or schizophrenia.[45]

In the UK, ECT data were routinely collected by the NHS until 1991, when specific ECT reporting was replaced by Hospital Episode Statistics. These are thought to significantly under-report ECT usage. In a survey conducted that year, two authorities, Mid-Staffordshire and Herefordshire, used very little while others in the same West Midlands region gave ECT to more than one in ten psychiatric admissions. Typically about two-thirds of recipients were women. In Great Yarmouth and Waveney, fewer than one in a hundred admissions were electroshocked, while in the adjacent East Suffolk, one in five admissions received ECT.[46]

ECT standards and practice vary remarkably, not only between different countries but also within them and even within individual centres. For example, there is an 18-fold difference in use of ECT between 11 general adult psychiatric teams within a single Edinburgh teaching hospital. During 2000–2001 the Mental Health Act Commission reported that there were substantial departures from best policy, practice or training in a fifth of 230 ECT facilities it surveyed in England and Wales.[47] To attempt to improve quality control of ECT administration, the Royal Colleges of Psychiatrists, Anaesthetists and Nursing launched the ECT Accreditation Service (ECTAS) in May 2003. ECTAS surveyed mental health trusts that had used ECT between September 2004 and February 2006. The protocol included a questionnaire for recipients of whom 72 per cent said that ECT had been helpful, 20 per cent that it had had no effect, 5 per cent that they would not want it again and 14 per cent that it had changed or saved their lives.[48]

ECT use was assessed in 56 clinics over three months in England in 2006 (private clinics were excluded). Compared with 1999 and 2002, the number of clinics providing ECT and the number of patients receiving ECT had declined (down to an estimated 1,276), of whom a higher proportion (30 per cent) received ECT as involuntary patients under the Mental Health Act.[49]

In England the Care Quality Commission (CQC) reports on monitoring the Mental Health Act. The report gives statistics on the use of ECT with patients sectioned under the act – that is, patients considered incapable of making an informed decision and treated without their consent. The CQC has a panel of psychiatrists (second opinion appointed doctors (SOADs)) who give their approval for treatment. These doctors seldom withhold approval. In 2009/2010, over a quarter of trusts had no reports of ECT, although they had made requests to the CQC for a SOAD visit to approve ECT for non-consenting patients. Among the trusts that reported no ECT were some with the highest rates of SOAD requests: Greater Manchester West (41), Leicestershire (33), North Essex (59), Northumberland, Tyne and Wear (39), South London and Maudsley (45) and West London (38). By contrast, two trusts made requests where ECT administration followed. As noted above, SOAD permission is rarely denied – SOAD requests can read, in most cases, as indicative of ECT subsequently carried out. Cornwall made 12 SOAD requests followed by 451 ECT administrations, and Kent and Medway made 43 requests followed by 547 ECT administrations.[50] Overall in 2011/2012 there were 1,006 completed SOAD visits, a slight increase (about 3 per cent) on the previous year – that is, approximately 1,000 people were given ECT without consent. Over 85 per cent of these were women.[51]

In Wales the estimated annual rate fell from 3.9 to 2.2 patients per 100,000 between 1990 and 1996.[52] In Scotland, according to the Scottish ECT Accreditation Network (SEAN), 418 patients received ECT in 2010. The commonest "indication for treatment" was the failure of prescribed antidepressants (63 per cent). SEAN reported that 75 per cent of patients "showed an improvement" after a course of ECT (on average eight treatments). Two-thirds of recipients were women.[53]

Elsewhere, female recipients are surprisingly old. In Rhode Island, for example, 37 depressed patients 80 years of age or older were given ECT at the Rhode Island Hospital in Providence between 1974 and 1983. Here, 28 other older people were given antidepressant drugs and the two groups compared. A one year follow up found a 73 per cent survival rate for the ECT group and a 96.4 per cent survival rate for the non-ECT group – that is, ten deaths among the 37 ECT patients and one death among the 28 non-ECT patients.[54]

Despite contradictory evidence, the Regulation and Quality Improvement Authority for Northern Ireland still claims: "Electroconvulsive therapy is an important and necessary form of treatment for some of the most severe psychiatric conditions and is, in many instances, a life-saving treatment. It is medically safe and has good efficacy."[55]

The consistent over-representation of women receiving ECT has frequently been "explained" in terms of larger numbers of women being diagnosed as depressed. In many countries, however, those diagnosed with schizophrenia make up the largest proportion of recipients. This finding is consistent with Nyirö's original speculations concerning an antagonistic relationship between schizophrenia and epilepsy. A second explanatory discourse emphasizes the relative longer lives of women: as ECT is more frequently given to older people there are more women in the target group. Other tentative hypotheses might include a more general antagonism to women from the male-dominated psy complex or, more radically, the possibility that "depression" is identified in a group who are actually exhausted by their multiple societal roles and who have less support for their travails.

Burstow suggests that 90 per cent of shock doctors are men and in every country where ECT is administered women receive ECT two to three times as often as men, and women over 60 are singularly targeted, accounting for half the statistics (despite research demonstrating that older women sustain the most damage).[56] She summarizes ECT as state-sponsored violence against women.[57]

In the UK's NHS, until recently, service parameters ensured that psychologists worked in separate services for older people and those under 60. The invisibility of ECT was maintained *within* services. Collective protest against the assault on their own sex, however, remains non-existent from clinical psychologists, some 90 per cent of whom are women, albeit generally younger.[58]

A treatment whose efficacy is predicated on the destruction of healthy brain tissue might be seen as a risk worth taking for a suicidal patient or for a family asked to give consent for the treatment of a child or elderly relative. The website of MIND (a UK mental health charity) claims that ECT is only given if a patient is diagnosed with "severe, life-threatening depression", or has not responded to medication or talking treatments. Mania and catatonia are claimed to respond, as is "postnatal depression", on the basis that ECT works quickly, thus increasing the opportunity for mother and baby bonding. Patients can explicitly request ECT on the grounds it has helped before.[59]

Although ECT is claimed to be an evidence-based treatment, research in the field is on the decrease. A review of research articles on ECT between 1992 and 2001 revealed 117 articles, of which 10 per cent were randomized controlled trials. The majority of articles were North American (47 per cent) and from the UK (14 per cent).[60] *The Journal of Electro-Convulsive Therapy*, founded as *Convulsive Therapy* in 1985 by Max Fink, continues to publish the majority of studies. Given the likely adverse effects of ECT, the conclusions of a review commissioned by NICE seem important:

> In people with depression, real ECT is *probably* more effective than *sham* ECT but stimulus parameters have an important influence on efficacy; low dose unilateral ECT is no more effective than sham ECT. ECT is *probably* more effective than pharmacotherapy in the short term *but the evidence on which this assertion is based was of variable quality.* (my emphasis)[61]

Sham ECT (a form of placebo, albeit using anaesthetics) has been investigated in some detail. Ross reviewed the literature on sham-electroshock (anaesthesia but no electroshock) and found the *same* short-term outcomes as electroshock and no evidence of a lasting beneficial effect in either sham or real ECT.[62]

In summary, a combination of the closed nature of institutions, lack of power and informed choice on the patient's part, a privileging of technical over humane procedures in psy and the authority of the psy professional with medical responsibility means that certain patients are quite likely to undergo ECT.

An historical analysis would perhaps suggest that a variety of factors maintain the practice. These might include clinical preference and changing theoretical justifications, paralleled by a failure to acknowledge adverse effects from memory loss to death, and desperation on the part of psychiatrists to change patients, often women. Other service demands and large case-loads prevent psychiatrists from exploring the social predicaments of their patients. In any case the complexity of social factors makes it unlikely that psy professionals could effect change at this level. A lack of public knowledge and the unwillingness of non-medical practitioners to speak out about the use of ECT maintain the invisibility of the procedure.[63]

Brain damage resulting from ECT might be regarded as one of the "wounds" suffered by those at most risk of devaluation by society – the mad, the odd and those without the physical or material resources to resist, frequently elderly people. The notion that "consent" can be obtained from people at risk of being *compulsorily* detained and treated has also been challenged.[64]

The idiopathic nature of an individual's physical make-up and metabolism makes any medical procedure something of an experiment. ECT is no exception. Effectively, every ECT treatment is an experiment. An analogy might be a suggested aeroplane flight where customers are warned that only half of them are likely to arrive at their destination while at least 5 per cent of similar flights are known to crash with no survivors. The rhetoric surrounding the procedure and the negative predictions about alternative – possibly already tried different ways of getting from A to B – will encourage some passengers to take the risk. If that risk is to a relative, then the parent, adult child or sibling may agree that the person described as depressed or psychotic should take the flight. The next section discusses ECT in relation to praxis with children, where a parent is frequently the person giving consent.

ECT with children

Child and adolescent mental health services are ambiguous concerning their definition of childhood. In the UK's NHS, different regions and health administrative structures differ in their definitions of the points at which a child becomes an adolescent and then an adult. For some the definitions depend on education: a child becomes an adolescent when he or she enters secondary education, and becomes an adult when he or she leaves the school system. For others there are age demarcations – "children" remain children until age 13, and are adolescents until roughly 20. In other words, adolescents are teenagers. For others, "children" effectively become "adults" if child services cannot cope; many patients have been admitted, aged ten, to psychiatric hospitals since the nineteenth century (see Chapter 3). Beyond the confines of structuralized service definitions, for many parents their children remain "children" all their lives. My mother still refers to her sons as her "boys" or "kids", and the youngest is in his 40s. For parents whose offspring never leave home or, due to being marked as "disabled", have been institutionalized, the social context re-languages the child as "lazy", "dependent" or, in the case of those with physical disabilities or psychiatric diagnoses, "eternally innocent" or "tragic". Service definitions of childhood reflect wider societal ambiguities: in the UK a ten-year-old can be tried for murder, but that same child would have to wait until 16 to legally begin a sexual relationship, 17 to drive, 18 to vote and so forth.

In the USA the age demarcation lines differ between states for driving, owning a gun and buying alcohol.

These fluctuations are not new:

> In 1800 the meaning of childhood was ambiguous and not universally in demand. By 1914 the uncertainty had been virtually resolved and the identity largely determined, to the satisfaction of the middle class and the respectable working class . . . each new construction . . . may be observed in approximate chronological order as pertaining to Rousseauian Naturalism, Romanticism, Evangelicalism, the shift from wage-earning labour to "childhood", the reclamation of the juvenile delinquent, schooling, . . . [65]

Here the perspective is limited again: though "class" and respectability are parameters used by the author, race and religion are absent. For Jews or Hindus, rituals such as the bar mitzvah and arranged marriage are markers where the child becomes an adult with no transitional period.

For neurologists it is, however, undisputed that the developing brain is vulnerable: any assault on brain tissue, whether biochemical, traumatic or through ECT, is injurious to brain cells and neuronal connections.

The first review of ECT with children published in the US literature appeared in 1947, where 100 were under the age of 12 and most were diagnosed with "childhood schizophrenia". Beneficial effects of ECT were reported in the majority but complete remission was rare.[66]

Writing in *Convulsive Therapy*, Cohen and colleagues reviewed the medical records of 21 children aged between 13 and 19 who had received bilateral ECT from 1984 to 1995. They found a 40 per cent relapse rate after a year. Partial "clinical improvement" occurred for some "schizophrenic and schizoaffective episodes." Adverse effects were transient but "frequent." The researchers concluded that "ECT is a safe and effective treatment for adolescents with severe and intractable mental illness."[67] For a sample where almost half the recipients relapsed and adverse effects were acknowledged as frequent, this seems a conservative reading of the data.

The conclusion exactly mimics promotional literature from both the American Psychiatric Association and the UK's Royal College of Psychiatrists. The latter body has published the definitive guide to ECT. After 300 pages reviewing the evidence to date detailing adverse effects from memory loss (in a third of recipients) to death (frequently as a result of the anaesthetic rather than the electric shocks), the Royal College *Handbook* ends with a few pages about what to tell prospective patients and relatives. The first recommendation is that people be informed the treatment is, indeed, "safe and effective".[68]

Numerous studies and reviews come to a similar conclusion. Wachtel and colleagues suggest that "the indications for electroconvulsive therapy in children and adolescents are similar to those in adults, including severe affective, psychotic and catatonic pathology". Arguing that it is bad publicity that prevents clinicians and parents considering ECT as an option, they urge the "removal of impediments to ECT access in this population", adding that children diagnosed with autism and neurodevelopmental disabilities should also be candidates.[69]

In Israel a study compared the results of ECT in two groups (adolescents and adults) in a community psychiatric institution. The files of 24 consecutive adolescent patients treated in the years 1991–1995 were retrospectively examined, and the findings were compared with those in 33 adult patients who started their ECT course on the same day. The authors conclude that ECT was equally effective for adolescents and adults (58 per cent in each group achieved remission).[70]

Willoughby reported a case study of *one* eight-year-old girl diagnosed with psychotic depression and concluded: “Nurses and other healthcare personnel should consider ECT in refractory cases of major depressive disorder, bipolar affective disorder, schizophrenia, and other psychotic disorders.”[71]

In July 2002 the Brazilian Federal Council of Medicine, in its Resolution n. 1640, regulated the use of ECT in Brazil. It prohibited its use in patients below 16 years of age, unless in exceptional circumstances.[72] Partly in response to this resolution, Lima and colleagues conducted an extensive review of ECT use with young people. The research is something of an object lesson in the academy’s demand for publication: there are 16 authors named in a study that was, in effect, a literature search and review.[73]

Inclusion criteria were: (1) manuscripts written in English, Portuguese, Spanish or French; (2) case reports, series of cases, case controls, literature reviews, cross-sectional studies, exploratory field research, and prospective and retrospective cohort studies; (3) studies regarding the use of ECT in adolescents, provided they respected at least three of the five PICOS (Patient/Problem, Intervention, Comparison, Outcome, Setting) criteria: adolescent, ECT, absent or only drugs, symptoms remission and study design. Studies assessing other conditions, editorials and letters to the editor were excluded. From the 212 studies surveyed the authors reduced their final total to 33, a further 6 being added from research referenced in the reviewed sample.

The authors conclude that ECT use in adolescents is “considered a highly efficient option for treating several psychiatric disorders, achieving high remission rates, and presenting few and relatively benign adverse effects”.

In their introduction they suggest that adolescents experience “self-destruction impulses”. At no point in the paper do the authors reflect on the possibility that agreeing to ECT is, in itself, self-destructive. They go on to describe the introduction of ECT as a revolution in psychiatry. This rhetorical device sets the scene for what follows: the authors are not able to make a morally grounded statement concerning ECT use, partly because their approach is not neutral and partly because morally based reasoning cannot be applied to these kinds of data; studies of this type always reveal a mixture of success and failure in the preferred treatment strategy. The *only* criterion used by researchers in recommending continuation of the treatment under review is an implicit appeal to Bentham’s notion of “the greater good”. If, for example, 2 children die and 20 others have profound cognitive deficits in a sample of 100 children given

ECT, the authors will conclude that those deaths and adverse effects are compensated for by the 40 children who showed no relapse after a year. The benefits are seen to outweigh the risks. This, however, is only one way to judge "benefit" and deliberately ignores the Hippocratic Oath's requirement to "first do no harm". A consent form beginning with the words "I understand I may die but my death may benefit others in the future" would be a challenging addition to the existing pretreatment literature. At present, consent forms are limited to acknowledging headache, nausea and vomiting, agitation and mental confusion as the most common adverse effects.[74]

Lima and colleagues define adolescence as the "state of being 13 to 18 years of age" and surveyed three medical databases: PMC (PubMed Central: United States National Library of Medicine), LILACS (Literatura Latino-Americana e do Caribe em Ciências da Saúde) and SciELO (Scientific Electronic Library Online).

The authors note that the American Academy of Child and Adolescent Psychiatry (AACAP) has established that eligibility for ECT in adolescents involves meeting three criteria: (1) diagnosis, (2) severity of symptoms and (3) lack of treatment response to appropriate psychopharmacological agents accompanied by other appropriate treatment modalities. ECT is recommended for adolescents with diagnoses such as persistent major depression, schizoaffective disorder, schizophrenia or a history of manic episodes, with or without psychotic features.[75] Other researchers have suggested that ECT can be used with child and adolescent populations to treat catatonia[76] and neuroleptic malignant syndrome.[77] The latter is one adverse effect of neuroleptic medication. Here, *further* brain damage is being recommended as a treatment for iatrogenic harm.

Notwithstanding the lack of validity of psy diagnoses, ECT is most frequently used with children labelled "depressed" – a supposed "mood disorder". It has also been used with children and adolescents marked as "bipolar"[78], "mentally retarded"[79], "autistic"[80], "schizophrenic"[81] or "endogenously depressed".[82] This last illustrates the unreliability of using even relatively recent research to support contemporary treatments in the field: "endogenous" depression was removed from the official lexicon over 20 years ago.

Despite its popularity among psychiatrists working with people over 60, ECT is much less frequently used for adolescents. Three studies retrieved by Lima et al. compared ECT use in adolescents with ECT use in patients of other ages. Adolescents subjected to ECT accounted for only 0.43 per cent of the total in India, 0.93 per cent in Australia and

1.5 per cent in the USA.[83,84,85] An Australian study involved a 53-item telephone survey with people who received ECT before the age of 19 years in New South Wales. Opinions about ECT were generally positive: the majority considered it a legitimate treatment, and would have it again and recommend it to others.[86]

Medicare figures show the use of ECT has tripled in Victoria in the private health sector in six years: 18,000 treatments were conducted in 2007–2008.

In Victoria's private health system, ECT use increased from 1,944 treatments in 2001–2002 to 6,009 in 2007–2008. In total some 18,000 treatments were reported, 12,000 in the public health system. Of these 18,000 some 6,197 ECT treatments were compulsory, and nearly three times as many women had shock treatment compared with men. Increasing numbers of patients who had been forced into ECT treatment were contacting the Mental Health Legal Centre claiming they were tortured. There were 203 ECT treatments on children younger than 14 – including 55 aged 4 and younger. Two of the under-4s were in Victoria. In the same continent the Western Australian Government has now banned ECT for children under 12.[87]

Finally, Lima and colleagues conclude: "ECT is the treatment of choice depending on diagnosis, severity of symptoms, and lack of response to psychopharmacotherapy. The majority of the studies in the scientific literature show the efficiency of ECT use in adolescents and consider this approach more efficient than psychopharmacotherapy isolated [sic]." and "an experienced staff and adequate physical conditions can minimize the risk of complications." Iatrogenic harm is thus reduced to "complications".[88]

In contrast, Jones and Baldwin remark in an article from over 20 years ago: "ECT has been repackaged in a manner designed to censor public opinion. Empirical research, based on adequate methodological data, does not exist ... ".[89]

Following a two-year investigation, Mental Disability Rights International (MDRI) released the findings on 28 September 2005 in a report detailing the human rights abuses perpetrated in Turkey against children and adults in the psy system. *Behind Closed Doors: Human Rights Abuses in the Psychiatric Facilities, Orphanages and Rehabilitation Centers of Turkey* describes the widespread use of ECT on psychiatric patients as young as 9 years old without the use of anaesthesia. The investigators also found evidence of children dying from starvation, dehydration and lack of medical care in "Residential Rehabilitation Centres".

The report documents Turkey's violations of the European Convention for the Prevention of Torture (ECPT), the European Convention on Human Rights (ECHR), the UN Convention on the Rights of the Child (CRC) and other internationally accepted human rights and disability rights standards.[90]

Repackaging revisited

All studies of ECT use patients who have been given psychiatric diagnoses. As these diagnoses are invalid – effectively opinion presented as fact using a lexicon designed to bolster the scientific credentials of psychiatry rather than describe subjective experience – *no* current ECT research can be regarded as adequate. This research praxis is further complicated by the interdependence of professional and public discourse wherein language is embodied and comes to limit possible experiences (see Chapter 3). An added layer of complication comes via ahistoriographic reading of psychiatric texts. Thus although ECT may have been used with those diagnosed with schizophrenia from the 1930s to the present day, researchers cannot know what earlier academics and clinicians meant by the term "schizophrenia".

The use of drugs – prescribed and illicit psychotropics, alcohol, caffeine and tobacco – seems to require little more than an appeal to a physician for "a good night's sleep", the means to enjoy a drink at a bar or café, or a willingness to stand outside and smoke. Despite daily health warnings about the use of drugs, they remain part of everyday life for the majority and require little repackaging beyond suggesting that alcohol or coffee might be good for the consumer. Illicit drugs are promoted by the media in articles describing the *bad* effects of the latest designer drug.

ECT falls into a different category: some psy professionals want to justify and expand its use, yet the public are suspicious. There are, for example, numerous service user websites and "educational" campaigns supported by "user and carer" organizations (frequently subsidized by the pharmaceutical industry) that support diagnoses and the use of medication. There are, however, no similar bodies supporting the use of ECT. Instead there are several *anti*-ECT websites and organizations most often supported by service user groups. This suggests that the suspicions of the general public are justified, hence the need to "repackage". The question of *why* psy professionals want to electrocute people while others remain silent remains unanswered.[91]

ECT has been featured in Hollywood films for 60 years. Some researchers have suggested that media portrayals exert a powerful and predominantly negative effect on public attitudes.[92] Initially portrayed as an effective psychiatric intervention, ECT on film has come to stand for the brutal, futile attempts of society to control and suppress. Filmmakers have been influenced more by profitable and Oscar-winning films such as *One Flew Over the Cuckoo's Nest* than by psy literature promoting the procedure as "safe and effective".

ECT has also been depicted on TV. Kellner detects a recent shift in the way that it is presented. *Depression: Out of the Shadows* by Larkin McPhee and aired on US TV, for example, portrays a Yale surgeon who had positive treatment for depression. Two recent books about ECT, *Shock Therapy: A History of Electroconvulsive Treatment in Mental Illness* by Edward Shorter and David Healy, and *Shock: The Healing Power of Electroconvulsive Therapy* by Kitty Dukakis and Larry Tye, attempt a public reappraisal of ECT, though their audience is unlikely to be "the public". Kellner suggests that positive media portrayals are helpful because patients are more likely to be open to considering it as a therapeutic option when a psychiatrist suggests it.[93] Computer literate patients, however, can now scan the web for information about diagnosis and treatment when faced with ongoing iatrogenic effects.

Herman and colleagues showed that rates of ECT use across American states were highly variable, more so than for most medical and surgical procedures. In some urban areas, access to ECT is limited. In 13 states, ECT is highly regulated by law, and in Colorado and Texas it is forbidden for children under 16. In Missouri a court order is needed. In Tennessee a child can be electroshocked only for "mania or severe depression".[94] For some ECT proponents, this is a denial of the "right" to be electrocuted at a psychiatrist's behest. Shorter objects to such regulation and claims ECT is the "penicillin of psychiatry". He states: "The legislative overreach concerning ECT in children leaves one open-mouthed ... This is ageism in reverse, and terribly unfair." And he asks: "Are we denying children access to a treatment that is safe and effective in adults?"[95]

Shorter uses a rhetorical device in saying that scientologists (vilified and depicted as a deranged cult in mass media), under the guise of various front organizations, lobby for tightening the ECT restrictions rather than loosening them. The implication is that any right-thinking American would support something scientology wishes to ban.

The poor public image of the procedure and "safe and effective" rhetoric is further addressed in a web-based article entitled "ECT in kids: Safe, effective, robust and ... underutilized."[96] The article reports on a 20-year retrospective study by investigators at the Mayo Clinic in Rochester, Minnesota, presented at the American Psychiatric Association's 2013 Annual Meeting.[97] The Mayo is one of the few centres in the USA using ECT with children and adolescents. The presenters claim that the procedure reduced “symptoms of affective disorders, psychotic disorders, and other disorders” up to one year post-treatment with a single series of ECT. They noted that a poor public image and the controversy over its use have led to subsequent underutilization of ECT and suggested the image was based on “outdated misconceptions”.

At the Mayo Clinic, ECT is done under the supervision of an anesthesiologist as well as a psychiatrist. For the study, the investigators examined the medical records of all patients from the ages of 12–19 years treated with ECT at the Mayo Clinic from 1993 to 2012. The study included 46 patients; one-year follow-up data were available for 29 of the patients.

The majority were marked as “suffering from severe, recalcitrant, and frequently comorbid mood, anxiety, and psychotic illnesses – with about an even split between recurrent major depressive disorder and primary psychotic disorder. Other disorders included anorexia nervosa, catatonia, and schizoaffective disorder.” Most were on at least four psychoactive medications simultaneously; the researchers make no causal link between the effects of these medications and the various “disorders”.

The most common adverse effects of ECT were nausea (15.2 per cent) and headaches (13 per cent), followed by “postemergent agitation” (8.7 per cent) and spontaneous seizure (4.3 per cent). The presenters concluded that “ECT remains the gold standard for severe illness.”[98]

The promotional campaign for ECT is not limited to the public. A paper in *Electroconvulsive Therapy* examined the knowledge, experience and attitudes towards the use of ECT in minors among child and adolescent psychiatrists and psychologists. A majority of the respondents said they had minimal knowledge about the use of ECT in children and adolescents. Lack of confidence in providing a second opinion was reported by three-quarters of respondents. The majority regarded ECT as a treatment of last resort. Compared with those with minimal knowledge, respondents with “advanced knowledge” reported a higher perception of safety and efficacy, perhaps unsurprising given the constant repetition of the “safe and effective” claim.[99] Publishers too must have some confidence in these promotional exercises by ECT proponents: in 2013, Oxford University Press published *Electroconvulsive Therapy in Children and Adolescents*.[100]

Finally, two essentially pro-ECT studies detail the necessary *medical* procedures necessary when considering electroshock. The first looked at adults referred for ECT and found that they have a greater number of pathological lesions of the central nervous system identified by a computerized tomography (CT) or magnetic resonance imaging (MRI) scan. The author suggests that some of these lesions may affect treatment outcome or seizure duration. Therefore an MRI or CT scan is indicated in adolescents *before* ECT, a costly recommendation unlikely to be carried out even by those few who have read the study.[101]

The second study examined the effectiveness and safety of ECT in "pharmacotherapy-refractory depression" in 11 hospitalized adolescents. A potentially serious complication of tardive seizure occurred in one recipient. Prolonged seizures were noted in 7 of the 11 patients. Pending further research on ECT in youth, the authors recommended that ECT should only be administered to youth in hospital settings, that *all* regularly administered psychotropic medications (including antidepressants) be discontinued before ECT and that physicians be aware that 12 treatments are "usually sufficient".[102]

The repackaging and marketing of ECT continues. ECT is predominantly confined to older women, performed with the consent of relatives or with the approval, in the UK, of second opinion doctors. Any "controversy" is limited by the lack of publicity for the praxis and its invisibility within the clinic. For children and adolescents, any debate is mostly confined to anti-ECT activists, frequently online, and within the pages of psychiatric journals.

At Shelton Hospital in the early years of this century, the procedure was recommended by – predominantly – psychiatrists working with older people. An exception was Dr David Myers, a consultant psychiatrist, with a considerable publication record. He approached me with a research proposal concerning the outcome of ECT at Shelton. Myers had been an advocate of ECT but the experience of its adverse effects and apparent failure to ameliorate symptomatology in patients he had diagnosed as depressed led him to question its utility. After a year of failed submissions to the local ethics committee he withdrew from the proposed study. The committee had objected to *any* research involving a control group of patients diagnosed with major depression but who were not offered ECT, on the grounds it was unethical not to offer them the treatment. The committee had few concerns with the proposed methodology (post-treatment interviews at three and six months, use of medication, etc.) but was persuaded that the treatment was *necessary* and could not condone research that might have demonstrated its utility – or otherwise. The suspicion remains that it is a discovery of *lack* of utility that holds clinicians and therapists back from researching the results of interventions from ECT to psychotherapy.

Research criteria invariably involve the subjects under scrutiny. In psy studies, these subjects are likely to be labelled with a psy diagnosis and are frequently in receipt of medication, psychotherapy or both. Criteria for *researchers* rarely go beyond a brief allusion to their academic qualifications. Research on ECT, a treatment designed to destroy brain cells, neuronal connections and memory, should perhaps include criteria for those very researchers. Do we know, for example, if the researchers are parents? If they are, do we know if they *like* children. The scientistic ethos in psy presumes that researchers are neutral observers. One relatively recent demand within academic journals has been for researchers to declare conflicts of interest – usually financial. It is clear, however, that some people do not like children. Any parent is likely to go through periods of wanting offspring to leave home as soon as possible. A stranger in a supermarket checkout might find the children of the person in front of him or her infuriatingly noisy or – in his or her terms – badly behaved. That same person may well be a parent grateful for a few hours free of parental responsibilities only to be confronted by another person's family in uproar. Presented with the option of harming one of the noisy kids – and getting away with it – one might speculate that some people would take that option.

Parenthood, then, is no guarantee of sympathy towards children and teenagers. One criterion for researchers might be to answer, as honestly as possible: "*Why* do you think you want to electrocute young people?" The vested interest would be in profiting through the satisfaction of harming people rather than material gain. Science demands the most parsimonious theories to explain results. Uncomfortable though it certainly is to contemplate the possibility that psy professionals set out to harm patients, particularly children, this is one hypothesis that might bear further scrutiny. Chapter 6 examines these themes further with reference to the prescription of psychoactive medication.

Contextual note

About half this chapter was written in the two weeks surrounding my 60th birthday. The weather was glorious, so resisting the temptation to leave my shed-cum-office was difficult. To ease the pain of writing I listened mostly to Prokoviev's piano sonatas and the bass-driven jazz of Charlie Hayden and Dave Holland. In a burst of final-day creativity and reference-checking, John McLaughlin's *The Promise* was the accompaniment.

6

The Oblivion Express: Big Pharma

"Patients and their families need to know that psychiatry is an uncertain branch of medicine, that well-qualified psychiatrists frequently disagree, that they deal more in judgement calls than in answers, and that the risk of a bad outcome is sometimes high."[1]

This chapter considers some of the "bad outcomes" consequent on taking prescribed psychotropics. The focus, however, is on a sociological view of the industry (Big Pharma) encompassing the ubiquity of drug-taking for millions of people, the marketing of licit pharmaceuticals, the part they play in the ongoing need to establish psychiatry as a genuine medical endeavour, and the ambivalence towards prescribed medications shown by other psy professions, service users and families.

"Everybody must get stoned"[2]

Drugs to enhance creative work are a familiar trope: "Coleridge used opium, Jean Paul Sartre amphetamine, A.E. Housman alcohol, Norman Mailer cannabis, and similarly Oscar Wilde and Bosie Douglas hashish."[3] T.S. Elliot claimed his inspiration derived from "gin and drugs", for some making "The Waste Land" more than aptly titled. Would this volume be more coherent without vodka? Would the reader enjoy it more over a glass of wine? Would Janis Joplin or Ella Fitzgerald have been great singers without alcohol and heroin? Marvin Gaye and musicians from John Coltrane to Keith Richards are as much known for their drug use as for their compositions. Jim Morrison, a musician who regularly drank bourbon on stage, died of a heroin overdose – a "warning" that led to teenagers like me drinking *more* rather than less and, like Kurt Cobain and Robin Williams, turning him overnight from drug-addled creative genius to alternatively tragic fool and martyr.

The transformation (via rapidly published biographies, immediate blogging and editorials) requires the decontextualization of the lived experience of these new heroes and villains.[4] Little account is taken of the normality of drug and alcohol use, although lip service may be paid to the drug-taking among high fliers or, as above, creative people. Citing an emotional intensity based on loved films or music, bloggers may express grief articulated in terms of the personal importance of dead icons (my own contribution – at first in print, now available on the Web – was to write a delayed obituary for Frank Zappa).[5] Obituarists may adopt the prescribed editorial line and find drug-induced death a "waste" or a reason to maintain the "war on drugs". Information about the person's (often secretive) drug use is not easily available; only guesses can be made at the "interiority" of the individual. These guesses, by necessity, use deductive reasoning to arrive at a view that the person was overwhelmed, sad or preoccupied with money worries and status. Witnesses are found to support these hypotheses – witnesses who will probably not have considered the dictum of Albert Camus that every day one should start with the question "Shall I kill myself today?" and if the answer is "No", one must get on with life, however painful.[6]

For publishers and companies producing DVDs, YouTube and music compilations or reissues of the artists' work, drug-induced death is a marketing opportunity. The estates of musicians such as Cobain and Morrison continue to benefit from selling their work, and some – for example, that of Nick Drake (a singer barely known before his death) – now benefit from links, as "an inspiration," to another past master (and notorious alcoholic) John Martyn. In these marketing campaigns, genius and creativity are motifs allowing companies and the public to "ask questions" about links between drugs and creativity while exposed to a sea of products.

Drugs promoted by psy and Big Pharma do not aim to promote creativity (though claims of this type are made for methylphenidate as a "study drug"). For pharmaceutical companies, drug production and promotion aim to increase share prices; deadening the spirit of patients is a "side-effect" of this aim. A popular aphorism suggests that 50 per cent of Americans use drugs the government doesn't want them to and the other half won't take drugs (anxiolytics and neuroleptics) government-backed physicians want them to. This ignores the billions who use alcohol and the proliferation of cafés selling double espressos the world over.

Psy professionals are witness to the nature of suffering. We tend to pay closest attention to embodied forms familiar within the discourse – tears, self-harm, reddened faces, shouting, the wringing of hands or clenching of fists, and silence or restless pacing around the room. These displays are more "obvious" than quiet and thoughtful responses. The latter may be the way the person has been socialized into polite conversation; after a few sessions (or less) of this type of conversation the professional – perhaps using a theoretical construct such as "suppression" – will challenge the patient on the basis that the patient wouldn't be there at all if he or she was not in some disguised *psychic* pain. The conversation might begin to focus on talk accompanied by visible signs of hesitation or agitation – the patient's distress and possible "causes" of that distress are now coconstructed.

I rarely saw patients whose socialization bypassed culturally normative signs of distress. These signs included displays of aggression (one patient threatened to kill me with his "bare hands"; another held a knife to my throat and asked what I would do if he pushed the blade home, to which I responded I would probably die, so he sat back down in his chair), the woman who rocked back and forth, others whose hands shook as they grasped a mug of tea. One woman in her 20s spoke only in Italian. She wailed incomprehensibly for almost an hour and then left, apparently much the better for the experience. Her GP wrote, asking what I had done as she seemed so much improved. The stories and consequent coconstructions would be familiar to any agony aunt: the woman whose husband regularly told her how useless she was in bed; the immaculately dressed farmer's wife who was sick of farm life and had tried a fling with the cowhand only to be discovered by her husband (who kept a shotgun in the bedroom for such eventualities); the landowner who was frightened to leave his estate but wanted to as he'd promised his wife a holiday in Hong Kong; the lonely wives living on a Royal Air Force base – all of them diagnosed as agoraphobic, the majority dependent on Ativan. Several women came for therapy to reveal that their husbands or partners had been "too busy" to attend. Invariably I heard one-sided stories about the relationships featuring uncommunicative or violent men who preferred nights down the pub or watching sport to conversations with their partners. A kind of truce had been declared wherein staying together "for the sake of the children" was preferred to the prospect of a lonely future or the fear-inducing complications of dividing the assets. Several women who opted for the latter approach found themselves confronted by partners who simply did nothing, a tactic that resulted in the woman leaving the home with little material benefit. Or for those who stayed together, the "price" they were prepared to pay was that one person would be diagnosed and medicated, the other withdrawn and drinking too much.

An increase in alcoholism among men was one of the consequences of industrialization described by Engels. He witnessed – as a mill-owning industrialist – the way in which machines, operated by less-well-paid female workers, could perform more efficiently the tasks of men. Only in heavy industry and in coalmines were men still necessary; those made redundant via the increased employment of woman turned to drink.[7] Similarly, prescribed drugs, to some extent, enable people to hide from ordinary life – crowds, debt, parental responsibilities, troublesome conversation, adulation (for celebrities), boredom (for the public). Individualistic constructions of these experiences might include agoraphobia, generalized anxiety disorder, depression and panic disorder. An alternative individualistic construction would be cowardice, one that is likely to invoke the response that the term is both derogatory and judgemental. The social acceptability of diagnostic labels *hides* their inherent judgementalism; a patient is *judged* by the psy professional in terms of whether conduct is "abnormal" or "abnormal but understandable", a modern version of the need to distinguish the deserving from the undeserving poor.[8] In the case of fee-paying patients, judgement focuses on their ability to pay.

More contemporary versions of the stories above might include the commuter who leaves the office late and drinks on the train; the journalist using cocaine to help meet a copy deadline; the person taking antidepressants who stays in a council apartment because the unlit streets on the estate are frightening; the person who feels unable to leave the house without repeatedly checking his appearance in the mirror; and the busy parent who drives too fast and eats too little because of the 101 things that must be achieved in a day. It is a truism that the media, via promotion of "healthy" lifestyles, diets and relatively expensive clothing, add to the pressure to display outward indicators of achievement. In effect, various media promote the attainment of cultural capital in a way that makes the *appreciation* of that capital short-lived as we strive for more. The most direct diagnosis for the majority might be that people are tired, a diagnosis to be read as a subtext of the regular promotion of aids to sleep or research into sleep problems. GPs will frequently prescribe antidepressants as an aid to sleeping in the absence of the power to reduce the demands in a patient's life. Consultations will also end in a "sick-note", enabling those with salaried employment to take a few days to recover from the immediate demands of work.

These trials and tribulations of ordinary life create opportunities for psy to capitalize on people's distress and disharmony. Psy "experts" in the media present scientistic justifications of any advice or analysis offered, a social move positioning them as more knowledgeable than the average reader. For pharmaceutical companies, the scientism of neuropharmacological theory is one aspect of features in the non-academic press. Reporting on a paper in *Psychoneuroendocrinology*, for example, one article describes a study based on a group of observers watching people being given challenging maths questions and "stressful" interviews. A tenth of the observers looking at the strangers had an increase in cortisol. One of the study's authors from the Max Planck Institute for Cognitive and Brain Sciences in Leipzig claimed: "There must be a transmission mechanism via which the target's state can elicit a similar state in the observer."[9]

Bryony Gordon, a journalist and regular contributor to the UK newspaper *The Daily Telegraph*, "reveals" that at the age of 17 she had been told she had "severe obsessive compulsive disorder and clinical depression". Her piece was a response to the launch of the Council for Evidence Based Psychiatry. At the launch, Prof. Peter Gǿtzsche also referred to "clinical depression".[10] This outdated usage attempts to distinguish "normal" depression from a state only amenable to expert analysis (see Chapter 3). Gordon continues: "anyone with even a passing knowledge of mental illness knows that time does not pass when you are depressed" and she blames "bad medical practice" rather than "evil drug companies". She adds that three-quarters of people claim their lives have been improved by antidepressants.[11] I have known people who say that antidepressants help them sleep, help them "chill" if the kids are too noisy, dull the fears of socializing and more. *None* has suggested these changes "improved" their lives, though Gordon may mix with people for whom medication is the norm, or may say things to reassure her and themselves that the adverse effects – impotence, nausea, constipation, headaches, insomnia, sweating and so on – balance any benefits.[12] Increased thoughts of suicide and actual suicide are one reaction to the agitation common to antidepressants.[13] For children, the adverse effects of methylphenidate (Ritalin), prescribed to *reduce* agitation, include restlessness, excitability and euphoria.[14]

I have only once taken an antidepressant (seroxat) in an effort to help a friend kick his habit. I have, however, experimented with other legal psychotropics. You wouldn't wish haloperidol on your worst enemy. It is supposedly an "anti-psychotic" neuroleptic. The marketing ploy is revealed in the term "anti-psychotic" and can be exposed by checking where the drug is most used. One might hazard a guess at psychiatric facilities or as an adjunct to "community care". The British

Medical Association's guide to prescribers, the BNF, states that positioning "antipsychotic" drugs as "major tranquillizers" is misleading as they "generally tranquillize without impairing consciousness . . . ".[15] In fact, haloperidol is used worldwide in zoos as a major tranquillizer: it calms horses and hippos requiring veterinary praxis, such as getting an animal to lift its leg before further examination. I have taken it once. Working on a research thesis concerning nurse uniform, I spent many hours on a "long-stay" ward in Lincolnshire's Rauceby Hospital.[16] All the patients were tranquillized, leading to symptoms of tardive dyskinesia (TD) – for example, shuffling as they walked, slurred speech and dribbling much of the time. Their shared secondhand clothing and general lethargy added to a picture of an institutionalized community of homeless men. This picture made it inevitable that, in a context of the ubiquitous psy diagnosis, these symptoms would be ascribed to the "disease" (usually schizophrenia) they were being medicated for rather than the adverse effects of haloperidol. In what seems to me now a misguided attempt at siding with the patients, I tried *one* 5 mg tablet; the patients were on at least five daily. My familiarity with the effects of various drugs and alcohol did not prepare me for the 24 hours of both insomnia *and* profound sleep that followed. I had been a pretty good swimmer and runner, and was then playing soccer for a local team. The generally high fitness level was no defence against the drug. Two days later, back on the ward, I could only marvel that the patients were still alive.

In addition to features on diet and exercise, the popular press uses the fear of many psy "conditions" to promote putative drug treatments. New features act as a signal that (1) the condition exists; (2) a treatment is not far away; and (3) researchers require more funding. An article in *The Daily Telegraph*, for example, suggests it may be "too early to recommend" citalopram (a selective serotonin reuptake inhibitor (SSRI) antidepressant) which has been shown to lower the production of the plaque protein amyloid beta by 37 per cent and 78 per cent in "*elderly mice*" (my emphasis). The Alzheimer's Society director of research and development, Doug Brown, adds: "more research is needed".[17] Pharmaceutical companies require new markets; as the highly competitive market for antidepressants expands, it is important to seed the idea that they may be effective for those not diagnosed as depressed. Alzheimer's disease is thus an ideal target.

In summary, the use of drugs – licit and illicit – to change consciousness is common. Legal medications are promoted by the pharmaceutical industry, which maintains the position that its products are necessary in treating individuals with psy diagnoses. The mass media act as one outlet positioning Big Pharma as a "scientific" endeavour. The next sections will explore the history of drug use and attempts by the drug industry to maintain an "ethical" public image.

A brief history

Although, in the 1500s, Paraclesus encouraged alchemists to isolate the "quintessence" of botanical substances via distillation and extraction, it was to be another century before chemically prepared remedies were included in European pharmacopeia. There is evidence that opium was used by lakeside dwellers in prehistoric times.[18] Therapeutically active ingredients were not extracted until the nineteenth century, some 400 years after the innovations of Paraclesus. Until then, sleeplessness and nervous restlessness were treated with opium in the plant form, a medicinal use first encouraged by Hippocrates in Greece, and Pliny and Galen in Rome.[19] Mixed with water and alcohol, opium was marketed as laudanum, "enjoyed" by as many artists and poets as those with diagnosed disorders. Widespread use of the preparation led to the 1868 Pharmacy Act, though it was freely available in pharmacy shops at the end of the century.[20] Morphine, cocaine and bromides, initially hailed as wonder drugs, followed a similar parabola, their medicinal use being tightly proscribed by 1900.

Barbiturates as anti-anxiety agents were first manufactured in 1904. By the 1930s they had replaced bromide and chloral hydrate on the grounds they were safer. The risks of barbiturate dependence were not acknowledged for another 20 years. After the popularity of their alternative, meprobomate, waned, the first of the benzodiazepines, Librium, was introduced in 1960. Followed by diazepam (Valium) in 1963, the two drugs rapidly came to dominate prescribing habits: "between 1965 and 1970 prescriptions for benzodiazepine tranquillisers in England and Wales rose by 110 per cent compared to a 19 per cent increase for all psychotropic drugs".[21] Over this five-year period the number of prescriptions for the main benzodiazepines more than doubled – from less than 5 million to over 12 million.[22]

These figures cannot reflect the number of people *taking* benzodiazepines. The 1960s saw a general increase in drug experimentation from LSD to cannabis. Barbiturates, commonly sold on the street as "barbies", resurfaced, while benzodiazepines are still used today as a way to either heighten or mask the effects of alcohol. One researcher has suggested that the overproduction of psychoactive drugs by pharmaceutical companies is a means to increase drug dependence through deliberately releasing these drugs to the street via supposed "burglaries" of warehouses.[23]

The prescription of drugs for children has surpassed the most optimistic predictions of Big Pharma. The BNF is *very* specific about an increased risk of adverse effects when prescribing to children. It offers a dosage calculation based on body-surface area estimates and notes that accurate dosage is hindered by factors such as a generally higher metabolic rate in children and factors such as obesity.[24] The volume's caution does not appear to be reflected in actual prescribing practice.

Some clinical psychologists working in services for children have abjured the use of psychometric tests designed to confirm a diagnosis of ADHD. Others have embraced diagnostic testing in much the same way they would embrace the prescribing privileges now enjoyed by clinical psychologists in several American states. The consequences of such diagnoses include families having access to much-needed financial support and, frequently, psychoactive medication for the diagnosed individual. Between 1994 and 2003, UK prescriptions for stimulants (e.g. Ritalin) rose from 6,000 to 345,000, a change not accounted for by the publication of DSM-IV-TR in 2000.[25] Between 1996 and 2003 the percentage of boys in US schools diagnosed with ADHD and prescribed stimulants rose from 6 to 17 per cent.[26] One of the *adverse* effects of stimulants such as methylphenidate – appetite suppression – makes it an ideal drug to sell on the street as a slimming pill. I have discussed this elsewhere.[27]

Thomas Szasz regarded schizophrenia as the "sacred symbol" of psychiatry.[28] Since its invention in the first decade of the twentieth century the vagueries around diagnosis and the numerous different theories "explaining" schizophrenia have made the construct invaluable to competing researchers, psy professionals and drug manufacturers (see Chapter 5). For the industry, medication is aptly described as its "holy water".[29] So-called antipsychotics are now the third-bestselling pharmaceutical compound in the world in terms of sales value, behind statins and antiulcerants.[30]

Branded as Largactil in Europe and Thorazine in the USA, chlorpromazine was marketed as a major tranquillizer soon after Smith Kline & French secured a licence for its sale in the 1950s. The term "antipsychotic" entered the marketing vocabulary in the 1960s with the production of competing drugs, such as reserpine and haloperidol (see above). When patents for these drugs expired for similar preparations in the 1990s, a new generation of "atypical" antipsychotics were promoted, their tranquillizing effect proving popular among those wishing to "calm" elderly dementia patients (see Chapter 1). A UK

Government publication, however, *Effective Health Care*, in reviewing this newest so-called antipsychotic medication, concluded: "Most relevant trials are undertaken by those with clear pecuniary interest in the results."[31] The government urged caution to prescribers preferring atypical antipsychotics, advice appearing in inverse proportion to the number of advertisements for the new compounds in the medical press.

Introduced in 1996, Zyprexa is the brandname for olanzapine, a chemical intended to bind to receptors in the brain to reduce psychotic hallucinations and delusions. Zyprexa also causes severe weight gain, and increases in cholesterol and blood sugar. Marketed for schizophrenia and bipolar disorder, by 2007 about 20 million people worldwide had taken the drug. It might appear that Eli Lilly played down to doctors the risks of Zyprexa as the drug's sales increased after its introduction. For example, in Lilly's clinical trials, 16 per cent of people taking Zyprexa gained more than 66 pounds after a year on the drug, a higher figure than disclosed to doctors. It was claimed that Lilly further marketed the drug as appropriate for patients not diagnosed with schizophrenia or bipolar disorder, Zyprexa's only approved uses. Lilly denied this allegation: although *promotion* of drugs outside the recommendations of the Food and Drug Administration is illegal, doctors may prescribe drugs in any way they see fit.

Early in 2007, Lilly agreed to pay US$500 million to settle 18,000 lawsuits from people who claimed they had developed diabetes or other diseases after taking Zyprexa. At the time of the 2007 settlement, 1,200 suits were still pending. The company has agreed to pay in total at least US$1.2 billion offered to 28,500 people who said they were injured by the drug. The settlement does not affect continuing civil or criminal investigations of Zyprexa by state attorneys' general and federal prosecutors.

A previous settlement (in 2005) led to a payment of US$700 million covering 8,000 patients, and the company has made 2,500 individual settlements whose total value has not been disclosed. The 2005 settlement valued claims at about US$90,000 for each plaintiff. The 2007 agreement valued claims at up to a maximum of US$27,000 per plaintiff. In a statement, Lilly said the settlement did not change the company's view that Zyprexa is a "safe and effective treatment" for mental illness – echoes of ECT marketing (see Chapter 5).[32]

In summary, one history of drug-taking might describe a trajectory where drug use has been widespread from the earliest times. By the time of the Roman Empire, opiates were part of the pharmacopeia of physicians. From the mid-nineteenth century the use of consciousness-altering drugs had been limited and licensed through legislation. The twentieth century witnessed a rapid expansion in the development of psychotropic medications in an increasingly profitable industry. This development has been matched by the increase in psychiatric diagnoses (see Chapter 3). Various authors have further suggested that psychiatric diagnoses are *invented* by the pharmaceutical industry in order to sell new compounds.[33]

The profit motive has led recipients and other critics to question the vested interests of researchers. The industry is now defending itself from articles on the Internet, other media, recipients and critical voices within the psy complex attempting to expose corruption among individual and corporate members of Big Pharma. The next section examines two examples of efforts by the industry to reposition itself as an ethical endeavour for the public good.

Selling snake oil in the twenty-first century

Branded "ethical" in the early twentieth century, pharmaceutical companies have, for over a hundred years, positioned themselves as distinct from the "snake oil" salespeople of the nineteenth.[34] For the consumer, the privileging of science in the public discourse aids Big Pharma in its efforts to be seen as superior to both individual experimentation with illicit psychotropics and manufacturers of, for example, automobiles. Any technological industry nested within modern capitalism is, however, bound to use whatever methods it can to increase sales. For advertising in the mass media, Big Pharma competes for space with anything from commercials for coffee to "special pull-out sections" on travel in newspapers.

For printed media, positioning stories as "news" disguises the key function of articles: that of filling space between advertisements and arresting photographs.

The US publication *Newsweek* has been wrapped in a foldover advertisement for ADHD treatment sponsored by Lilly. There is no *article* on ADHD inside the magazine. In fine print the front cover says: "Through special arrangements with the publisher, this Eli Lilly and Company promotional coverwrap has been placed on a limited number of copies of Newsweek. It does not constitute an endorsement by Newsweek and no endorsement is implied." Inside the coverwrap is a questionnaire to aid self-diagnosis of ADHD before seeing a primary care physician. The text includes "If you've felt this type of frustration most of your life, you may have Adult ADHD, a neurological condition partly related to the brain's chemistry and anatomy. Fortunately, it is a condition that your doctor can help treat." A website is cited.[35] It is well known that half those visiting a primary care physician or general practitioner do *not* want medication, while half receive a prescription. A simple advertisement in the national press saying "Have you seen your doctor recently?" has been shown to increase drug prescriptions. Patients using – increasingly non-technical – terms such as "anxious" or "depressed" during the consultation are likely to receive a prescription. The scientistic gloss provided by a questionnaire makes drug treatment (or referral to a counsellor) more probable.[36]

Numerous blogs and Internet articles detail the adverse effects of diagnosis and drug treatment. These stories are in a minority when compared with positive pieces on the beneficial effects of prescribed medication and expert help. Personal accounts of harm may feature in the national press but must compete with "news" concerning celebrities and "advances" in medicine.

Founded in 1889, the School of Medicine at Johns Hopkins University receives more funding from the National Institutes of Health than any other medical school in the USA. In a Web-based advertisement of over 3,000 words, the Mood Disorders Center at Johns Hopkins uses specific advertising techniques – repetition, fear promotion, generalization, scientism – to promote psy diagnoses and treatment.[37] The website uses a common trope in its name – "Health Alerts".[38] The aim – to sell – is immediately disguised by an appeal to two modern shibboleths – "health" and alarm.

The site introduces the reader to a "special offer" headed "New Treatment Options for Managing Mood and Anxiety". It begins: "When your emotions cloud your outlook, interfere with your relationships or affect the way you sleep at night and function during the day, you may be suffering from depression or an anxiety disorder. Johns Hopkins physicians have achieved *stunning* success managing these *life-altering conditions . . .* " (my emphasis). The two sentences introduce the concept of disorder related to ordinary feelings, expertise via the auspices of medical personnel and urgency through the term "life-altering".

The commercial heralds the 2013 Johns Hopkins "Depression and Anxiety" white paper, written by "Depression and Anxiety Expert" Karen L. Schwartz, MD.

The director of clinical and educational programs in the Mood Disorders Center and associate professor of psychiatry and behavioural sciences in the School of Medicine, Schwartz specializes in "premenstrual dysphoric disorder (PMDD), mood disorders during pregnancy, postpartum depression and psychosis and menopause-related depression".

The reader is informed that "Johns Hopkins specialists" offer "new medications that promise greater relief with fewer side effects, as well as dramatic breakthroughs in diagnosis and treatment". "Conditions" covered by the specialists include "major depression, dysthymia, atypical depression, bipolar disorder, seasonal affective disorder (SAD), panic disorder, generalized anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and phobic disorders".

The advertisement continues: "While medication is often a significant part of treatment for mood or anxiety disorders, these conditions often have multiple causes and may respond best to a combination of treatments." It invites readers to consider "What causes mood disorders like depression and bipolar disorder, and what kind of chemical changes take place in the brain when people get depressed? Does depression 'run in the family?' " Readers of the white paper will find coverage of research on "identical twins, fraternal twins and adopted children whose biological parents had a mood disorder", in addition to speculation about the relationship between genes and treatment.

There are paragraphs about the "difference" between atypical (noted as "very common") and typical depression, "brain changes" in people diagnosed with SAD, hypothesized behavioural changes resulting from head injuries from trauma or tumours, and what the sufferer might do to enable the brain to "bounce back" faster during recovery. Information is presented concerning "which medications can worsen" depression and anxiety. It is claimed the reader will be enabled to recognize when normal reactions "cross the line" to become an illness and signs of OCD.

The commercial utilizes emotionally directive words and phrases to emphasize authority. These include "ignorance", "erroneous thinking", "accurate", "responsible", "information", "worry", "advances in understanding", "development of newer, safer, more effective, NEW DRUGS [*sic*]", "better results", "fewer side-effects", "best medications" and "intimate knowledge". The patient is informed that "doctors zero in on the right medication for a given condition".

In summary, the commercial uses a series of clichés embedded in the text to persuade the consumer. French and Raven, in examining social power, posit that authority, expertise and the legitimate power to reward or sanction via hierarchical status are important factors.[39] "Referent power" (i.e. the perception that the other person is essentially similar to you in status or culture) is seen as the most influential. All advertisements feature some or all of these tropes. A commercial for a car, for example, might feature a busy housewife without time to change out of her slippers, crowding several children into a vehicle in order to get them to school on time. The car will be portrayed as *safe* and *efficient*, proving *effective* in its role in family life. It may be newer (and cleaner) than the average family vehicle, but otherwise appeals to expert, reward and referent power are made.

The John Hopkins advertisement (relabelled here as an "announcement") focuses on authority, reward and expert power but, other than identifying the author of the white paper as a woman concerned about other women, it lacks referent power. In this it is relatively unsophisticated, instead mimicking numerous similar "infomercials". It also invites a response encapsulated in the remark made by my brother (a council-employed groundsman) to TV promotion of psy "experts": "Not another bloody 'ologist."

As "alternatives" to an exclusively medical approach to easing suffering, exercise and light therapy are referred to in the white paper in scientistic style. Neither is new (see for example, the beneficial effects of cycling or holidaying in sunny climes claimed since the mid-nineteenth century). Nor is either approach *necessarily* medical, though both have fallen under the umbrella of psy. In the UK it is possible to get "exercise on prescription" and, in the absence of resources to go on holiday, patients are also recommended so-called light therapy.

Anyone ordering the white paper will receive "Managing Your Moods: Identifying and conquering the symptoms of depression and anxiety" as a "FREE GIFT".

Finally, the advertisement offers ten points in the white paper's favour. The fourth states that it is "Consumer friendly and easy to understand", translating scientific research into plain English, "simply, brilliantly and accurately".

With a "no-strings, can't lose" heading, the section on cost offers a saving of 50 per cent off the regular US$39.95 cover price. "Clicking below" will deliver a "30-day risk-free preview" of The 2013 Johns Hopkins "Depression and Anxiety" white paper, and "Managing Your Moods" can be retained as a "free gift" if the purchaser returns the white paper.[40]

These claims position medical experts as part of a scientific community that assiduously researches the physical and psychological benefits and adverse effects of prescribed medication both in production and on its release to the public. Chapter 9 examines some of the consequences of such praxis for the industry. The next section briefly outlines research emphasizing the adverse effects of prescription drug use.

Counterevidence

Considerable literature exists on research demonstrating the harmful effects of medication recommended by physicians and psychiatrists. Many authors are themselves from the medical profession. This literature examines methodological flaws in the published research, the vested interests of researchers and alternative treatments. Some authors focus on the *meaning* the power to prescribe has for psy practitioners and the wider profession. For example, Joanna Moncrieff, a psychiatrist, discusses the role prescription rights play in the century-old struggle to establish psychiatry as a branch of "real" medicine.[41] This theme also features in the work of sociologists and historians.[42]

Editors of psy journals and the general media are under pressure from their professional consensus or advertising agencies to ensure that pro-psy articles are in the majority. The outcome is the maintenance of professional hegemony and a position wherein critique is viewed as outwith professional norms. An article published in *Clinical Psychology*, for example, was more acceptable to the readership through its disparagement of *medication* rather than any criticism of clinical psychology *per se*. The article states that aged 8, Brian Spence of Milford, Connecticut, was put on a combination of "stimulants" and antidepressants. He had taken Ritalin under "pressure" from the school and social workers for two years. By age 11 he was suicidal. The author adds that in the USA "nearly all children who are the products of broken homes are labelled ADHD", and later says that Matthew Smith from Oakland County, Michigan, died aged 14 with a heart weighing a third more than a full grown man's. The certificate of death reads: "Death caused from long term use of Methylphenidate (Ritalin)."[43]

As a probationer clinical psychologist in the late 1970s, I frequently saw patients addicted to Ativan. A benzodiazepine, the drug is prescribed to those diagnosed with agoraphobia or panic attacks. The BNF highlights the addictive potential of the drug, noting that the likelihood of dependence is heightened in those with "marked personality disorders".[44] This last diagnosis was not then common. I can only conjecture that the patients (numerous housewives and unemployed, lonely and frightened people living on various Lincolnshire council estates) were hiding their disorder from view. The BNF is accurate in its warnings concerning dependence. I first approached prescribing doctors to suggest that rather than referral for psychological therapy it would be more cost-effective to simply stop prescribing. They acknowledged the point (repeated 30 years later when a Shrewsbury GP asked me to help his patients withdraw from an anxiolytic *he* had prescribed to them for decades) but suggested that dependence was so extreme that considerable input on my part would be necessary. I discovered patients who had halved and then quartered their 1 mg tablets in attempting to withdraw. A few had succeeded and carried the *empty* pill containers around to remind them that "help isn't far away".

Five years later, tired of the conflicts within psy, I applied for a research post at Wyeth (the manufacturer of Ativan). The role was to conduct research trials conducted by primary care physicians in Germany and Italy. The salary was excellent, the expenses considerable and research publication guaranteed. At interview I asked what happened to research demonstrating that the products were of little benefit or harmful and was told: "We don't publish that." This selective publication of Big Pharma-sponsored research has been explored in depth. Published work has been criticized in terms of methodology, use of invalid diagnostic categorization (frequently based on the DSM; see Chapter 9) and bias suspected of arising from the drug company affiliations of the researchers.[45]

Leo and Lacasse, for example, suggest that in the current medical literature some studies in "highly respected journals" are, in fact, "stealth advertising that is probably more effective at marketing pharmaceutical products than the glossy ad on the facing page", and "when legitimate scientific critics respectfully point that out, they may be the recipients of what can only be described as academic stalking".[46]

Rosenthal claimed over 30 years ago that negative data from drug trials are rarely published in the medical literature.[47] Negative results can also be reinterpreted in a positive way and published. Within the antidepressant literature (where articles can be underwritten by the industry),[48] for example, there are as many negative studies published with a favourable interpretation as there are positive studies.[49] This skews the literature on which clinicians rely in any attempt to help patients make informed choices.

"Academic stalking" involves the harassment of researchers who have refused to ignore negative data or present such data as positive.[50] Leo and Lacasse go on to suggest that the voice given to academics and consumers by the Internet means that academic stalking can be more easily exposed, and they cite the "scores of critical comments to the online Wall Street Journal health blog".[51]

As noted above, there is considerable literature refuting claims concerning the importance of the brain and its metabolites as a primary "cause" of undesirable conduct labelled as "disorder". Siebert discusses the lack of evidence and logical fallacies involved in the defective brain hypothesis.[52] In proposing his sociology – medical, eugenics and diathesis-stress model, Pam discusses the errors in methodology and conception leading to the current view of the validity of biological psychiatry, including professed biological markers.[53] A volume edited by Pam and Colin Ross exposes the "pseudoscience" of biological psychiatry with extensive critique of logical analysis, genetics and "preposterous conditions". Ross devotes an entire chapter to a critique of articles in *The American Journal of Psychiatry* with subheadings including "Statements of bioreductionist ideological bias", "Biological fishing expeditions with no significant findings" and "Twin, family and genetic studies".[54] The format could serve as a template for a critique of the *British Journal of Clinical Psychology*.

Drug treatment for most so-called psychiatric conditions is frequently found to do as much harm as good. Approximations of the benefit/harm resulting from prescribed use are limited by numerous factors. BNF, for example, includes a yellow card reporting scheme for physicians. There are *four* such cards in each monthly volume. Over almost 600 pages, BNF lists thousands of drugs for prescription. Each listing includes sections headed "side-effects" and "contra-indications". Once an adverse effect has been noted in print, a prescriber, constrained to offer consultations as brief as five minutes or by telephone, is unlikely to complete the yellow card. This suggests that adverse reactions are underestimated. Sedative or stimulant effects of medication will impact on the user's subjective experience, again leading to the under- or possibly over-reporting of adverse effects.

Social factors are important. The "gift relationship" between patients and physician makes the expression of gratitude for the prescribed drug more probable than any complaint. In simple terms the patient shares intimate information with the prescriber who, in a socially normative way, returns the favour via the "gift" of medication. Any admission that the drug has not been taken due to adverse effects may come after many similar consultations.

It might be assumed that physicians and members of psy also take psychoactive medication (certainly around 10 per cent of the clinical psychology trainees I have lectured to over 30 years *admit* to using psychiatric medication). Therefore some personal experience – in family members and loved ones – of using these compounds will also influence prescribers. Physicians are also influenced by reports from individual patients on the adverse effects of medication: of the seven GPs in a monthly Balint-style discussion group I facilitated for 17 years, only one said she would willingly take anything other than an antibiotic for a sore throat.

The medical context of the consultation combined with these factors make prescription more probable. In the UK, primary care general practices with a dispensary profit financially from prescribing. For the majority of medical practitioners, this kind of profiteering may not be the primary goal; the presence of a large room marked "Pharmacy" simply reinforces any notion that drugs should be high on the agenda. Wolfensberger would argue that these factors – the patient–doctor relationship and imbalance in proximal power, the privileging of technical means to obtain humane ends, the need to minimize consultation times – make physicians integral to the devaluation of others: medical practitioners "wound" patients, frequently from the best of intentions.

The attempt to legitimize the use of psychotropic medication (and psychiatry itself as "real" medicine) is unending, though separating cause from effect remains a challenge only met by ignoring both context and the linguistic cocreation of madness. In the case of ADHD, for example, Leo and Cohen reviewed studies of neuroimaging in children with an ADHD diagnosis. They conclude that differences observed in the neuroimages of brains of children with the diagnosis and "normal" children may be *caused* by medication.[55] The wider cultural context has been found to be critical: the World Health Organization found that people diagnosed with schizophrenia are more likely to "recover" in non-industrialized countries, adding that "being in a developed country was a strong predictor of not attaining a complete remission".[56]

Adverse effects of medication, as noted above, can be as powerful as the effects of ECT (see Chapter 5). Cohen states: "negative parts (adverse effects) are perceived as quite often worse than the illness itself . . . even the most deluded person is often extraordinarily articulate and lucid on the subject of their medication . . . senses are numbed, their willpower drained and their lives meaningless . . .".[57] There is no doubt that neuroleptics exert a tranquillizing and subduing action on episodic agitated, aggressive or disturbed behaviour, hence their use in zoos (see above). For those regarded as psychotic, only a modestly critical look at the evidence on short-term response to these agents will suggest that they produce only an abatement of psychosis and do not help people diagnosed with schizophrenia remain stable enough to be rated as "improved". Small doses, however, produce disabling toxicity.[58]

Following a road accident in 2003, I was kept in an artificial coma to avoid potentially lethal body movement (among other injuries I had sustained a broken neck and twisted spinal cord). For almost three weeks I was "tranquillized" with a combination of anaesthetic and adrenaline, the former to keep my body still and the latter to preserve vital organ function. One result (apart from my survival) was the development of acetyl anti-cholinergic syndrome, a condition affecting one in 2,000 people treated with the same combination of drugs. If we assume possibly a million similar uses of the drugs annually in the UK alone, this amounts to 500 new cases a year. The syndrome mimics a frequent adverse effect of neuroleptics: TD. This describes a group of persistent or permanent movement disorders caused by antipsychotic (neuroleptic) drugs, including Risperdal, Zyprexa, Abilify and Seroquel. Typically, TD produces spasms and twitches of the face, eyelids and tongue, and an unusual gait. Some people will also develop tardive akathisia involving painful internal agitation and unrelenting motion. These symptoms are typical of many institutionalized patients treated with neuroleptics. Peter Breggin suggests that TD indicates motor brain damage, though the circular theorizing common to psychiatry more often suggests that any brain damage is the cause of a particular psychiatric disorder rather than an iatrogenic effect caused by the treatment.[59]

Psychiatrists have reservations about any advantage of so-called atypical neuroleptics over their predecessors. In a review article Emmanuel Stip asks the following questions: "After 50 year of neuroleptic drugs, are we able to answer the following simple questions: Are neuroleptics effective in treating schizophrenia? Is there a difference between atypical and conventional neuroleptics?" He answers: "At this point in time, responsibility and honesty suggest we accept that a large number of our therapeutic tools have yet to be proven effective in treating patients with schizophrenia." He also notes: "One thing is certain: if we wish to base psychiatry on EBM (Evidence Based Medicine), we run the genuine risk of taking a closer look at what has long been considered fact."[60]

One might surmise that *any* research into long-established praxis from psychotherapy to ECT will challenge long-held views. For the academy, whose role it is to publish research that may indeed question the status quo, this is less problematic. For practitioners, however, the possibility that their practice has done more harm than good may lead to disinclination to research preferred methods. A less obvious example may be the work of marriage-guidance counsellors who may see couples in an attempt to sustain a marriage or partnership but soon find that their efforts do nothing to change the divorce rate. Indeed, many such counsellors now prefer to be seen as offering the possibility of amicable separation, a move embraced by the court system, particularly where children are involved (see Chapter 7).

Cohen has analysed flaws and biases in research on typical and atypical neuroleptic medication and suggests that "These flaws raise serious doubts about the scientific justifications for the widespread use of neuroleptics."[61] A further systematic statistical analysis concludes: "There is no clear evidence that atypical antipsychotics are more effective or are better tolerated than conventional antipsychotics."[62]

Finally, in relation to neuroleptic treatment, Harding has challenged one of the most persistent "myths" concerning drug treatment in psychiatry: the common view that *life-long* treatment with psychoactive drugs will be necessary. Her paper presents evidence accumulated across two decades to challenge seven myths in psychiatry about schizophrenia which impinge upon the perception and thus the treatment of patients. These myths maintain the pessimism about outcome and reduce opportunities for improvement or recovery. For Harding, "Myth Number 5 is Patients must be on medication all their lives." She goes on: "Reality: It may be a small percentage who need medication indefinitely . . . Evidence: There are no data existing which support this myth."[63]

As noted in Chapter 3 "depression" is seen by Jackson as "a relative latecomer to the terminology for dejected states".[64] In 1801, David Daniel Davis' translation of Pinel's *Treatise on Insanity* rendered *l'abbattement* as "depression of spirits".[65] Being "depressed" is no longer something that is *done to* the person (i.e. an *oppression*); it is constructed and languaged as an *internal* state. For the majority of English speakers it is the way we might describe our mood. The marketing of depression as a *condition* goes hand in hand with the marketing of a host of treatments, both "psychological" and physical.

The adverse effects of antidepressants have been recorded since their introduction. Tricyclic antidepressants – for example, Tofranil and Elavil – can produce weakness, nervousness, agitation, headaches and vertigo. One tricyclic, Ascendis, is turned into a neuroleptic in the body and can induce tardive dyskinesia, a condition more frequently associated with long-term tranquillizer use in psychiatric institutions.[66] These symptoms may be ascribed to the original complaint – depression. If the drug is seen as the cause, a patient may attempt to stop taking it. Someone *reducing* their use of tricyclic medication, however, can experience the physical effects of dose reduction, including nausea and vomiting, myalgia, headache, fatigue and anxiety.[67] Abrupt withdrawal may induce insomnia, cardiovascular symptoms and "psychotic decompensation".[68]

Paxil, Zoloft and Prozac are all SSRIs marketed as antidepressants. During Prozac's new drug application (NDA) approval phase the official "Safety Review" noted that the "profile of adverse effects more closely resembles that of a stimulant drug . . . ".[69] Adverse effects of SSRIs listed in the BNF include anxiety, sexual dysfunction and suicidal ideation – all concerns that may have led to the original prescription, though positioned as symptoms of "depression" by the prescriber. The mimicry of the original complaint frequently encourages both patient and prescriber to assume the "depression" is still present and the drug regime will be restarted. "Rebound" and delayed withdrawal effects in the case of neuroleptics can take more than six months after finishing a course of psychoactive medication.[70]

DeGrandpre has challenged the marketed idea that SSRIs are better than non-SSRI antidepressants, including those they have come to replace – for example, tricyclics such as Tofranil and Elavil. He suggests that SSRIs have not been clinically proven to be more effective or safer than these older, less expensive antidepressants. Nor do tricyclics pose the risk of severe mental agitation and violence seen with SSRIs.[71]

The concept of "suicidal ideation" is fraught with epistemological difficulty. Seen as an honourable course of action by the ancient Greeks (and one that preserved the right of inheritance for relatives of those accused of major crimes), *thinking* about suicide is now regarded as a sign of mental illness. For centuries the act of suicide was illegal, and for the Church an act that would lead to eternal damnation. Despite these changes, *film* of suicide, particularly among young people, can easily be accessed on the Internet. There is now a discipline – suicidology – specifically devoted to the study of suicide. David Webb, a suicide survivor and ex-member of the board of the World Network of Users and Survivors of Psychiatry (WNUSP), is unusual in wholly rejecting a medical conception of the act, calling instead for a public discussion of suicide as a *public* health issue.[72]

The attribution of suicide to a particular drug can only be seen in a wider context – one that includes the vested interests of both pro- and anti-drug campaigns. The possibility that SSRIs, including Prozac and Paxil, might trigger suicide and other violence in a small percentage of users has been the subject of isolated reports in the major media since they first arrived on the market. Researchers and bloggers have also highlighted the possibility.[73] The concern has, however, been recognized by the federal government. Following actions taken by NICE in the UK, the Food and Drug Administration (FDA) has now recommended that physicians refrain from prescribing Paxil to new patients under 18.

GlaxoSmithKline funded studies of its SSRI Paxil, indicating it was no more effective than placebos in the treatment of so-called childhood depression. The same studies also showed an increased occurrence of emotional disturbance in those taking the drug. The likelihood of a suicide attempt, for example, was about three times as great for Paxil users compared with those taking placebos. Wyeth Pharmaceuticals drew essentially the same conclusions about its SSRI, Effexor, sending out a two-page letter to health-care workers stating it may not be safe for paediatric use. The FDA reanalysed data for Effexor as well as for several other SSRIs, and issued an advisory note citing similar findings for Celexa, Effexor, Prozac and Zoloft. Since then, NICE in the UK banned all but one SSRI from use in children due to evidence of suicidality. This leaves prescribers in the curious position that a drug deemed unsafe while a person is less than 18 years of age is considered "safe" the day after the person's 18th birthday.[74]

Activists such as the Prozac Survivors' Group in the USA emphasize newsworthy examples of SSRI-induced acts of violence. In May 2001, for example, Australian David Hawkins two days after going on Zoloft strangled his wife, then attempted to kill himself. In a similar case, a jury found that Paxil caused 60-year-old Donald Schell to shoot dead his wife, adult daughter, infant granddaughter and himself. Like Hawkins, he had no history of violence of any kind and had been taking the SSRI for only two days.[75] These headlines ignore the fact that millions of people take antidepressants, claim benefit and, importantly, kill neither themselves nor anyone else. Cases such as that of Donald Schell, however, demonstrate that antidepressants do not *prevent* violence to self or others, a finding confirmed when reviewing mass shootings (e.g. the shooting at Columbine in the USA) where *all* the killers have been shown to be taking psychiatric medication.

DeGrandpre notes that "These and other civil actions have given plaintiffs' lawyers access to private company archives, wherein they have found a wide variety of unpublished studies, including many from the 1980s, confirming a link between SSRIs, agitation and violence." A study conducted by Pfizer, for example, found that "many healthy female volunteers given either Zoloft or a placebo began complaining of problems of agitation and apprehension. Twenty-five per cent of individuals – *all GSK employees* – experienced agitation after taking Paxil" (my emphasis).[76]

A recent meta-analytic study attempted to assess the risk of deliberate self-harm by antidepressant dose, by age group. Drawing data on health-care use of over 162,000 American children and adults prescribed SSRIs at modal or higher than modal doses from 1 January 1998 to 31 December 2010, the researchers found that "The rate of deliberate self-harm among children and adults 24 years of age or younger who initiated high-dose therapy was approximately twice as high as among matched patients initiating modal-dose therapy."[77]

This section has examined some of the reasons why people may wish to stop taking psychiatric medication. The abundance of information about adverse effects, and public and professional campaigns exposing suspected fraudulence and deceit in drug research and promotion in combination with experience of adverse effects, may add to the desire to withdraw. The next section will explore the difficulties around withdrawal – difficulties that can be compared to stopping taking any addictive substance.

Withdrawal

Imagine your first day in the "Tobacco addiction withdrawal unit". It has been situated five miles from the nearest village. The one store doesn't sell tobacco products but is adjacent to a bus stop. The bus runs into a much larger town three times weekly. Some patients have made the journey and the unit now has a secreted supply of loose tobacco and cigarettes. Your first fears are allayed but you are determined not to return to your habit. The first day isn't so bad: there are discussion groups, and a couple of ex-residents come in to tell of their success. The programme is described: daily discussion groups, two lectures a week from experts describing the physiological nature of addiction, and a "buddy system" whereby you will be assigned a fellow addict to help you through the rough times. There is also an introduction to the "holding room". Here, patients are gently held by staff if they have indicated they are desperate to go into town and buy tobacco. You are informed that in extreme cases of withdrawal the door to the holding room will be locked but a small window will allow you to be observed in case your "self-harm" escalates into something more dramatic (the information leaflet describes smoking as "self-harm").

During a meeting in the morning of your second day, a fellow patient announces he is "quitting *quitting*". This is his second time in the unit after years of failed attempts to stop smoking without help. He snorts, "It's not as if it's illegal!" and gets up to leave the group. Two staff firmly lead him to the holding room. That evening the secret hoard seems to beckon but you hold your nerve and wake up with a clear head – the first for months – early in the morning of day three. You have been advised that day three is the worst: if you can get through day three you are on the way. Admissions are organized so that the third day of residency is a Sunday: there are no buses on Sundays.

The following day you volunteer to walk to the store to buy some cakes, and the unit doctor says he will give you a ride at midday. His car smells of tobacco. You notice the tell-tale sign of a veteran smoker in his brown-stained index finger. At the store your doubts increase: "What harm would one cigarette do? You can always take the bus and buy a packet as a stand-by." Cakes in hand, you pay and leave the store just in time to see the doctor's car disappearing in the direction of town. At that moment the bus pulls up . . .

Any drug – tobacco, caffeine, legal and illicit psychotropics – has addictive potential. For many, that potential is realized in the effects of the compound and in the experience of community shared by other addicts. The embodied experience of drug-taking – talking about it, ingesting, feeling high or calmer – are in part the outcome of a presumed neurochemical physical dependence. As noted above, the addictive nature of laudanum, barbiturates, morphine and many other compounds has led to their proscription or legal controls necessitating either criminal activity or the input of a physician.

Anxiolytics, sedatives, antidepressants and prescribed stimulants are no less addictive than their illicit counterparts; the popularity of groups such as Narc-anon attests to the desire on the part of users to reduce or cease their addictive conduct. The range of ways people stop taking medication is as varied as the contexts that have brought about their addiction. Growing up in families where a parent takes antidepressants is just as likely to lead to a person abjuring the drugs as taking them; pregnancy may lead to taking psychotropics or stopping them for life; physical harm may introduce a person to the benefits of analgesics, only for the "addiction" to cease the moment the person is prescribed a less powerful pain-killer. The film *Trainspotting* offers one account of an addict withdrawing from heroin. The scene involves "excruciating" pain, hallucinations and physical craving that leads to the addict begging his parents to find some of the drug for him. He is locked into his bedroom until the worst of these experiences abates. Withdrawal from prescribed medication can mimic these experiences or appear less threatening.

Psy professionals usually suggest prescribed drugs should not be simply stopped; instead, "advice from a physician" and a guided withdrawal programme is promoted. This requires the availability of other resources – a "safe" environment, support from fellow addicts and an individually tailored regime – that may not be close at hand. The programme necessitates willingness on the part of the physician to change or reduce the medication and an acknowledgment that they have been an integral part – as the previous prescriber – of the addiction process. Prescribers must also acknowledge the harmful potential of their principle means of delivering "health care" – that is, medication.

A person attempting to stop taking prescribed drugs knows that at some point he or she will face the world without using the medication. The particular ways medication is used can make this challenging – long-term tranquillizer use may be intermittent or used in particular situations – "mother's little helpers". Studies have shown that Valium, for example, might be taken *in anticipation of anxiety* rather than when experiencing feelings of fear in any given context.[78] In a context where both participants in the transaction realize that there will have been a considerable number of life events following the cessation of drug use, it is unsurprising if both patient and prescriber ascribe a renewal of symptoms to a resurgence of the "disorder" rather than drug-withdrawal effects.

I have attempted to account here for why patients might want to stop taking medication and why they might recommence. For those in a context where drug withdrawal seems possible, certain resources need to be made available. *Caring* physical environments similar to that in the fictitious *Trainspotting* can be found in a small number of service-user-run establishments. A friend regularly admits himself to a local psychiatric unit for drug withdrawal, though pressure on bed space means that delayed withdrawal effects are still to be faced on discharge. For the majority, however, withdrawal will be tried in the *same* context the person has experienced during addiction. This may be a relatively caring family home or shared accommodation, but is just as likely to be an environment where to some extent the person's tranquillized state has suited all concerned. The example of John Bailey coping with his Alzheimic wife's wandering and tantrums through the administration of a neuroleptic (see Chapter 1) may be representative of a struggle faced by millions of otherwise caring relatives every day.

Peter Lehmann has edited an account of people withdrawing from psychiatric drugs. Some have the benefit of a change of physical context. Others recount life changes and adverse effects that necessitated withdrawal, however arduous and painful. Although it is possible to broadly categorize the different paths to withdrawal, the accounts remain highly individual and specific.[79] The literature on withdrawal continues to grow: the number of websites as well as printed text on withdrawal remains dwarfed by the number of positive accounts of psychiatric drug use, but the willingness of publishers to publicize withdrawal literature indicates a growing market.[80]

In summary, a history of drug use must acknowledge very early efforts to reduce pain, increase performance or change consciousness. Since the end of the nineteenth century, governments have attempted to limit the dangers posed by drug use (e.g. the "gin laws" of the early twentieth century or the criminalization of public smoking in the twenty first) while legislating the use of psychoactive medication marketed by pharmaceutical companies, self-branded as "ethicals" for over a century. Such legislation has failed to prevent adverse effects (including death) among patients and has led to exponential growth in litigation, while the popular press continues to offer a narrative of increasing effectiveness for new treatments for overwhelm, fear and madness.

The unique nature of the individual human metabolism makes any drug ingestion an experiment. As such, informed consent is difficult to achieve, and any use of prescribed drugs by psy professionals may be positioned as "invasion without consent".[81] This is most obvious in the use of PRN medication to calm patients on psychiatric wards but is equally true of the daily prescription of psychoactive medication by physicians.

The town layout is unfamiliar, though any number of stores are in the ubiquitous chains (a new McDonald's is said to open every three days somewhere in the world). There are a few money-stores, a dozen charity outlets and numerous banks, the frequency only matched by cafés. A store assistant is smoking outside her workplace. After a few pleasantries about being a "fellow leper", she directs you to the town's only tobacconist. As you approach, calm descends – all suddenly feels well. Inside you consider buying a stash of supplies for the unit but instead settle for one pouch of your favourite tobacco – filter cigarettes are too dry and give you a headache. You recall that tobacco is imported by weight: the weight of 20 filter-tips is minimal but they still retail at the same price as ten far heavier cigarillos made up of only the precious weed...

Outside a nearby café you realize you have no cigarette papers. It doesn't take long before a fellow outcast sits down and pulls a tobacco packet from his pocket – along with some papers. You ask for one and, in time-honoured fashion, he hands you a couple before offering to roll a cigarette too. The banning of smoking has reforged a community – oppressed by governments and now the subject of legitimized ostracism and devaluation from complete strangers. You take the smoke into your lungs and immediately feel what? Slightly dizzy, slightly ashamed, back in the world of the outcast – but vindicated . . .

The ubiquity of drug prescription and the competitiveness in the marketplace increases public suspicion that the vested interests and infiltration or sponsorship at the distal level of research and publication has a direct impact at the proximal level of the medical consultation. There are continuing attempts by the industry, psy professionals and government to alter public perception, compensate for harm and promote adjuncts and alternatives to medication. Chapter 7 examines one particular alternative, psychological therapy, and suggests the praxis is also based on untestable theory, again masking the vested interest of practitioners and, in many cases, constituting another "wound" to recipients.

Contextual note

Drugs taken during the composition of this chapter included Warfarin, caffeine, minimal amounts of white wine and about 80 cigarillos: "Petit: Fine Sumatra, 100% tobacco" by E. NOBEL of the Scandanavian Tobacco Group. Music included Chick Corea, Van Morrison, J.S. Bach's Sacred cantatas for soprano, nos, 51, 52, 84 and 199, Ravel's "Gaspard de la nuit" and – again – Frank Zappa's "Make a jazz noise here".

7

A Mouthful of Air: Talking Therapies and the Emperor's New Clothes

"This is not only the best book on counselling and therapy which I have ever read but it's the only one of which I have read every word."[1] Happy Xmas, Love Dorothy.[2]

This chapter (the first words of the title taken from a volume by Anthony Burgess[3]) examines the claims and counterclaims made for the benefits of psychotherapy. The psychotherapy project is clothed, variously, in mysticism, magic, untestable hypotheses, all-pervasive individualism and questionable praxis. It has adherents worldwide and has been subject to approbation, the support of governments, and critique from within and outside the professional domain.

The next section begins by briefly describing some historiographical challenges before giving an account of a reading of one historical perspective on psychotherapy.

History

History is written by the winners. For much of the past only winners *could* write. A cave in southern France may show markings representing the pursuit of mammoths, but there is no accompanying text. Brilliant though Caesar's *Conquest of Gaul* may be, few, if any, of the legionaries on the eight-year-long campaign could have read it. In any case the seven volumes were neither written nor published until the episode's penultimate year, by which time many eyewitnesses were dead.[4] Similarly, at the time the predominantly French-speaking court of Richard the Lionheart held sway in England, laws were published in Latin or French, and literacy was limited to the court and cloister. Further, historians have the task of translating documents from, for example, Latin or – in the case of Cathar scholars – medieval Occitan, a language studied in universities but rarely spoken.[5] An advantage may be the immense detail to be found in official records; countered by the disadvantage that there is no way to confirm accounts, a problem now faced by oral historians. French schoolchildren of the mid-nineteenth century were, for example, taught that Napoleon won the Battle of Waterloo. With restricted communication beyond local village schools, generations were dependent on hearsay – much as historians struggle to confirm such an account of French history despite the availability of contemporary texts. French schoolteachers may have been *instructed* (according to official records) to teach a particular version of events, but we can't know if they followed these instructions; perhaps, like modern teachers, they were more concerned with controlling unruly classes.

An historian's task is complicated by the Web. Conflicting accounts on Twitter or Internet blogs bedevil an accurate reading of events. The *present* is currently written by winners – whether journalists, government spokespersons or members of the public keying in idiosyncratic accounts. Data can be distorted, falsified, invented or disguised to service agendas invisible to the reader.

Psy historians may offer accounts of heroic endeavour, a gradual success in the search for truth and descriptions of painstaking research to verify theories of powerful ideologues. Much of this fulfils scientistic and professional agendas. Critical accounts examine the pattern within such histories to discern possible readings beyond those presented. Typically a pattern might be theorization, research, refutation and effort towards a new praxis. For integrative therapies, this will involve dismissing "flawed" research and consequent results, then drawing "successful" aspects of praxis into an integrative whole. The impact of the *zeitgeist* is ignored in order to present integrative work as going beyond the cultural and historical context of the researchers. Thus "Western" and "Eastern" scientific and spiritual mythologies meet with little acknowledgement that the former developed in a post-industrial landscape involving a measurable individual self and Judaeo-Christian ethos, while the latter developed in a world of gods and emperors.

Forming psy

Three early nineteenth-century German figures can perhaps be considered the major theoreticians preceding the development of a form of Romantic psychiatry and German thought on psychotherapeutic praxis and attempts to cure the mad.[6] These thinkers eventually led to the establishment of an influential German psychiatric tradition involving Freud, Jung, Kraepelin, Jaspers and Binswanger.

Reil published *Rhapsodien űber die Anwendung der psychischen Curmethode auf Geisteszerrűttungen* (Rhapsodies about the Application of Psychotherapy to Major Disturbances) in 1803. Pre-dating 2014's British Psychological Society statement on psychosis[7] by over 200 years, Reil's volume similarly implicates physical factors in mental illness but as an effect rather than a cause, the brain curable by *psychological* change. Integral to Reil's proposition was consciousness as the highest manifestation of *lebenskraft* or "life-force". For Reil, madness was a disruption in consciousness, internal disruptions reflecting the unnatural conditions of modern life. Although not specifically citing Reil, the general idea of disruption to the "soul" or spirit of industrialized workers is to be found in the later work of Marx and Engels on capital, and Weber on alienation. For late twentieth-century psy theorists, echoes of Reil can be found in the equally disruptive impact of (*un*)-employment, relative poverty and – for the wealthy – ennui. Like Reil, numerous contemporary commentators urge a "return to nature" (an essentially Romantic view) for everything from disruptive modern family life to "me-time" or "quality time" for harassed parents and their children.

Reil's proposed methods were, however, not as humanitarian as the theory might suggest. As Dorner has remarked, the methods were not based on any experience of the mad, nor did they fall short of "non-injurious" torture. Reil's suggestions for re-establishing the rational synthesis of consciousness involve a kind of short, sharp shock to the system of the unbalanced individual. Pulled high via a hoist, the patient was to be threatened with hot irons, experience cannon fire nearby or be hurled into "raging torrents".[8] As *proposals* for treatment methods, the "megalomaniac Gothic fantasy"[9] of Reil established a tradition of psychological theorizing about madness rather than a practical solution. Nor were the proposals exclusively extreme and they included "anticipations of psychodrama and sex therapy".[10]

Heinroth's *Lehrbuch der Störungen des Seelenlebens* (which Richards renders as Textbook of Disorders of the Soul) appeared in 1818. His system stresses madness having its source in sin and seems to predict Freud's tripartite division of the mind; the id, ego and superego are anticipated via the hedonistic/instinctual, central ego and conscience levels. The system uses an orthodox religious framework wherein submission to the demands of conscience lead to "the sole path to God".[11] However subtle the psychological structure of Heinroth's theorizing, therapeutic praxis remained at the level of establishing dominance over the mad person.

Nor were his theories based on experience of the mad in asylums – prior to 1818 he had worked only in prisons and orphanages.

Generalized categories of therapeutic praxis are shown to be something of a mixed bag. Just as we have no way of knowing how "humane" a modern humanist therapist might be, the "moral therapist" Francis Willis established a repertoire of treatment methods displaying a "mingled sense of desperation and sadism".[12] Therapeutic techniques included the cold douche, the spinning chair, immersion in tubs of live eels and whipping with nettles.

Twenty-first century dilemmas in psychology and psychotherapy – the importance of will, the centrality versus consequentiality of nature and nurture, the significance or otherwise of environment to unreason – much preoccupied German thinkers in the early 1800s. These debates formed the context for the rise in popularity of Freudian notions at the end of the century. Kant, for example, had suggested that the nature of the soul is rationally unknowable as – beyond the assertion, "I think" – the essence of "I" cannot be found. Although sensory experience is the basis for knowledge, processing of that experience follows *a priori* principles that do not themselves derive from experience – for example, time, space and causation. The world we experience – the phenomenal world – is constituted by our mind; the world as it is "in itself" is beyond the grasp of reason.

The mind's operations are here considered to be of three kinds: knowing, willing and feeling. These categories – again a tripartite system – were fundamental to later systems structuring the mind – for example, Freud's id, ego and superego; Berne's adult-parent-child; and the system of thought, behaviour and action vital to CBT. A recurring problem for psy is that any system of mind can *only* be theoretical. The idea, for example, that thoughts can influence feelings remains only an idea, despite its popularity with psy practitioners from CBT to dialectical behaviour therapy (DBT) via cognitive analytic therapists.

Thomas Szasz prefers to trace the origins of counselling to Martin Luther's "cure of souls".[13] This reading links therapy to religion, placing it in the realm of pastors and their flock mutually in awe of an invisible G-d. More recent commentators have expanded the metaphor, discovering any number of invisible processes – love, catharsis through the interpretation of unconscious drives, healing, "body-work", cognitive restructuring and reframing, witnessing – as the key ingredients to relief of suffering. Prayer, still practised by some religious counsellors, has – in the main – been replaced by prompts to freely associate, regress, keep thought diaries and much more besides. This reading would see counsellors and therapists as a priest class; the high priests and rabbis are now the originators of psychological therapy (Freud, Jung, Maslow, Beck, Rogers, Haley, etc.) and their acolytes. The latter promote therapy as art, science and relationship, adding to the profits of publishers and universities as the Lutheran pastors once did to the coffers of their church.

Szasz's reading places counselling in the professional domain. For thousands of years, however, people have turned to neighbours, friends and family for support and succour. As theories have placed the blame for suffering onto the shoulders of family members, those people with few friends or respectful neighbours have turned to psy professionals. For others, wealthy enough to seek out private psychoanalysis, the faith in individualism and interiority leads them into a world of constant self-examination, in particular a part of the self – the unconscious – only accessible to expert interpretation. The next sections explore in more detail the origins of professional psychotherapy.

Massaging the European mind

Freud's analytic method included massage of the patient's temples, though subsequent developments in the Freudian school shifted the therapeutic hour to the more commonly proselytized "blank screen" analytic stance. Here patients lay on a couch and spoke as freely as possible while the analyst sat behind offering the occasional interpretation. The extent to which analytic therapists followed this method is unknown.[14] Certainly analysts such as Ferenczi eventually developed an approach wherein patients were quite literally held, and in some cases kissed.

Freud's correspondence suggests a figure neither a blank screen nor concerned about revealing strong opinion. The correspondence describes fractures in the early stages of the Viennese Analytic Society and its leader's opinions about colleagues.

In a letter to Jung dated 19 December 1909, Freud describes Ferenczi as "trustworthy, superior" and an, "absolutely authentic man".[15] Honegger, too, made a, "splendid impression", though Stekel's approach is described as "brutal".[16] By April 1910, Freud is describing Modena as "a swarthy Judaeo-Italian".[17] In response, Jung notes that Isserlin has "a twisted mind".[18]

Honegger was soon to kill himself with a morphine overdose in March 1911, an action Jung ascribes to a wish to avoid military service. He suggests Honegger "did not want to give up living in accordance with the pleasure principle".[19] Honegger's was one of several suicides among the early analytic group. Victor Tausk, for example, previously a journalist and lawyer, finished medical school in 1914 and killed himself five years later.[20]

In a further letter of November 1910, Jung accuses Bleuler, Stekel and Adler of trying to "squeeze the flexible and fruitful psychological approach into the crude schematism of a physical and biological straitjacket".[21] Freud's response to Jung compares Bleuler to Fleiss: "The same paranoia."[22]

The ambitions of Bleuler and others find some resonance in recent research attempting to show that therapy produces brain changes.[23] One interpretation of this ongoing drive to link psychotherapy and psychological methods to real physical changes in the brain is the way such a link, if ever discovered, would remove psychotherapy from the world of metaphor and relationship, and place it firmly in the realm of natural science.

Within two years of Jung's concerns about Bleuler, Stekel and Adler being expressed (albeit in *private* correspondence), Ernest Jones had been pulled into the fray. He concludes that Bleuler, Stekel and Adler are "thorny people".[24] Freud had previously written to Jones describing Adler's behaviour as "malicious".[25] Sociohistorians might search Freud's voluminous correspondence in order to divine any number of "patterns" to justify any given thesis about Freud the man or the state of disharmony among his followers, friends and would-be detractors. One conclusion might be that relationships between Freud and friends frequently soured, often over points of theory or practice. Here, variations and splits lead to the establishment of "post-Freudian" schools developed by, among others, Adler and Jung.

In the case of Jones, early respect seems to have turned to something bordering on adulation. The Freud–Jones correspondence is marked by a rapid shift from Jones signing off "Yours sincerely" (13 May 1908) to "Yours ever" (6 June 1909), "With warmest regards" (5 August 1909), "Yours ever" (12 February 1910), "Yours always" (1 January 1911) and "Yours always affectionately" (6 November 1912). This last concludes a letter discussing snake symbolism, the interpretation of a copied patient's sketch as "nates" (buttocks) and another sketch supposedly of a finger but more closely resembling a penis and testicles.[26] Freud's reaction in his *immediate* response is to sign off "Yours in love".[27]

This mutual appreciation could be read as seduction, grooming or a form of politesse wherein the respondent is obliged to match the sender's text. Over some 31 years the ways in which the two men signed their correspondence rarely deviate from the affectionate. There is a hint of competition in these letters too, Jones at one point responding: "Yours always devotedly"[28] to a letter Freud signs "Yours affectionately".[29] Or perhaps the whole show is a mischievous charade drawing the expected historian into speculation about the latent homosexuality in both men – latent and suppressed homosexuality is ascribed to *other analysts* throughout the correspondence.

Jones' view of Freud is clearest in a letter of August 1912 where he relates a discussion with Ferenczi. The two had talked about a few men being analysed by Freud "to guard the kingdom and policy of the master . . . ".[30]

By then, Freud had already "conquered" the doctors of the mind in the USA; the kingdom was on the way to becoming an empire. He had been accompanied by Jung and Ferenczi following an invitation to speak at Clark College in Massachusetts in 1909. William James had greeted Freud thus: "Yours is the psychology of the future." Within six years, "psychoanalysis had eclipsed all other psychotherapies in the nation's magazines".[31] The next section explores some of the context underpinning this success.

Managing the American mind

In the early 1980s a possibly apocryphal story was doing the rounds in Boston. It was said that a certain New York psychoanalyst had become hysterically deaf (his own analyst was said to be quietly baffled). The psychoanalyst continued to see patients who lay on the couch and freely associated. He heard nothing. He eventually informed his analysands that he couldn't hear them. A dozen continued their analysis with him. The story was used variously to illustrate the gullibility of patients, the importance of the "holding" environment, the value of committed and honest relationships, the power of financially disciplinary contracts and the benefit of unanalysed transference. For some the tale demonstrated the importance of taking an hour a day to lie down and talk to oneself. The history of the analytic invasion of the USA reveals something of how modern America is dominated by psychotherapy and its ideas.

Chapbooks dispensing advice had been produced in their millions in England for a century or more. By the mid-1850s the US middle classes were purchasing advice manuals in huge numbers. These promoted "self-discipline, thrift, hard work, cleanliness and religious instruction".[32] In the secular twentieth century the ideal of moral character was replaced by a version of pleasure and achievement-focused individualism where "self-help" books (the majority of which are remaindered by publishers and line the shelves of charity shops) instead promote “overcoming” challenges such as “depression”, “anxiety” and obesity. Again psy expertise holds sway and quite trivial notions such as “face your fears” and “eat less” are presented as complicated routines with the gloss of science. The ordinary, unworried parent is regaled with disciplining advice from child-rearing manuals, psy experts, the Internet, and government-sponsored leaflets and programmes. Appeals are made to the notion of child development, sociability, educability and potential contribution to the workforce.

Mesmerism was a dominant force in European intellectual and psy professional life in the early nineteenth century. Claiming an essentially mystical and relational technique as a science was a move bringing mesmerism in line with the growing popularity (and saleability) of “science”. The doctrine, as originally espoused, had direct links to astrology – the human being was a magnet, the aim of mesmerism being to align patients with the cosmic flow of animal magnetism. Mesmer’s ideas had rapidly developed in France in the late eighteenth century, with variants on the theory soon incorporating electricity rather than magnetism. Two facets of this history stand out: (1) Like any untestable and unprovable psy theory, praxis resulting from that theory will change, develop and *survive* a long time (despite its relegation to the status of “interesting historical artefact”, forms of mesmerism – for example, hypnotism – are still practised over 200 years later; even the purer form lasted some 70 years); and (2) psy theories do not *need* the usual proofs of science for their popularity. All that is required is the *claim* that they are “evidence-based” (see section on research below).[33]

Mesmerism arrived in the USA in 1836. Poyen, a follower of Mesmer, found people suffering from listlessness, physical weakness and moral confusion. According to some historians, these were socially induced symptoms brought about by urbanization and industrialization. For others the symptoms have all the marks of the much later (1890s) diagnosis of hysteria, a constructionist reading of which might posit that the classic symptoms of hysteria (a condition confined almost exclusively to middle-class women) flowered in a patriarchal and repressive climate wherein men dominated political and sexual discourse; universal suffrage was still many years away. Poyen’s technique developed a “characteristic American cast” featuring optimism and pragmatism.[34] Hypnotism featuring spiritualism was a key feature of the technique. Added to a claim to be a scientific technology, the practice of mesmerism blossomed, forming the root of many psychotherapeutic techniques that continue to link the physical to the spiritual via an “expert” (e.g. so called New Age therapies, trance therapies, movement therapies and compassion-focused therapy).

At the University of Pennsylvania in 1896, Lightner Witmer established the first psychology clinic, predominantly an academic setting. The first case was a child with an academic difficulty.[35] The first US psychoanalytic clinic for adults was created by Austen Riggs at Stockbridge, Massachusetts, in 1919, soon changing its name to the Austen Riggs Center. After the appointment in 1947 of Robert Knight as medical director, its staff included David Rapaport and Erik Erikson.[36] Psychoanalytic training institutes in the USA formed in the 1930s in Chicago (1932), Baltimore-Washington and Boston (1933), New York (1940) and San Francisco (1942).[37] By 1990 in California alone there were around "10,000 psychologists, 6,500 psychiatrists, 11,000 clinical social workers and 19,000 marriage, family and child therapists".[38]

By 1912, psychologists William James and Adolf Meyer had taken control of the Mental Hygiene Movement started by Clifford Beers, a former psychiatric inmate, a few years earlier. The movement, federally funded, emphasized quantification, objectification and cleanliness as applied to emotional complaints. It was to become a force in psychiatric hospital reform and preventive education. Psychoanalysis was to be used by the middle classes to purge unclean desires and thoughts, while religious judgements on social deviance were to be replaced by scientific facts. No longer undesirable or bad, deviants were to be administered to by state-employed mental hygienists. In effect, deviants were assailed by ills beyond their control, just as a person might develop cancer and be "treated" via objectifying assessments and therapy or medication. This "scientific" approach meant that therapeutic input could be costed and quantified, a vital feature of capitalist endeavour.[39]

Freud's nephew, Edward Bernays, became a leading light in public relations, while Brill, an analyst, developed advertising to encourage women to smoke. Eventually tobacco advertisements incorporated appeals to "manliness" (via, for example, campaigns featuring Steve McQueen) and the popular trope "health" (via campaigns featuring John Wayne looking healthily active with cigarette in hand). Now *anti*-smoking campaigns use the same trope, emphasizing dangers such as heart disease, cancer and impotence.[40]

Psychologists from the behaviourist wing were soon joining their analytic colleagues. Less than ten years after his election as president of the American Psychological Association in 1915, John Watson was vice president of a major advertising agency. An industrial psychologist, Walter Scott, president of the APA in 1919, advised that industry should – through psychological testing – attempt to fit the person to the job. Despite its lack of reliability and validity, the Myers–Briggs test is still a popular tool for companies hoping to employ the "right" manager, lecturer or other professional. The triumph of the therapeutic has become the triumph of psy in all its manifestations.[41]

Managing the self

The modern self is configured for some commentators (e.g. Foucault) by socioeconomic structures. As feudalism gave way to capitalist enterprise, previous serfs were disconnected from their communities, religious ties loosened and the "working class" formed. It was a grouping to be exploited and controlled to sustain social order and profit. Foucault traces the development of this new self – the individual – by reference to the nature of criminal punishment.[42] No longer were selves under the absolute control of the monarchy, to be publically punished in order to demonstrate that control, but under the control of the state. In theory free, the emerging individuals were confused about right and wrong, and ambivalent concerning personal pleasure versus duty. First philosophers and then social "experts" developed means to regulate and control the citizenry, a citizenry where men were the primary work and military force, and women a domestic equivalent to be controlled through marriage and the patriarchy of family life. Experts were on hand to count, observe and predict the behaviour of potentially unruly individuals, now "free" to choose satisfaction through indolence rather than productivity. It is no accident that the first major theories of the emergent discipline of psychology concerned crowd (potentially revolutionary) behaviour and riot control.

Descartes, Locke and others contributed to an intellectual discourse which constructed a self that was self-conscious, observing and judging itself, and preoccupied with the individual's place in the family and society. Bentham designed a new form of prison – the Panopticon – emblematic of the modern self. Here, guards could continually observe the prisoners but the prisoners – who knew of the arrangement – could not see the guards. The prisoners rapidly developed a tolerance for being observed and increasing pressure to be "normal" by practising self-observation and self-discipline. It is a short step from this to existential crises of the twenty-first-century self, worries about being a good-enough parent or spouse, and the "homework diaries" representative of obsessive self-examination in CBT. The popular conception that psychologists are expert in "seeing into" the minds and conduct of others is matched by the psy survivor movement's emphasis on "expertise through experience". In both cases the "expert" trope is used to garner cultural capital. In both cases it is hope rather than fulfilment that pervades the *zeitgeist*. Support for the dominance of psy expertise might be evidenced by reference to French and Raven's conception of "expert power". Support for the dominance of "expert by experience" discourse might be evidenced by reference to "referent power".[43] The increasing popularity of the latter form of expertise might be explained by reference to Foucault's earlier point about the loss of community: in a world where individualism holds sway, meeting others oppressed by the authority of psy offers the opportunity to stand alongside those others even where the lived experience of any given person is, by definition, unique.

In summary, theories of tripartite divisions of the mind led to conceptions of an individualized and internalized soul subject to examination, control and change. First in Europe, then in the USA, psychoanalysis and other forms of psy have come to dominate the discourse of therapeutics and a politics of individual liberation encompassing workers, the unemployed, families and communities.

The following sections will critique the psychotherapy industry in several ways: as an adjunctive enterprise to medicalized psy and Big Pharma; as an industry based on untestable – scientistic – theories; as part of a government-supported enterprise with the aim of individualizing distress and reinterpreting oppression as depression (thus suppressing dissent); and, in Wolfensberger's terms, part of a wounding praxis wherein people are blamed for what ails them, frequently leading to labelling and further marks of entry into more obviously harmful aspects of the psy complex. None of what follows will be unfamiliar to critics of psychotherapy and counselling, now, themselves, part of an industry either promoting alternative approaches (e.g. community psychology) or presenting a sociological overview of the scene.

Critiquing psychotherapy: Shooting fish in a barrel

Cushman suggests that the "discovery" of the unconscious not only entered therapeutic praxis and opened up opportunities for industries such as advertising and entertainment (for some, the *same* industry) but also became a tool for government. Unconscious motivations could be used to sell sex, food and cars. Government propaganda could utilize unconscious fears to promote military agendas (including now anti-terrorism measures) or unconscious sibling rivalry to sway voters between candidates. More recent political campaigning in the UK may seem to be *generated* by unconscious factors in male-dominated public relations firms who projected images of the beer-drinking Nigel Farage of the UK Independence Party or man-of-the-people David Cameron pictured, Guinness in hand, down the pub. It is hard to see *which* members of the electorate these images appeal to in a culture of increasing intolerance to alcohol, with younger and female voters less likely to be swayed by photographs of middle-aged ex-public schoolboys having a good time.

Although counselling and psychotherapy are promoted at every turn within the media, systematic critiques of psychotherapy and counselling might be positioned as the general versus the specific. For some, counselling is positioned within a personal and moral frame; seeking solace through talk reveals a "lack of backbone" in the distressed person or an exploitation of misery by the psy professional. Some editors of sports pages in national newspapers take a different tack by promoting psy theorizing. Here, sports commentators claim that players lack "confidence" rather than competence, or in increasing numbers are suffering from diagnosable distress. Attendance at health spas or alcohol recovery units is ubiquitous for sports professionals; sportsmen who publically display emotion through tears are now applauded (by the press) for their humanity rather than vilified for their "weakness". Disapproval of public emotional display has subtly shifted to approbation, and it is "better" to wear one's heart on one's sleeve than cover up. The moral high ground is now held by sportsmen who show their ("female") feeling side and sportswomen who reveal their ("male") competitiveness.

These turns in the general critical position on selfhood and counselling are matched by critiques of specific elements in the field. Theory and practice, for example, have been shown to be based on untestable notions (e.g. transference or self-actualization), or inapplicable due to the uniqueness and non-generalizability of relationships, whether they be contractual, as in therapy or marriage, or haphazard encounters within families or work. Leading theorists have been shown to be inconsistent, flawed (from an idealistic perspective) in their own relationships or, in some cases, abusive in their practice. Therapeutic praxis since the mid-nineteenth century has been questioned on the grounds it ignores numerous factors over which the therapist has no control – for example, the environment, employment, and the financial and physical context of the patient's life. For some critics the much repeated finding that those who benefit most from talking therapies – the young, articulate, verbal, intelligent and single – has given rise to the suggestion that people benefiting most from the approach are those who need it least.

Research has been criticized for its essentially medical nature (comparing one treatment with another, much as medications are compared for effectiveness in physical disease – the "illness" metaphor) and for its support of the disease model with an uncritical approach to psychiatric diagnostic terminology. The approach ensures publication for researchers, thus increasing their cultural capital while simultaneously reinforcing the promotion of medical jargon – "disorder", "psychosis" and so forth – thus maintaining the mystification of distress via the use of invalid and unreliable constructs. Mary Boyle has suggested that this simple repetition – in journals, books and mass media – establishes, for the reader, the "reality" of depression, schizophrenia and related terms *as valid descriptions* of disease processes.[44] Authors, researchers and commentators might be regarded as *calling into existence* illnesses that are actually metaphoric constructions. Research has similarly been criticized for its scientism. Sample sizes when compared with research in other areas of medicine are small, populations frequently self-selecting and the subject under observation – the therapeutic method – impossible to replicate as therapists within trials cannot be consistent across time or patients. These criticisms match the form and codes of their subject matter rather than questioning the *possibility* of researching people. This position is summarized by Richards thus: "Forms of liberation are necessarily conditioned by those of oppression."[45]

Research has also been questioned due to the hidden assumptions behind questionnaires or less formal means of assessing "outcome". It is assumed, for example, that patients have some way of accessing internal thoughts and feelings that can then be relayed to the therapist during conversations or be utilized when completing questionnaires. It is – generally – assumed that patients will be honest, both during therapy and during attempts to assess therapeutic "outcome". Many studies utilize therapist assessments of therapeutic impact. Again, honesty is assumed, and possible influences such as vested interest (financial or otherwise) in positive results are ignored. Despite this, it is well known that psychotherapeutic journals *rarely* publish negative results though contextualizing passages in written reports frequently refer to *previous* negative results in order to maintain the notion of "progress" in therapeutic endeavour.

The critics

In a recent volume, Colin Feltham critically examines counselling psychology (a term embracing psychotherapy and counselling) in chapters devoted to theory, practice, research, counselling as profession and some 20 pages on the discipline's key figures.[46] Referring briefly to the "controversial" Wilhelm Reich and the arrogance of Janov, Feltham goes on to focus on Rogers, Perls and Berne as progenitors of the most widely accepted counselling approaches that are typically taught on "integrative" courses.[47]

Feltham highlights the cultural contexts of early figures – Austria, Germany and Switzerland for late nineteenth-century analysts, Freud's Jewish background, the way psychoanalysis holds sway on the east coast of the USA while the humanist movement dominates the west, and the fact that most of the founders were white males. Quoting Livingstone Smith, he reminds the reader that "unethical breaches of boundaries and confidentiality" are not "uncommon" in the counselling profession, and those hoping to find a way out of suicidal feelings via therapy might be informed that during the life of Freud's Vienna Psychoanalytic Society (1902–1938), 9 of its 149 members killed themselves, a proportion some 20 times as large as the norm.[48]

It is some 25 years since Jeffrey Masson achieved lasting notoriety through the publication of *Against Therapy*.[49] Already despised by the orthodox Freudian community for his previous bestselling exposé, *The Assault on Truth*,[50] he now set about the founders of other psychotherapeutic schools. Some of his targets, such as John Rosen, an American psychiatrist specializing in assaults masquerading as therapy on people diagnosed as schizophrenic, were not well known, certainly in the UK, though Rosen did publish a critically acclaimed book about his methods.[51] Other targets, such as Jung and Rogers, were renowned leaders in their field, with thousands of professional acolytes and millions who knew their names, if not their theories.

Masson tends, in *Against Therapy*, to offer evidence against the major thinkers in psychotherapy, marking them as flawed, sometimes corrupt, individuals. For example, Jung he reveals as having altered his theories *post hoc* in order to continue living under the Nazi regime.[52] A similar technique has been used against Masson himself: Malcolm's *In the Freud Archives* portrays the ex-director of the archives as narcissistic and overly proud of his numerous sexual encounters. While acknowledging the gritty determinedness and academic integrity of Masson's oeuvre, the reader's doubts are raised by the account's references to his character rather than any flaw in his methods.[53]

A Sanskrit scholar, Masson learnt German in order to read Freud in the original before embarking on his dogged critique. His approach to Carl Rogers required only English and was just as thorough noting along the way that so-called Rogerian theory underpinning person-centred approaches could be learned in half an hour. This is not necessarily a *flaw* in the theory; after all, many weight-loss programmes might be condensed to "exercise more, eat less". For Masson, however, person-centred theory, despite its appeal to numberless therapists worn down by the scientism of behaviourism and the speculative ideas behind psychoanalysis, was an untestable and subtly grandiose attempt to explain the ineffability of being human.

To the cognoscenti, Masson was neither original nor accurate in his criticism. Jung and Freud had their detractors from the outset. More recent targets of Masson's, such as Albert Honig and John Rosen, were regarded by the psy community as renegades who deserved either sanction or a rapid descent into obscurity. For sociologists and historians, Masson's style might, perhaps, be regarded as acontextual and accusatory. Nonetheless, *Against Therapy* lit the blue touch paper. Libraries now contain numerous books critiquing psychotherapeutic praxis. As noted in earlier chapters, there is also a tendency for new therapies to be presented as an alternative to practice and theory critiqued in the early chapters of any given volume. Though not criticizing therapy *per se*, authors are bound by the rules of capitalism that demand old products are deemed not good enough before new ones are presented. The approach might be likened to asking a child if he or she prefers Book A or Book B as his or her bedtime story. There is no question that it *is* bedtime, the suggestion of choice disguising the imperative. Researchers *comparing* psychotherapies are in no way questioning the need for psychotherapy, merely the "best" option.

Critics such as Masson have another hurdle to cross – the satisfied *consumer*. If I have exchanged my car for a newer model that is more efficient, reliable and safe, I am unlikely to listen to friends telling me the new one was a waste of money. If, as a member of psy, I find my training inadequate to alleviate the distress I witness in patients, I may continue with more focused training in the approach or switch to new practice that I shall declare "better". Similarly, a fee-paying patient is likely to claim he or she feels "better" thanks to psychotherapy, especially if he or she has switched from one form of therapeutic regime to another. Like the new car owner or someone embarking on the latest diet, he or she will only have doubts when familiar problems arise.

For the psy professional there are numerous opportunities to maintain therapeutic employment without the need to question therapy *per se*. There are over 500 therapies to train in and new ones arrive every few months.[54] This century so far has seen the popularity of mindfulness, DBT, narrative approaches and eye movement desensitization and reprocessing (EMDR) gaining ground over even recent arrivals such as cognitive analytic therapy (CAT) and, in the UK, government-backed CBT practised by thousands of IAPT workers.

Unlike Masson, I didn't doubt the usefulness and sincerity of my first encounters with analytic professionals (all Kleinians), and my two experiences of lengthy analysis (with a Freudian and a Horneyian) were marked by neither abuse nor vacuity.[55] I was happy to train in psychodrama, personal construct psychotherapy and group analysis, and experience weekend retreats featuring bioenergetics, Gestalt therapy and more ("weekend retreats" in the world of therapy might be a code for "sleeping with strangers"). Familiarity with object-relations theory, personal construct theory, self-psychology and group-dynamic accounts of human interaction all added to what might be described as a personal "tool-box" for dealing with the world inside and beyond the consulting room. The range of tools available to me was not so unusual in the UK's NHS in the 1980s. They would prove invaluable if I were following the Division of Clinical Psychology's (DCP's) guidelines on psychological formulation.[56] Added perhaps to a reflexive version of "power-mapping"[57] and a *mutual* endeavour to contextualize distress in terms of distal and proximal forces, the tool-box would be formidable. Such formulation can be a natural part of ordinary discourse, not by any means the sole preserve of psy practitioners – imagine *not* attempting to converse with another person without automatically contextualizing the other's utterances as products of culture, family history, taken-for-granted assumptions, unchallenged beliefs and so on.

In designing the first semester's programme for a new doctorate in clinical psychology based in Staffordshire at the turn of the millennium, Carolyn McQueen and I had been careful to introduce trainees to people and ideas – epistemology, power, critique, the "wounds" – essential to a critical view of psy.[58] The programme missed the target by some distance. Trainees were interested in what to "do" when confronted by a person in distress. That person was likely to be older, less intellectually able, unemployed and highly sceptical of a young psychologist's efforts. Patients were *frightening*. Familiar to a greater or lesser extent with media stereotypes of psy praxis and frequently harmed by medical interventions such as prescription drugs (see Chapter 6), patients are suspicious of psy, with their suspicions heightened when meeting a trainee therapist for the first time. For many, the importance of cultural and class differences between the trainee and themselves are exaggerated as it is made clear that therapy sessions are to be limited in time and number. Rapid decisions are made in terms of how much to *tell* the professional sitting opposite. The doctoral course was rapidly transformed into a means of gaining a qualification in CBT as well as a doctorate.

Employed as agents of individual change rather than societal critics, clinical psychologists and other psy professionals tend not to critique their own profession. In a professional endeavour supporting one form of psy rather than another, psy practitioners form schools where critique of praxis and ideas of other schools forms a platform on which to bolster confidence in the preferred intervention. The next section explores some of this "conflict".

Psy versus psy

Something of a spectator sport, the infighting between professionals about theory and praxis expressed in private conversations (*pace* Freud and Jung), case conferences or published correspondence and journal articles has become a more public spectacle. Psy professionals regularly appear in the mass media in order to promote their own brand of therapy, latest book or research project. As noted in Chapter 3, the language of psy is ubiquitous, distress converted to "illness" or disease at the touch of a journalist's keyboard, or boredom and accompanying inattentiveness renamed ADHD by teachers and parents.

Typical of this medicalizing agenda is the gradual emergence of sports people as quietly stigmatized sufferers of a diagnosed condition who "speak out" in order to normalize concepts such as "depression". Thus the psy project barely requires the public performance of its experts. "Sufferers" taking a public stance may be described as "brave" or "at the forefront" of sportspeople and others still keeping their diagnoses behind closed doors. In an interview in the French edition of the *Daily Telegraph*, Mike Yardy, England cricketer, describes how he withdrew from a tour of India in March 2011 due to an "all-enveloping torpor . . . a condition that had stalked him much of his adult life . . . he was suffering from depression". His experience of "clinical depression" is positioned as a "condition" resulting from "issues in my head". He encourages others to "declare" their depression and went on to study as a sports psychologist.[59]

Languaged into reality, Yardy's experiences can be interpreted as signifiers for a state of mind understood by – and marketed to – millions. He does not discuss his way out of several years of misery but presents instead as a newly made public example of triumph over adversity. Yardy now has a vested interest in maintaining his position. Experiences of others who "come out" in similar ways sustain a disease-orientated vocabulary owing much to psy: one which can then be deconstructed in relation to, for example, power, culture and – in the world of professionalization of distress – cause and effect. Responses to the presentation of distress in these terms offer hypotheses concerning the cause of malaise and its "cure" (drugs or therapy) while ignoring the context (publicity, the ubiquity of individualism) of the "sufferer's" declaration. Thus "experts" and the public at large are invited to decide what has caused the travails of the person (childhood trauma, overwork, lack of support, brain–biochemical imbalance, etc.) in a modern context of "tolerance" and "anti-stigma" where the influence of that context is ignored. To take a Szaszian view, that those diagnosed with depression are simply lying, knowing full well that their malaise is more accurately described as laziness or anomie, is considered intolerant, "right wing" (uncaring) and potentially libellous.[60] Few juries at law courts would find the suggestion that those diagnosed as depressed, schizophrenic or in other ways were lying about their so-called distress unless the advantages of such a position were made clear and juries were not themselves exposed to regular stories in the media concerning "mental illness" and the supposed possibility of overcoming distress via diagnosis followed by professional help or remarkable feats of will.

In summary, in a *zeitgeist* dominated by a discourse of disease and adversity, any return to a "common sense" view that some people do bad things, lie and have a rough time will be seen as unsympathetic, unscientific or "dated".

This context now involves the Internet, blogs and numerous media-reported stories of "recovery". The language of psy has been adopted to such an extent that only a few people feel fear – they are "anxious" – while fewer still are overwhelmed and oppressed; rather, they are "depressed". In the words of Ray Miller, a past president of the British Psychological Society and chair of the Division of Clinical Psychology, "Psychology has won!"[61]

Szasz discusses at length the common sense possibility that psy professionals and their patients simply lie. He traces professional lying from Mesmer to claims about the benefits of hypnosis and lying by patients from claims of possession to hysteria presented as irresistible behaviour. The latter group proved profitable to nineteenth-century analysts willing to accept the reality of their patients' claims while theorizing underlying causes only accessible via the analytic method. Szasz suggests that putting forward the view that impersonating the patient role (by pretending to be mentally or physically ill), feigning illness or malingering (for personal gain) is now regarded as "taboo". For Szasz we act as if psychiatrists are too honest to ever lie (e.g. by claiming that psychic distress has a physiological basis) and patients are too sick to lie and "hence can do so only *unconsciously*".[62]

Thus patients and psy professionals are now excluded from one simple explanation for their conduct. Ergo case reports or published articles are accurate accounts of patients' progress as a result of a particular treatment regime. and people who act antisocially do so because they are unable to resist "voices" in their heads or suffer from a widening range of disorders. For the latter group the "get out of jail free card" remains an option used repeatedly in court.[63] The willingness of experts to voice their ability to see into the mind of the accused can be remarkable. At the trial of serial killer Ted Bundy, for example, John Henry Browne, his defence lawyer, said: "Ted Bundy was someone who was born evil . . . He acted very well. Totally manipulative . . . But Ted did tell me something that showed he was 2% not sociopath. He said, 'John, I want to be a good person, I'm just not.' "[64] Browne, advised by psy experts, is here claiming an exact reading of Bundy's degree of psychopathy based on *one* utterance.

The insanity defence is not a guaranteed tactic. It can not only lead to a lifetime's incarceration in a secure psychiatric facility, courts can be sceptical. Alexander Spencer-Churchill, for example, had not paid value added tax (VAT) on a property deal. The defence claimed that his bipolar personality disorder meant he was unaware he should have registered for VAT. The court dismissed this argument as "simply irrelevant".[65]

Parents are familiar with claims by their children that a glass has been broken or a sibling struck "accidentally". The claim that a person cannot be held responsible for actions due to an "illness" is more tolerated due to psy-induced notions of "unsoundness of mind". This is a way of reducing the adults to a child-like state where responsibility is suspended via the trope of "mental illness". The next step is the provision of "care and therapy" rather than chastisement and punishment (though Szasz and numerous patient accounts attest to the punitive agenda of psy "care"). An example (see Chapter 5) might be ECT, acknowledged in Turkey as a form of torture and administered to incarcerated children, but regarded as a "treatment" elsewhere available from registered and accountable psychiatric clinics. Less dramatically, psychotherapy may be offered to those committing crimes under the influence of "voices". Here the lack of demonstrable effectiveness of therapies is a feature of the dishonest psy professional's sales technique, therapeutic interventions becoming varied, interminable *and* ineffective. The consumer (patient) is consumed by the psy system using the experience of distress and claimed uncontrollability of actions for its own ends. For some, if not possible to prove that therapy *causes* criminal conduct, it is possible to state that, like antidepressants (see Chapter 6) it doesn't *prevent* it. Elliot Rodger, for example, who killed six fellow students and himself in Isla Vista in May 2014 had been in therapy for *14* of his 22 years.[66] For others, the *performance* of a crime can be positioned as producing a psychiatric condition. Although three psychiatrists and a psychologist found no evidence of Oscar Pistorious experiencing Generalized Anxiety Disorder at the time he shot his girlfriend, the psychiatrists agreed he suffered from PTSD *after* the crime.[67]

Intradisciplinary squabbling

There have been several attempts to delineate perceived mutual factors across divergent therapies. These efforts generally position therapy as a helpful endeavour – "gains" by patients are ascribed to factors present in many relationships and heightened by the intensity of the therapeutic context. Clarification of pressures in the patient's life may be offered in terms familiar to many – the pressure to succeed, to be a good father, to "look one's best" and so on. Therapists of different persuasions might offer understanding couched in the technical language of psychoanalytic theory or the easier to follow cause-and-effect model obtaining in therapies such as CBT. All interpretations of this type position distress as essentially rational and amenable to change; "madness" is rendered logical through a mapping of the patient's behaviour and feelings onto a template provided by particular therapeutic theory.

Common to some theories of therapeutic change is the idea that "being attended to" by a powerful other is, in itself, a key aspect of the comfort provided by the presence of the therapist. It is the experience of someone *trying* to understand us that makes therapy so powerful. The rationalization of misery by a concerned other has less impact than the appearance that the therapist *wants* to understand.

This kind of analysis assumes that therapists have the best interests of patients at heart, and their particular training has raised them beyond the level of ordinary discourse so that their own concerns, worries and preoccupations are suppressed in order to help the patient strive for meaning and health. Authors such as David Stein, however, have criticized the training of psychologists for an over-reliance on a generalist, heavily technical content. He notes that in a survey of the core course content of 115 American Psychological Association doctoral programmes, 98 teach "assessment", 94 "psychopathology" and a substantial majority topics such as psychometrics, statistics, research design, ethics and social psychology. An examination of the 76 elective and speciality courses' content of the same cohort reveals 1 programme offering cardiology, 3 offering animal–human communication, 49 ethnic and minority issues modules, 43 child and adolescent psychotherapy, 4 depression and 1 play therapy. Stein concludes that doctoral-level courses in psychology are "abstract, theoretical and fail to focus on specific human problems".[68]

In the UK, where practitioner clinical psychologists must obtain a clinical psychology rather than general psychology doctoral qualification, course content might be regarded as less abstract, though the "core competencies" promoted by the Division of Clinical Psychology might be positioned as abstract in that they are meant to be transferable across different age groups and patient populations.

Stein's proposed solution to this divide between training and the everyday experience of being part of the clinic as a psy professional is to focus teaching on "human problems". In a far from exhaustive list he recommends reading relevant research and extensive practice pertaining to marriage, divorce, grief, parenting, terrorism, "overcoming growing up in a dysfunctional family", the elderly, religion(s), prostitution, gender issues, shyness and 30 other areas of human discourse.[69] The list is remarkable for its (conservative) comprehensiveness, its unreflective use of technical terminology (e.g. sexual dysfunction(s) and "listening skills") and the repositioning of a predominantly white, middle-class young intelligentsia (psychology students) as the potential saviours of humanity.

These young people would, if the programme were possible to follow, be transformed into a modern combination of sage, healer, resolver of conflicts, priest, marriage-guidance counsellor, parental advisor and expert on homeland security. Stein's examination of the challenges faced by doctoral programmes in trying to match content to external reality may be accurate. His solution, however, does not challenge the need for experts – critically psy experts – to offer therapy and advice to ameliorate the ills of contemporary society (as he sees them). My intention is not to accuse Stein of grandiosity. The general tone is one to be found in numerous other texts, especially those produced by psy associations and societies (Melanie Klein claimed that if *everyone* were to be analysed when a child, the world would be a better place). These publications, despite the demand of science to be modest in the absence of proof, are unlikely to reflect on the place or history of psy in the subjectification, measurement and objectification of the citizenry. Rather, they utilize the trope of progress and previous alignments of psy with, for example, eugenics, or the labelling of millions of people as "disordered" are ignored in favour of positioning psy as leading the way in creating more beneficent praxis. As noted previously, this ahistorical approach ignores the way in which the language of conduct and psy itself is reinvented to match the prevailing *zeitgeist*.

It is tempting here to echo Ray Miller's words, but, as previously noted, struggles for dominance within and between the psy professions is only one factor in a broader picture where the public are exposed to and recycle what had previously been the language of psy technicians. Thus despite the popularity of wholly unstandardized tests of "personality" and the like in popular media, the term "personality" has come to mean an attribute that someone may "have" or a description of someone in the media spotlight; hence the success of TV programmes such as *BBC Sports Personality of the Year*. Divisions of "personality" into disorder, extraversion, introversion and similar subcategories remain in the narrowly defined and minimally influential realm of the psychometrics expert. The reliability or validity of such tests and the "disorders" they are supposed to measure, though hotly contested in the professional literature, are of no interest to editors in the mass media who may use them to fill space between advertisements or add a scientistic gloss to an article by a psy expert promoting his or her latest venture.

I have critiqued the individualist doctrine and scientific pretension of psychotherapy and counselling for some 30 years. Outcomes included being elected chair of the BPS Psychotherapy Section, appointed editor of the in-house publication of the DCP – *Clinical Psychology Forum* – and, for almost 20 years, director of one of the most highly regarded psychological therapies departments in the UK. My continuing critiques – post-retirement – have seen me branded a renegade, a traitor to the profession (clinical psychology) and *bitter*. Previous publications in a similar vein are somehow forgotten as ex-colleagues "explain" my position via an internalizing discourse positioning me as mad, bad *and* dangerous as I live out a resentment-filled retirement.

As noted, however, my position has been reasonably consistent for 30 years and similar to that of numerous critics, from sociologists and historians to fellow professionals. The "scientific" status of psychotherapy, for example, is regularly challenged by counsellors who read no research and critics who deny the *possibility* of a scientific approach. This has been summarized as "People considering psychotherapy should be aware that it's more art than science, that treatment can take a long time and be very expensive, and that rapport may be more important than the therapist's orientation."[70] The illusion that NHS psychotherapy is "free" – at least at the point of delivery – might give prospective patients pause for thought: Why, for example, would the state pay for therapy? Why do so few therapists actively research the outcomes for their patients? Is rapport possible where the majority of therapists are white, middle-class women in an organization dominated by older, white, middle-class men while the majority of patients are from different age, race and social backgrounds? If rapport relates to the power to influence, then ignoring "referent" power seems important for therapists maintaining a self-deluding position of influence.[71]

Within the academy the critical position is given more status (though the fates of certain UK critical psychology doctoral courses and their directors might suggest otherwise). Critique, however, has a long history. Prilletensky argues that psychology corrals its notion of critical thinking within positivist science and logic, failing to critique those paradigms for their usefulness. This leads, he argues, to critique which focuses on "methodological rigour, logical reasoning in deriving conclusions and adequacy of generalisations", and not examination of the ideology these approaches are grounded in.[72] The position is reinforced by Hare-Mustin and Marecek, who state: "Psychology is an institution that reflects and reinforces the dominant cultural themes and ideologies."[73]

The above commentary would suggest that within the discipline of psychotherapy, different practices and theories jostle for power. *Any* of these theories might be used to explain – in their own terms – why psy practitioners act this way, but, with the exception of the academy, critical reflexivity is rare. Even here, academic researchers rarely examine the possible determinants of their own position.[74] The next section continues a critical view of psychotherapy research.

Researching praxis

"Let's develop theories, patiently and honestly thinking them out, in order to promptly act against them – acting and justifying our actions with new theories that condemn them."[75]

Theory should lead research. For theorists, a Kantian perspective, familiar to phenomenologists, would suggest that "in principle it is quite wrong to try founding a theory on observable magnitude alone. In reality, the very opposite happens. It is the theory that decides what we can observe."[76]

Psy research appears to be frozen in a non-reflexive state where a lack of acknowledgement that theories are grounded in the *zeitgeist* leads only to discovery of what is already known. To paraphrase the previous quote, we can only look for what we know to be there based on theories that tell us where and how to look.

Theories and research in psy have a further – some critics would suggest, equally profound – difficulty. Theories of the cause of so-called disorders are rooted in a deterministic philosophy that fails to examine whether the disorders are more than metaphorical. Thus research on "what works for whom" is already embedded in notions that diagnostic categories represent more than a purely descriptive psychopathology. Researchers are entering castles built in the air and then wandering around the rooms led by assumptions with no basis in reality.

The various "inscriptions" of the self (see Chapter 8) can be based on the slightest of evidence. In the famous Kinsey Report purporting to delineate the sexual habits of the average American citizen, for example, discussion of the sexual behaviour of 317 boys "was in fact culled from the diaries of *one* paedophile".[77]

In describing and diagnosing supposed abnormal behaviour, research and subsequent nomenclature can be equally idiosyncratic. Falret and Esquirol, for example, introduced new diagnoses based on the observation of one individual.[78] Their fame ensured the survival of the new category for a few years – a process reflected in the way that new diagnostic categories are *voted* into the DSM via an expert panel.

Psychotherapy and counselling in the industrialized West increase the cultural capital of practitioners through alignment with popular cultural tropes. "Science" has been privileged for more than a century. The last 20 years have witnessed the rise of "evidence".

In the UK, "what counts is what works" became the rallying cry of the evidence-based practice lobby for government policy in the 1990s.[79] NICE was launched to assess evidence from RCTs, systematic reviews and meta-analyses, and produce clinical evidence guidelines.[80]

The procedures of NICE, like those of the processes within the DSM committees, are wholly social rather than scientific. Expert panels decide which treatments are to be supported by NICE and recommended for funding. RCTs are the first rank of research accepted by industry and professionals, who then vote on which treatments are to be supported for individuals with idealized access to the full range of therapies with *no* waiting-list constraints. These discussions ignore the likelihood that the majority live in areas with highly restricted access to therapies of *any* type.

Within the scientific paradigm where psychological research is positioned as a search for truth, its methods do not seem adept at finding it. For many years the *British Journal of Clinical Psychology*, for example, has asked authors to include brief remarks about the limitations to findings. In 2013, 32 papers, including one "brief report" were published. Among the studies, 6 omitted a "limitations" section. Of the remaining 26, 12 suggested that one limitation was a failure to establish causality in identified relationships between conduct and the variable under investigation – for example, the direction of causality (if any) between shame, self-criticism and conduct diagnosed as eating disordered.[81]

This failing is not a moot point; numerous statistically significant correlations are found between a variety of supposed "causal" agents and most, if not all, conduct subsumed under psychiatric diagnoses. The finding, for example, that young black men smoking "skunk" cannabis are more likely to be diagnosed with schizophrenia cannot be a causal finding because the incidence of diagnosis of schizophrenia among young black men is already four times that of whites. The finding is wholly undermined by the invalidity of the schizophrenia concept.[82] The finding that school-age children diagnosed with anxiety disorder are likely to have impaired daily living skills is a further example of a correlational rather than a causal finding.[83] The study failed to examine whether the diagnosed children were receiving medication, hence no causal link could be made with the variable. A brief reading of the study might, however, lead physicians to prescribe to anxious pupils in order to increase their daily living skills – an unwarranted conclusion.

Psychotherapist researchers turned to meta-analytic studies in a search for plausibly hard data. In their classic study, however, Smith and Glass mixed results not only from different types of therapy but also from different types of outcome measures. They calculated the effects of psychotherapy on palmar sweat, inkblot scores, therapist ratings of adjustment, grade-point averages and self-ratings of improvement. No matter what the original unit of measurement, the researchers expressed the difference between treated and control subjects in standard deviation units. They analysed the collection of all indices of effect size in the same regression analysis and reached the following overall conclusion: "The average study showed a 0.68 standard deviation superiority of the treated group over the control group."[84] But a superiority of 0.68 standard deviations of what? Palmar sweat? Self-satisfaction? Academic achievement? Job performance? The answer is that the superiority is in some unspecified combination of these measures, all or none of which may be related to the concerns brought by patients to therapists.

In 2008 a meta-analysis of one such concern – described as "depression" – examined the outcomes of seven common therapies. These were CBT, psychodynamic therapy, behavioural activation therapy social skills training, problem-solving therapy, interpersonal therapy and non-directive supportive therapy. The 53 studies involved 2,757 subjects – by the standards of psy research a large number. The researchers claim: "No large differences in efficacy between major psychotherapies" and the dropout rate was significantly higher in CBT.[85] The result is familiar to those conversant with the "Dodo bird verdict": "Everyone has won and all must have prizes."[86]

It is also consistent with the non-reflexive nature of psychotherapy research which rarely questions psychotherapy *per se* but insists on comparing technique. King-Spooner "skimmed through" all copies of the *American Journal of Psychotherapy*, the *British Journal of Psychotherapy* and *Psychotherapy: Theory, Research and Practice* from 1980 (the year the second edition of Rachman and Wilson's *The Effects of Psychological Therapy* came out) to late 1993. In a total of 1857 articles he found 13 (0.7 per cent) on effectiveness, 14 (0.75 per cent) discussing the issues of power and abuse, and *none* on the problematics of introspective self-knowledge and self-report.[87]

The omission of any articles about power and abuse is notable. Whatever the supposed benefits of psychotherapy, the potential harm has been well documented, offering rich material for modernist critics. Noting that "Standards of care are more clear cut and widely accepted for physical than for mental illnesses,"[88] Kelley quotes an interview with psy experts Gutheil and Halleck, who state: "there are no 'accepted standards of medical practice' for psychotherapy".[89] More pertinently for psychotherapy trainers, Stone concludes: "no amount of training or personal psychoanalysis seems to confer immunity on therapists".[90]

Surveys suggest that 12 per cent of male and 3 per cent of female psychologists *admit* to sex with patients,[91] and 13 per cent admit to sex with three or more. In a national survey of American psychiatrists, similar results were found though of 5,574 questionnaires, only 1,423 were returned, of which only 1,316 answered the sexual contact question.[92]

Kelley concludes: "Patients and their families need to know that psychiatry is an uncertain branch of medicine, that well-qualified psychiatrists frequently disagree, that they deal more in judgement calls than in answers, and that the risk of a bad outcome is sometimes high."[93] The conclusion is not one to inspire those entering therapy, nor one which has led to regular questions about assault as an automatic part of "outcome" research. For the psychiatric profession, however, these findings have led to a shift in the *legal* status of assault (frequently termed "abuse") within the context of a therapeutic contract. By 1996, 14 American states had made it a crime, usually a felony, for a psychiatrist to have sex with a patient, "typically without regard to a patient's consent".[94]

In summary, psychotherapy researchers continue to use a scientistic methodology rarely acknowledging the importance of the *zeitgeist*, grounded in invalid diagnostic categories, and then offer psy practitioners and funders recommendations that fail to include research on the ill effects of psychotherapeutic praxis.

The present

As noted above, psychotherapies continue to proliferate, each new method claiming superiority over previous efforts to ease suffering. For the USA and Europe, the popularity of yoga and "consciousness-raising" via hallucinogens in the 1960s was, for some psychotherapists, paralleled through integration with "Eastern" traditions. In this century the media promote "mindfulness" as a means of attaining or remaining calm in threatening situations, and psy professionals have incorporated the concept in praxis from CBT to DBT.

Mindfulness – from a Western viewpoint – is integral to Acceptance and Commitment Therapy (ACT), now presented as central to a number of clinical psychology programmes in the UK. Developed in the late 1980s, ACT was originally called *comprehensive distancing*.[95] Shpancer has described ACT as getting to know unpleasant feelings, then learning not to act upon them, and to not avoid situations where they are invoked. Its therapeutic effect is, according to him, a positive spiral where feeling better leads to a better understanding of the "truth".[96] Individually focused, the approach – if taken at face value – ignores the possibility that many people likely to receive psychological therapies survive toxic circumstances where feelings such as fear *should* be acted upon. Further, a meta-analysis by Öst concluded that ACT did not qualify as an "empirically supported treatment", that the research methodology for it was less stringent than for CBT, and that the mean effect size was moderate.[97]

Meditation too has for over 50 years been promoted by psy professionals as a route to acceptance of self and others. Beneficial effects of meditation as indicated by increased levels of compassion and altruism are claimed to be shown after between 10,000 and 16,000 hours of practice. Assuming that a particularly committed adherent practised for two hours per day (twice the time Bert Weedon recommended to master the guitar), the average practitioner would show the effects (to others) after 18 years.[98]

For some researchers the grail of establishing psychotherapy as a natural science by reference to physiological change continues to be the goal. Well over 160 years ago, Griesenger saw madness as essentially physiological but the absence of evidence forced practitioners to approach it psychologically: "A classification of mental diseases according to . . . the anatomical changes of the brain which lie at their foundation – is, at the present time, impossible."[99]

More recently, Koehler, for example, has proposed a long-term study on psychotherapy outcomes in persons with a severe mental illness (comparing CBT and psychodynamic therapies) using neuroimaging as one dependent measure.[100] Near-infrared spectroscopy (NIRS) allows for the measurement of cortical cerebral blood flow (CBF) and could permit simultaneous measures of patient and therapist, corresponding with a "contemporary relational approach to the psychoanalytic setting and dyad". Koehler proposes to investigate patterns of relational processes occurring between both members of the dyad and any "correlation with outcomes, e.g., mirror neuron activity in the dyad, synchronization of blood flow, glucose metabolism, empathic linkage reflected in certain neural regional activity, neural regions mediating insight into psychotic processes which serve to maintain the patient in an isolated and withdrawn state, etc.".[101] Simply reproducing mirrored neuron activity and so forth *without* the necessity of psychotherapy is not an option as the researcher proposes as one key aim that of placing psychotherapy onto a (physical) scientific footing.

Wholly unaware of NIRS and unconvinced that madness was either diagnosable or explicable, I practised psychotherapy for 30 years. Blessed with a good memory and a firm belief that all therapy was subsumed within the notion that countertransference rendered the words spoken by patients a small part of the process, I kept no therapy notes. I would write the occasional report for people seeking retirement on the grounds of ill health or compensation for injury. Reports were couched in a non-technical language understandable by the subjects of the reports and the court. One outcome of this praxis was the occasional telephone call from legal representatives wishing to confirm my qualifications (on the grounds that they could never normally comprehend a psy expert's reportage).

I have made my views on note-keeping clear; if I was to be part of the Gaze I would not add to the position through inscription of selves via diagnosis and other technical aspects of psy praxis.[102] A further outcome was a degree of trust in the confidentiality of meetings rare among professionals and patients. This had obvious benefits in my role as a staff counsellor where my knowledge of the NHS system from a management perspective probably had more utility than years of training in psychotherapeutics.

The importance of context was clear; even though I frequently didn't remember the names of patients unless I had seen them several times, their stories seemed to reappear in the ether the moment they sat down – and probably would again if I was to see them now. I saw high-ranking health staff obsessed with money, promotion or failing relationships, as well as clinicians struggling with drug addiction and alcoholism. Long-standing recipients of psy interventions might arrive barely able to speak due to neuroleptic medication or with memories destroyed by ECT. Some were supposedly violent, others too scared to leave their homes. At least three women turned up with increasingly revealing clothing, and I was twice threatened by men with knives. As patients, I saw clinical psychologists who could not speak to their parents and were addicted to antidepressants, and psychiatrists who could not speak to their spouses and were likewise addicted. A host of counsellors came my way, including those struggling with relationships and drug addiction. Several couples were taken aback when, instead of offering the sought after "marriage guidance", I suggested they find a decent solicitor to ease their divorces. And none of this was written down to be reread in years to come by a stranger with little idea of what the interactions had involved. Professionally, I was an historian's nightmare.

The experience, however, left me with a profound impression of the similarity of people's travails. The position of psy professional gave my professional patients no protection against the problems of living faced by their own patients. It was equally clear that any of the professionals I saw as patients carrying out psy research were likely to produce results wholly in keeping with their perspective on life and *entirely* dictated by the mores of scientism rather than philosophy or sociology. Their commitment to a psy career inevitably precluded them from asking one potential question concerning their troubles: "Is there something fundamentally wrong with the context I work within – psy itself?" Instead, like myself and thousands of other psy professionals, they individualized and internalized their conflict, concluding that the problem lay with their approach to life or the profession's aims – perhaps further individual therapy or training would lead to the "solution". In this they mirrored the millions of people seeking professional help who have been persuaded that it is them rather than the world that is at fault.

Thus therapeutics and the underlying theory have come to dominate the twenty-first century. Perhaps psychology has, indeed, “won”.

Chapter 8 describe the psychologizing process in more detail, and further attempts to slow and critique that process.

Contextual note

Half this chapter was written to silence and half to the sounds of *France Musique*, a blend of jazz and – this week – several versions of Mussorsky’s “Great Gates of Kiev” from *Pictures at an Exhibition*. The number of variants on the piece – from solo ukulele to electrified string quartet and numerous full orchestral versions – makes the number of theories of psychotherapy look positively tame.

8

Governing Professions I: Us and Them

This and Chapter 9 discuss the ways in which psy professions govern themselves and others, and are themselves governed by the state, vested interest and a technical lexicon that influences and is influenced by common speech. Metaphorical constructions of psy create an interiority to be disciplined and corralled.

Psy inscribes and disciplines the self through language and direct intervention. The language of technopraxis pervades modernist discourse, promoting inscription of the public self. Within professional discourse a lack of reflexivity results in theories, research and psy interventions founded in language that consistently has no parameters beyond itself. Psy professionals are involved in a social rather than scientific process where an unexamined lexicon of “disorder”, “progress” and so on is accepted as part of a broader psy project.

This chapter explores the ambitions of that project that include a global objectification of its subject matter: people. The literature of psy is exclusively metaphorical; indeed *all* language is metaphorical, a fact that psy consistently fails to notice. The first section illustrates how the discourse of psy is unquestioned by the majority of psy professionals disciplined through nonsensical text.

Psychospeak, so to speak

Governmentality is “the ensemble formed by institutions, procedures, analyses and reflections, the calculations and tactics, that allow the exercise of this very specific albeit complex form of power, which has its target population”.[1]

One aspect of governmentality is the inscription of the self. The gaze of psy has been fundamental to this inscription. Rose suggests the origins of observational psy praxis can be traced to the work of, among others, Darwin, Sully and Stanley Hall.[2] All three observed and documented infants and drew parents into a disciplinary space in order to collate observations of their own children. This "developmental psychology" can be traced to the work of Gesell at Yale in 1911. By the 1920s, Gesell's "Psycho-clinic" had incorporated a small, well-lit laboratory sided by two-way mirrors. The experimenter and child could not see the observers and camera technician as the scientist (in white coat) was observed "testing" the child.[3] Rose states: "The child is here caught up within a complicated arrangement that will transform it into a . . . analysable object, within a particular rational scientific discourse (developmental psychology) making a particular kind of claim upon our attention – a claim to truth."[4] This kind of observation obtains in the training of child psychologists, child analysts (who frequently observe parent–child interactions during training) and family therapists. For some critics this is psy at its most naïve: practitioners and experimenters act as if the experimental and observational context is irrelevant to the behaviour observed.

Experiments of this type, work with patients, research on "normal" subjects and more have led to psy inscribing a problematized self as disordered, abnormal or developmentally delayed. Relationships between partners, parents and children or communities have been inscribed as "damaging", "abusive", successful or otherwise due to "failure to adjust" and "failures in communication". Inscribed personality types are said to be unsuited to certain types of relationship, employment or education.

As noted in Chapter 3, the categorizations and theories of psy rest on a particular kind of language that permeates, influences and is in its turn influenced by non-technical discourse and the discourse of other disciplining bodies. A leaflet from the Jehovah's Witnesses, for example, is entitled "What you should know about mental disorders".[5] The word "disorders" has been substituted for "illness" in a move consistent with the contemporary language of psy professions. The opening paragraph, however, states: "Thankfully, mental *illness* can be treated" (my emphasis). In an attempt to clarify the use of technical terms familiar to the authors of the DSM and the majority of psy practitioners publishing research articles or opinion pieces, a footnote is added: "For the sake of consistency, in this article the term 'mental disorder' includes mental illnesses as well as behavioural and psychiatric disorders." The reader is informed ("Key facts") that, according to the World Health Organization, one in four people will be affected by mental disorder at some stage, "depression" is the largest single contributor to disability worldwide and "schizophrenia and bipolar disorder are among the most severe and disabling disorders".[6] The emotive language of severity and disability is used to produce possible reader reactions of fear or concern. The untestable figure of one in four is much repeated in other literature and couched in terms ("affected") difficult to dispute: reading the leaflet "affects" any reader in the same way that regular press coverage of so-called disorders affects millions of people. An experienced psy *professional*, however, might be surprised to find bipolar disorder (barely discussed ten years ago) now ranked alongside schizophrenia in severity.

The leaflet features a kind of advertisement for the psy profession. For example, "The first crucial step is to obtain a thorough medical assessment from a competent health professional." There is no irony intended here; *pace* Szasz, a *thorough* medical assessment would reveal *nothing* wrong with someone diagnosed with a metaphorical malady.[7]

The recommendations for "dealing with mental disorders" repeat tropes common to contemporary medical advice to be found daily in the mass media addressing anything from obesity to Alzheimer's disease. After first following "the treatment prescribed by qualified mental health professionals", eight further points include maintaining a daily routine, staying physically active, getting enough sleep, relaxing, eating a "nutritious and balanced diet", and limiting alcohol and non-prescribed drug intake. Consistent with similar advice, the points are ill defined and lead to circular reasoning: *How* physically active should a person be? What is *enough* sleep? *What* constitutes a balanced diet? How *limited* should alcohol intake be? All of these elements of the advice are found in daily media coverage which is frequently contradictory (e.g. in advice about drinking alcohol during pregnancy) and derived from research published by manufacturers of dietary aids, alcohol or licit medication. Aspirin, for example, can be presented as both a wonder drug for stroke prevention and harmful or lacking in the supposed benefits.

The launch of the online "Mental Health Access pack compiled by Livability and Premier Mind and Soul" claimed to "increase mental health literacy within our churches . . . " repeats the figure of one in four said to experience "a mental health issue each year" and called for support to "these people". There is no attempt to pursue the one in four estimate – as almost any experience can be described as a mental health issue it might be further suggested that all of us intermittently constitute "these people". The launch was headed by the Liaison Bishop for Mental Health, the chief executive of Livability and a director of Premier Mind and Soul.[8]

Rhetorical devices are to be expected in commercial advertising. The language of psy is ubiquitous in advertisements concerning psy-related products. Hogrefe, for example, is based in Oxford, England, and publishes over 700 tests as well as 35 journals.[9] A brochure advertises products concerning autistic spectrum disorders. Suggesting that "diagnosis can be challenging . . . ", the introduction continues: "the characteristics of Autism, ADHD and learning disorders can often strongly resemble one another". Use of the advertised tests – The Autism Diagnostic Observation Schedule, Second Edition (ADOS-2), the Autism Diagnostic Interview-Revised (ADI-R), Social Communication Questionnaire (SCQ) and Social Responsiveness Scale, Second Edition (SRS-2) – is restricted to "professionals who fulfil certain qualification criteria". Those criteria include "LEVEL 1: Evidence of eligibility to practice professionally within the clinical/educational population at which the product is aimed . . . , LEVEL 2: . . . Certified training and experience in a relevant discipline and membership of a professional organisation appropriate to the focus of the test." For level 3 the user must also complete test-specific training – ". . . for example, Griffiths Mental Development Scales (GMDS) or Autism Diagnostic Observation Schedule (ADOS)." [10] The tests take from ten minutes (for the SCQ) to two-and-a-half hours (for the ADI-R). The website also offers online testing.[11]

A second Hogrefe leaflet advertises "Clinical Assessments: Executive Function and ADHD". The reader is first introduced to the idea that ADHD is a "neurological condition" where testing of "executive function" is recommended as an aid to determining treatment. The statement is illustrated by a multicoloured illustration of the brain represented by cogs and wheels. The opening section ends by noting that "Unfortunately, the condition can be difficult to tell apart from other disorders as well as that of high normal activity." The leaflet recommends three assessment tools – the Behaviour Rating Inventory of Executive Function and accompanying software, Conners' Adult ADHD Rating Scales and Connors 3, a test purporting to address oppositional defiant disorder and conduct disorder. Despite the recent publication of DSM V, the third test is aligned to DSM IV-R.[12] None of the tests physically address brain function even though the "disorders" are claimed to be neurological in origin – as with any psychometry, they test how people fill in tests. Publication and marketing of such assessments in the context of broadening criteria for disorders increases the likelihood that actual brain injury leading to specific behaviour – for example, an apparent inability to remember numbers – will be missed. CAT scans, though not consistently reliable, *can* identify brain trauma (e.g. tumours) but will not be the first recommendation in assessment in part due to cost and in part due to the ubiquity of diagnosis and accompanying positioning of undesirable conduct as genuine medical/physical conditions. In this way psy procedures may delay, or sometimes deny, physiological testing. This is common in medicine and psy; a person already diagnosed with "depression", for example, is likely to have physical symptoms ascribed to the supposed disorder rather than investigated. A pertinent example in the busy lives of general practitioners is to refer for help with "hypochondria" when physical examination has failed to reveal the cause of symptoms.

It is, on the face of it, too simple (*pace* Foucault) to randomly access and deconstruct text. Referencing a volume such as this could follow a similar praxis: mass media, the Internet, blogs, journals, psy texts and autobiographies (particularly from those self-defined as "survivors") offer many analytic opportunities to the historian, sociologist or anthropologist. The text can be scanned and sections selected using no *criteria* before analysis of style and content. Such analysis might be seen as mimicking the psy endeavour whereby *people* are scanned and conduct selected arbitrarily before labelling and intervention.

Writing reifies and makes thought captive. However lively the prose – a rare event in the writings of psy – the written word is dead, already distant from the thought processes of the writer. Socrates didn't write down his philosophy; this was left to Plato in *The Republic*, a volume that may be unread by therapists claiming advantages to the method of Socratic questioning. His position was revisited by the philosophes sans oeuvres of the 1950s, a group that preferred the conviviality of Le Coupole on the left bank to the material rewards of publication. For psy professionals, however, writing and publication are integral to their cultural capital and, for academics, a required aspect of employment. The *act* of publication is more important than the readability of the text as publication adds to the curriculum vitae of the author and may harness research finance for the institution (see Chapter 3).

Psy writings are richly nonsensical. A concern for the deconstructionist is how to discern *any* meaning in the text. An example is provided by the October 2014 issue of *The Psychologist* devoted exclusively to "Autism: Myth and Reality".[13] An introductory article by Uta Frith suggests that autism is a "puzzle" solvable by considering "myths and realities". Describing her "attraction" to Asperger syndrome, Frith notes her interest in "the autistic mind", going on to say: "we now know that autism can occur at all levels of intellectual ability, including very superior levels".[14] The author cites "profound social communication problems" as the "core of autism".[15] Noting that Asperger syndrome no longer appears in DSM, Frith suggests that the expansion of criteria for inclusion in the grouping Autism Spectrum Disorder (ASD) means that some people with "problems in social relationships and other features reminiscent of autism" have been labelled Asperger's but "actually belong to a different category" which remains "sadly" ill defined and "even part of neurotypical individual variation".[16]

After a discussion of the "ability to provide insightful observations about their experiences" and "new possibilities to investigate the autistic mind ... " among adults diagnosed with autism, Frith notes the publication of her subsequent book on autism and Asperger syndrome, continuing: "Many psychologists and psychiatrists had only just become aware of autism, and now they had to embrace a whole autistic spectrum ... ". The lack of validity of the concept does not deter Frith from then remarking that "the impact is still felt even if the label Asperger syndrome no longer appears in the 5th edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association".[17] The nature of the "impact" is not explored in detail. , Like autism and autistic spectrum disorder, however, Asperger syndrome has entered the vernacular. A lack of validity is not a bar to such terms entering ordinary discourse. This aspect of habitus is familiar to any historian or social commentator: terms such as "mongol" or "imbecile" lose their scientistic gloss to become part of common speech. As Boyle has remarked, it is the *repetition* of technical language (e.g. the everyday use of terms such as schizophrenia or "clinical" depression in the mass media) that gives technical terms the appearance of referring to real disease or disorder *without the need* to establish their existence on scientific grounds.[18] Frith's two-page article uses the word "autism" 33 times.

She positions as "provocative" her suggestion that "the mildest of the mild cases of Asperger syndrome should be classified as having 'autistic-like personalities' rather than an autistic spectrum disorder".[19] There seems no sense of irony here that such individuals are indistinguishable from the supposedly normal population; thus we are *all* now to be seen as "autistic like". The position is similar to Freud's all-encompassing theory of the unconscious wherein all are analysable, all subject to various psychic defence mechanisms and all fall under the gaze of the suitably qualified expert. Later, Frith "draws a line", claiming that "people with autism really have a very different mind and different brain", though she is prepared to change her mind "if the weight of evidence" convinces her.[20] Smail might argue that the vested interest in maintaining her belief leaves Frith in a position of faith rather than science: she requires "evidence" that something doesn't exist rather than convincing proof that it does.[21]

The article maintains tropes of science, expertise and allusion to "mind" or brain for an audience dominated by similar vested interest and conversant with the same tropes. Similar rhetorical devices appear in Patricia Howlin's later article on understanding autism after 70 years of research.[22] She notes the origins of "the condition", going on to remark that subsequent to the inclusion of "the disorder" in the DSM-III of 1980, prevalence has risen steadily – from 0.4 per 1,000 to 14.7 per 1,000. Addressing perceived fears of "an epidemic of autism" as mythic, Howlin claims that the increased incidence reflects increased professional and public "awareness". Perhaps again attempting to dilute alarm, she notes Rutter's work demonstrating the "differences between autism and schizophrenia".[23] This raises one straw man against another – a classic rhetorical move – as neither schizophrenia nor autism are valid entities. It is *only* possible to suggest they are similar to or different from each other via definition. Simply changing the definition of the terms will exclude some individuals and include others; no "research" is necessary.

Howlin cites Frith's studies of cognitive processing and the subsequent suggestion that one "characteristic of the disorder" is a difficulty in "understanding others' minds".[24] This is simultaneously a far cry and very close to Sartre's position that understanding *anyone* else is impossible (hence "Hell is other people").[25] By locating this universal phenomenon in the realm of a particular population, however, Howlin maintains the expert praxis of "othering" and places those seen as autistic firmly within the purview of the gaze. Howlin suggests that functional imaging techniques (for the brain) have been used in the context of "very small or poorly ascertained groups of participants ... ", makes a plea for "changes in brain structure, functioning and connectivity" in autism and concedes that "the condition is characterised by wide aetiological and phenotypic heterogeneity".[26] A more succinct summary might be: "The people we studied are very different from each other." Again, the justification for grouping people within a particular diagnostic banding is open to question. Howlin acknowledges: "There are currently no imaging techniques that can reliably identify autism at an individual level ... ".[27] Theories of "causation" – parental "pathology", organic conditions and genetics – are shown to be either unproven or common across other diagnostic clusters. "Treatments" show equal variability and lack of impact whether based on psychoanalytic or behavioural theories. Unsurprisingly a 20 hour *per* *week* two-*year* treatment programme focusing on communication problems "suggests" improvement in some modalities if measured against "un-treated" children.[28] Acknowledging that there is "great variation in treatment response . . . ", Howlin says that generalization of treatment effects to new skills is "limited" and there is "no evidence of long term impact . . . ". Despite this she suggests a broadening of the target treatment population to include less affluent families. The gaze is thus extended *from* the middle classes *to* the working or unemployed classes *in the absence* of the gaze having positive results for the population observed. This is consistent with Foucault's original conception of the gaze offering the more powerful professional and middle classes a further tool in disciplining the less powerful poor.

Howlin concludes by urging a consideration of the limitation of the diagnosis to children, suggesting "studies and systematic reviews" of adults with the diagnosis and the impact of ageing.

In summary, identification and treatment of the so-called disorder has been haphazard and unsuccessful for 70 years. In order to retain the gaze, not only are the characteristics of autism to be widened (*pace* Frith) but so are the age and class parameters. A more *scientific* approach might be to conclude that psy has no place in interfering with the lives of children (and adults) who are struggling in ways increasingly described as "autistic". Howlin uses a simple rhetorical device to draw an opposing conclusion, stating: "*If* the advances in comprehensive treatment programmes for very young children can be applied across the lifespan, then the current generation of children with autism *may* face a more positive future."[29] As the article gives no examples of successful treatment, and psy professions have made no in-roads in 70 years, Howlin's conclusion is, like remarriage, more a statement of hope over experience and cannot be justified in her own – scientific – terms.

Disciplinary Psy

We are surrounded by a crippling society – one that psy embraces and inscribes through an individualistic discourse. In the UK there is limited community praxis and occasional professional documents suggesting more integrated processes for service survivors and social "inclusion".[30] In general, however, classrooms are not boredom-inducing day-care facilities; they are small panopticons where children are inscribed as educable (or not) and marked as "suffering" from ADHD or self-label as backward. The plastic wrapping – too tight to easily remove from a host of products – is promoted as "safe" or "convenient", and difficulties in removing it ascribed to infirmity or clumsiness, or the individual inscribed as “dyspraxic”. The technology of mobile phones is heralded as progress as it simultaneously outstrips the ability of the majority to use. Again, “clumsiness” or even “age” may be seen as the culprit. As each “advance” is made, new challenges fail to be met by people who find their difficulties inscribed by psy jargon. In such a context, psy thrives, either in “assessing” a person’s difficulties or in offering treatments. Younger, computer-literate psy professionals may fail to empathize with the challenge of technology set for their patients. Others may recognize, for example, the difficulty faced by many of simply clambering onto a bus but may not incorporate that perception into a “psychological formulation” that, by definition, focuses more on the person than the environment, an environment over which the psychologist has no control. Wolfensberger names the inherent physical challenges of many service institutions a further “wound” (see Chapter 4), but the wounding nature of so much in contemporary life passes us by unless we are suddenly confronted by a boring classroom, overly tight plastic packaging or an infuriating mobile phone or computer.

If I’m not interested in gainful employment citing as my rationale its distance from my home, low remuneration or lack of employee protection, the machinery of government may pay benefits only on condition that I seek work or undergo therapy provided by IAPT workers.[31] If I am not interested in principle, governmentality operates through processes including derogatory language (I may be branded idle – one of the “undeserving poor”) or a presumed interiority (the experience of shame).[32] If I am a minor aristocrat with independent means that enable my “indolence” to stay hidden from public view, the state may ignore me.

If, however, my lack of interest is part of a more generalized politicized reaction to the oppression of work, I may be seen as a “threat” to order. This position is enhanced if I am more interested in voices telling me to undress in the shopping mall or to beat myself publicly around the head and face. At this point the state machinery of psy will intervene.

There is an interplay between images and tropes of madness used by the mass media and the rhetoric of justification for psy services. Assaults or murder by diagnosed individuals are given prominence in the media, leading to rebuttals by psy professionals and service user groups. The latter point to a supposed increase in stigma of psy recipients resulting from misleading news stories.[33] In the absence of newsworthy material the press can simply promote some of its own.[34]

Service user advocates and psy professionals maintain a public discourse in regular debates about the exaggerated dangerousness of diagnosed individuals. This debate simultaneously positions some psy professionals "on the side" of patients and the majority of patients as maligned. A challenge for publically funded psy services, however, is prioritizing funding. *If* the majority of people referred to psy services are *not* dangerous or potentially disruptive – as accurately claimed by survivor groups – what is the justification for seeing this majority within services? One trope employed is that of "compassion" – a just society looks after those in need. If "need" is the criterion then that "need" must be measured and codified – one aspect of the inscription of the self. A more pragmatic approach – to be found in more "totalitarian" societies – is to emphasize the disruption to social intercourse (particularly "normal" family life or "acceptable" social interaction) emanating from mad conduct. This is the approach taken by the media.

Psy professionals are affected by these same tropes and stereotypes. Thus psychologists will respond to words such as "psychopathy" or "psychosis" in ways similar to the non-expert public even when witnessing the *lack* of any conspicuously threatening behaviour in the majority of patients seen with these labels. In a career spanning over 30 years, I was referred only 50 people regarded as dangerously "psychotic". Each time I took precautions at the first appointment (informing security staff and sitting close to an alarm button or having a psychiatric nurse present at the interview). Almost every time the meeting proved to be only mildly diverting by comparison with hundreds of meetings with those not regarded as psychotic by the referrer. Only on two occasions (see Chapter 6) was I threatened. My experience could not be claimed to be wholly representative of clinical psychology praxis in the NHS. There are, for example, clinical psychologists who work in secure forensic settings where the threat of danger – partly dictated by context – is more prevalent. My position as head of department shielded me from daily community mental health teamwork where disturbing behaviour among referred patients may have been more common; my role in relation to these teams was both managerial and as a recipient of referrals of people considered too dangerous to be seen by female clinical psychologists in the teams. The titles of the majority of papers in *Clinical Psychology Forum* and *The British Journal of Clinical Psychology* would, however, suggest that the majority of patients seen by clinical psychologists are not marked as "psychotic" or dangerous.

My role within the disciplinary project of psy has not been slight. Editing the DCP monthly journal *Clinical Psychology Forum* involved reading and publishing hundreds of articles supporting psy endeavour, only occasionally critical endeavour and less often lay views about psy. Additionally I chaired the BPS Psychotherapy Section, a notoriously conservative body, and directed an 80-person strong psychological services department within an NHS trust. Research and supervision took up 20 per cent of the working week and, however critically focused, both activities reinforced my role as expert. Here, however, I shall focus on one example of early disciplinary therapeutics. For modernist psy practitioners the intervention might be regarded as "unsuccessful". For those acknowledging the disciplinary nature of psy it might be seen as a failure of one discourse inscribing the self as "disordered" to overcome a pre-existing discourse wherein the self is inscribed as "faithful" to religious edict.

Married, with an active if not particularly satisfying conjugal sex life, I turned to regular masturbation. Recommending masturbation to couples – both mutual and individual – became something of a habit when confronted by people complaining of unsatisfying sex lives. The suggestion was supported by psy literature on the subject and, for a physically active male therapist in his 20s, made complete sense. It was to be some years before I read Szasz's views on the sex therapy industry,[35] and probably a decade or more before absorbing Foucault's views about sex therapy as part of the disciplinary apparatus.[36] As a newly qualified clinical psychologist my own role in this disciplinary process was constrained by a focus on methodology rather than morality; couples were duly offered behavioural advice and "homework" tasks already popularized in works such as *The Joy of Sex*[37] with a brief review of supposed parental influence. In essence my role as therapist supported marriage manuals published as early as the 1920s that promoted "good sex" – "sex that was both morally and emotionally legitimate".[38] "Bad sex" in these manuals was a more complex affair. After the publication of *Married Love*, questions concerning whether the light could be on during sex or if both partners could be naked arrived through the post (from men and women) for Marie Stopes.[39] Anything, however, that "savoured of masturbation" in her writings was considered "dubious".[40] By the late 1970s when I was seeing my first sexually dissatisfied couples in therapy, it seemed – to me at least – that masturbation was both normal and desirable for couples and individuals alike, a position underlined following a conference talk by Martin Cole who had had great success in Birmingham by recommending that couples seek the advice and more direct ministrations of prostitutes.[41] It was something of a shock when couples were appalled at my suggestions, denied *ever* masturbating or, in one case, left the room in high dudgeon saying the act was against the teachings of their religion.

The proposed treatment – masturbation – inverts one theory of madness prominent in the nineteenth century while illustrating one way in which "scientific discovery" tends more to a circular than a linear trajectory. Both Rush in the USA and Esquirol in France regarded masturbation as pathogenic. Both invoked masturbation as a symptom of mania that might, among other possibilities, lead to vertigo, epilepsy and death.[42] Almost 150 years later I was suggesting this pathogen as a treatment – the equivalent perhaps of offering in a few years' time cigarette-smoking as a cure to cancer sufferers.[43]

In baleful retrospect I might see my efforts as examples of projecting my own difficulties (and solutions) onto patients or an ill-considered attempt to discipline patients into enjoyment; even at the time there seemed an artificiality and lack of spontaneity to the homework tasks that had little to do with desire or lust. Rather, patient and therapist were locked into a kind of new morality, the aim being to achieve the necessary number of orgasms consistent with a presumed norm. This kind of endeavour is seen by Rose as an injunction to be "free", an injunction pursued by millions seeking "authenticity" or "integrity" but, nevertheless, an injunction. A contemporary clinical psychologist might question my lack of attempt at a more rounded psychological formulation, including religious belief. Had I known, however, that the couple cited above were Jehovah's Witnesses, I would still not have known the detail of expected religious duty and the couple – steeped in a lifetime of faith-based praxis impossible to step beyond and observe – would not have been able to tell me of the rules without extensive questioning. Had the couple been devout Catholics or Orthodox Jews, the same proscription against masturbation would have applied; something I knew but had never believed people complied with.

These therapeutic efforts can be seen as representative of the paradox at the centre of therapy. The promotion of a politics of liberation offers an apparent possibility to choose new ways of being in much the same way that one chooses a new washing-machine or t-shirt. Government of the individual is only now to a lesser extent government by law, subjugation or religious injunction and duty. Rather, capitalism *requires* the appearance of choice in a marketplace emphasizing individual consumption. The "self" construes a life in terms of its choices, powers and values. Personal attributes are realized through decisions, justified in terms of motives, needs and aspirations. For those in the industrial West and an increasingly industrialized world, a search for the means to live has become a search to find meaning and satisfaction through the construction of a life for oneself. For Rose, "We are obliged to fulfil our political role as active citizens, ardent consumers, enthusiastic employees, and loving parents as if we were seeking to realize our own desires."[44]

Individuals who find themselves unable to construct meaningful lives through recourse to choice (of partner, job, house, clothing, etc.) are deemed in need of the science of psychotherapeutics, a science congruent with the values of achievement and avoiding suffering. The paradox inherent in this scheme is that people are everywhere encouraged to choose and be "free" but, like the couple who found masturbation abhorrent, cannot simply shrug off *unchosen* values. This is common in couples where one person does the majority of household chores to the extent that they complain that the other person "does nothing to help". A couples therapist might quickly discover that the person is constrained by familial or cultural injunctions while simultaneously wanting to break free from those injunctions. The therapist is bound by an injunction (not recognized as such) to encourage the autonomy of clients and re-entry into the world of choice. If the therapist fails it is likely that the client will be seen as "stuck" rather than the therapy – in its promotion of the capitalist ideal of choice and autonomy – seen as not up to the task.[45]

The disciplinary nature of psy is a product of a *zeitgeist* wherein "the self", "choice", productivity and success are privileged, no less for therapists than patients. Psychotherapy can, however, make claim – quite separate from its overt project, healing – to praxis seen as abusive and detrimental. Therapists label (diagnose) patients using terms describing fictitious disease (use of DSM or ICD codes is obligatory for fee payment from insurers). Many clinical psychologists acting as therapists will have first "assessed" patients using assessment tools with no validity, going on to offer therapy with poor outcomes (as assessed by modernist protocols). Stein, for example, claims that "Validity and reliability of psychological tests are low, almost worthless... ".[46] Therapy follows from assessment and, according to Stein, efficacy rates for therapy with some patients are particularly poor. For sex offenders the rate is an astonishingly low 0.05 (i.e. 1 in 200 patients don't reoffend), and for children diagnosed as conduct disordered, 0.17 (less than 1 in 5) experience a change in conduct in the desired direction. These figures are far more discouraging than those of Eysenck, who suggested a success rate in the region of 60 per cent for most therapies. When Eysenck's figures are further examined, we find that some ten per cent of patients feel worse after therapy, about 30 per cent feel better and the rest don't experience much change. These percentages are frequently compared with the "outcomes" of non-therapeutic interaction. A third of relationships leave a person feeling pretty good, a few worse and most have a neutral impact.[47]

Therapists can invent disorders (see e.g. recovered memory therapy)[48] and false memories can be a route to further referral into the more physically invasive psy complex and, like any of us, can lie (see Chapter 7), pretend expertise and cheat employers or insurance companies. Their role in the management of family life continues to expand.[49] Psychologists and psychotherapists, however, are bound by rules of conduct that can *include* some of these actions (e.g. assessment) and prohibit those that would be seen as detrimental to *any* relationship – that is, assault or explicit abuse of patients.

The next section illustrates the global spread of the psy project by reference to some of these professional strictures.

Governmentality and psy

In the UK the BPS held, until recently, the position of arbiter in cases where practitioner members working for the NHS had been accused of negligence or assault (termed "abuse" for reasons of political expediency).[50] The role is now subsumed under the duties of the Health and Care Professions Council, a body overseeing other professions, including counselling and speech therapy. The BPS claims a scientific (and charitable) status positioned as in the best interests of the citizen. As the first psy professional organization it can also lay claim to the first formalized and legitimized attempts to inscribe the self. It is a position that some commentators might regard as the origins of an ongoing attempt to globalize psy. There is no doubt that the formation of the BPS set the professional ball rolling. The project continues to appear both arrogant and scientistic.

Calcutta University opened the first Indian psychology department in 1916, and the Indian Psychological Association was formed in 1925. Indian academic psychology was colonized by early BPS praxis and structure. According to Clay, "Convinced of the universal applicability of Western psychology, many Indian psychologists tried to keep the discipline free of any Indian traditions."[51]

Professional psy authority in India is now vested in several different bodies: the Indian Psychiatric Society (IPS), the Indian Association of Private Psychiatry (IAPP), the Indian Association of Clinical Psychology (IACP), the Indian Association for Social Psychiatry, the Indian Academy of Applied Psychology, the National Academy of Psychology, India, and the Indian Association for Child and Adolescent Mental Health.[52]

India Education, a website promoting careers in the humanities, positions psychology in an exclusively Westernized way with no acknowledgement of the diversity of spiritual and cultural customs within a population exceeding a billion people. The following paragraph would be familiar to any UK clinical psychologists training in the 1960s:

> Psychology is the study of human behavior and mental processes. Psychologists study a person's reactions, emotions, and behavior, and apply their understanding of that behavior to treat the associated behavioral problems. Treatment is focused on therapy and counselling . . . Psychologists are therefore responsible for identifying psychological, emotional, and/or behavioral issues, as well as diagnosing any specific disorders, by using information gleaned from patient interviews, patient's tests and records, and medical reference materials. Clinical psychologists . . . may act as therapists for people who are experiencing normal psychological crises (e.g., grief) or for individuals suffering from chronic psychiatric disorders.

India Education is explicit about the financial benefits accruing to qualified psy professionals. Under the heading "Psychology Pay Package", the potential applicant is informed: "Psychology is a highly rewarding and lucrative field of study. Professional psychologists with M.Phil and Ph.D degree earn quite handsomely. Those engaged in private practice have more scope for earnings."[53]

Barnette's summary of his observations following a tour of Indian clinics and universities in the early 1950s included a view that clinicians were "preoccupied with the Rorschach, and TAT [Thematic Apperception Test]", a phenomenon that would have been familiar to observers in the USA and the UK in the second half of the twentieth century. Barnette suggested that

> Clinical testing is done by poorly trained people and . . . experts are apt to appear on the scene after one reading of Klopfer [who developed a popular analysis of the Rorshach Ink Blot Test] . . . there are as many "local adaptations" of the TAT as there are schools where this type of research secures sponsorship.

Barnette was "informed of one young man, with only an M.A. degree in philosophy, who was 'practicing' psychoanalysis".[54]

Referring to Barnette's findings, Misra and Rizvi in 2012 conclude: "It seems little has changed over the past 57 years." Further, for these authors, "Credentialing of clinical psychologists is in a 'big mess.' " They suggest a national licensing board of psychology to conduct written and oral examinations for credentialing clinicians. The licence is to be renewed every two years contingent upon up to 25 hours of continuing education (post-master's-level degree) including 3–4 hours training in professional ethics. In the absence of a subcontinent-specific diagnostic nosology, the authors recommend "diagnosing mental disorders using the current edition of a standard diagnostic system, like, DSM-IV-TR (American Psychiatric Association, 2000), or ICD-10 (World Health Organization, 1993)". Rather than assuming validity for culture-specific concepts of illness, the authors suggest "a need for a verifiable and replicable body of data demonstrating not only incremental validity of using Indian concepts but also, inapplicability of Western concepts in India". Consistent with the Western popularity of "evidence-based" therapies, the authors suggest that practitioners "consider" using CBT, DBT or Mindfulness-based-CBT. They add: "clinical psychology in India appears to have flirted with a 'soft' romantic view of mental disorders. There is need to strengthen the empirical base for diagnosing and treating mental illness within a comprehensive framework of professional ethics and code of conduct."[55] Misra is based in private practise in Ohio; his recommendations have a decidedly US cast.

The IACP was formed in 1968 with a view to advancing concepts of mental health and the profession of clinical psychology. By 2009 it had 852 members. Beginning in 1974 the association also started publishing the biannual *Indian Journal of Clinical Psychology*.[56] An Internet forum was started in November 2006. There are over 4,000 members.[57] Commenting on the website, Misra and Rizvi note: "one is nostalgically reminded of informal groups of people in coffee-houses, wayside tea-stalls, and village-well or river-banks providing a non-judgmental platform to exchange thoughts and opinions".[58]

The Chinese Psychological Society (CPS) was founded in 1921. By 2007 it had 3,200 members. It is funded by the Chinese Association of Science and Technology. Membership qualifications are possession of the equivalent of a master's degree, three years' work experience following a first degree or "considerable work experience in psychology" for non-graduates. The aim of the society is to "unite psychologists throughout the country, to develop academic activities, and to promote research and exchange, in order to accelerate the development of psychological science, so as to contribute to China's social development".

The society publishes two journals: *Acta Psychologica Sinica* and *Psychological Science*.[59] The CPS has 15 professional committees covering specialties that include industrial psychology, medical psychology, military psychology, personality psychology, psychological measurement and counselling psychology. The *first* Ethic Codes for Psychological Assessment were issued in 1993 – over 70 years after the society's formation.[60]

In October 2011, representatives from the society met with American Psychological Association staff and the two organizations signed a memorandum of understanding "to facilitate future exchange and interaction". Focusing on discussion concerning models of continuing education, disaster response and public education, the meeting was reported as opening "the door to collaborations between the two organizations".[61] The APA is positioned here as influencing the psy project in China – a role liberatory psychologists would regard with some suspicion.

Like their Indian counterparts, Chinese psychologists cannot be accused of a lack of ambition: a grouping with less than 4,000 members aspires to influence in a country of 1.5 billion souls. Claiming a scientific agenda, the CPS hopes to influence a country dominated by folk religion or Taoism. Estimates of religious adherence in China vary and are difficult to verify due to factors such as the essentially familial basis of religion and the corresponding lack of organizational structures, in addition to the official suppression of religious practice during the Cultural Revolution. Estimates thus vary from 11 to 30 per cent of the population as practising Buddhists, while some 23.8 per cent are said to worship gods and ancestors. A conservative estimate might be that half the population – perhaps 750 million people – follow forms of folk religion more keenly than they might ascribe to modernist forms of psy science.[62]

Adair compares the process of indigenization in India and Taiwan, highlighting the role of language. For him the language of science is a technicalized form of English; the language of culture may be Hindi, Mandarin, Spanish or German. He notes a psychologist interviewed in India about indigenization of psychology who says: "As a psychologist I think in English; but as a person I feel in Hindi." He suggests that indigenous research is likely to be "more successful" if it is conceptualized and the data are collected in the native language.[63]

The notion of indigenous psy is, however, problematic. The term can include individual practitioners claiming privileging alignment with the background of their constituency or theorists who reject the imperialist agenda of psy privileging instead a culturally located discourse. The former may involve psy practitioners using Westernized interventions – for example, ECT or pharmacotherapy – from a position of expert power, the only use of referent power being to draw patients into the embrace of psy. Early in 2015, for example, a Chinese psychiatric clinic was ordered to pay compensation to a gay man who was given electric shocks and hypnosis in an attempt to make him heterosexual. The patient agreed to the therapy following pressure from his parents and as a political act to demonstrate that homosexuality is not a mental illness; homosexuality has not been classified as a mental illness in China since 2001. A Beijing court decreed that the clinic would have to pay RMB3,500 (US$560/£400) as reimbursement for costs rather than compensation.[64]

Indigenous theory and theorists face several difficulties in aligning themselves with a liberatory discourse. One challenge is the *number* of potential indigenous populations. In North America, for example, there are over 500 indigenous groups with differing customs, cultural traditions and languages. Critically focused praxis is, by necessity, here best offered by collaboration between a particular community and a psy practitioner from within that community. The language of psy – English, German or French – must be either translated or "borrowed". As noted above, religion (maligned by Freud as neurotic or modernist psy as "unscientific") is a factor largely ignored in the empiricist tradition. A psy practitioner might share a cultural heritage with a particular group but not the group's religious beliefs or practices; a psychoanalyst may be able to incorporate the dream life of certain Polynesian groups into a theoretical interpretative framework but accepting the first premise – that dreams are more real than a generally accepted external reality – would make the framework untenable.

Theory arises in context, reflecting and influencing that context. Thus the liberatory psychology of South America tends to provide a rich source of material for Western academics but does not lend itself to practice in regimes regarded as less repressive. As Rose has noted, the essential *production* of the self for governance renders self-governance a goal in such regimes, while external governance and oppression remain the norm in militarilistic societies and dictatorships to be found from Africa to Tibet.

These caveats do not prevent the assumption of some tenets of liberatory psy by certain theorists and practitioners. One such might be that theory and practice should be in service to liberation and egalitarianism rather than in service to a notional "greater good" and a colonialist endeavour. Theory as much as practice should be grounded in the non-colonizing of language or the mind.

In summary, the *professional* project of psy continues to expand. The BPS, formed as the Psychological Society by a small group of academics and medical doctors at the turn of the twentieth century, now boasts well over 100,000 members. There are hundreds of national psy societies worldwide, with many subdivisions incorporating feminist, militarist and liberatory discourses. The language of psy dominates popular discourse to such an extent it is impossible to talk of the self without invoking inscribed characteristics. A perceived need to limit the conduct of psy professionals has led to attempts to constrain professional morality within federal and national government protocols. Chapter 9 examines some of these attempts.

Contextual note

Rage Against the Machine (1992) Sony Musical Entertainment. Nuff said.

9

Governing Professions II: Them and Us

This chapter discusses the ways psy praxis and efforts to influence it are governed within frequently contradictory and confrontational moves by government, professional and service survivor campaigns, and the legal system. This disciplinary endeavour is itself constrained by the ubiquity of the psy lexis. Psy has become spy.

Case conferences and other contests

There were several stories to tell the buyers of the house I was selling. One concerned the wooden shed that a friend of mine and I had dismantled and moved down the garden. The shed had been a mess: a leaking roof, smashed windows and worse. Ignored for a couple of years while various house renovations were undertaken, it was on the point of being ditched when a neighbour who had long before lived in the property happened to visit. As it turned out, the shed had been his home for several years. A general practitioner had diagnosed a childhood lung condition and suggested to his parents that sleeping upstairs in a frequently smoky house was ill advised. So his dad, a builder, erected the shed for his son to live in, which he did until he built his own bungalow in an adjacent field. His tale saved the shed.

In the late 1990s the neighbour's 40-year-old son was killed in a climbing accident. By now almost 80, he was overwhelmed with grief. A few days after the accident his wife called to say he had been admitted to the local psychiatric hospital and the consultant psychiatrist was considering ECT. She asked me to visit. Though employed by the same hospital as a clinical psychologist, the visit was in my capacity as a neighbour. The early part of our meeting seemed to go well. I reminded him that he was a voluntary patient and couldn't be compelled to undergo ECT.

He asked me to sit in on his case conference as an advocate. It had been a very long time since I had experienced one and knocked on the meeting-room door with some trepidation. I entered into the tail end of a discussion about a previous patient, just at the point where a nurse was telling the consultant that the patient's spirits "seemed to be lifting a bit" after her second bout of ECT. The consultant nodded sagely and recommended that the "course of treatment" (four more sessions) should be completed.

Psychiatry mimics medicine in order to assert itself as a bona fide branch of the parent discipline.[1] In addition to using Latin-derived terms for arbitrary clusters of behaviour, psychiatry prefers physical to social interventions and, for the purpose of team discussion, case conferences and ward rounds. The case conference reinforces a particular hierarchy:[2] The consultant psychiatrist at the apex, followed by the clinical psychologist, social worker and nurses. The patient's relatives, if present, are between the patient and other staff in a hierarchy wherein, despite rhetoric around "patient-centredness", the recipient of services is last. This arises in part from the educational function of the ward round. Here, patients are "cases" used to illustrate diagnoses and medical conditions to junior staff. It might be argued that patients termed, in the business jargon of the last 20 years, "consumers" are in fact *consumed*.[3]

Material resources, social class and education are all examples of proximal power. We all experience proximal power at different times, though that power is mediated in a social context where distal powers – for example, culture and language – are of at least equal importance.[4] In the context of a patient's encounter with a psy professional, the immediate proximal influence of the patient's distress on the professional may be counteracted by the power of technical language and psychotechnical procedures (e.g. psychometric tests) used by the professional.

Patients encountering the psy system and its employees may have access to different types of social power.[5] In their working or family lives they may be a parent with a degree of authority or the power to *reward* or *coerce*. In a hierarchically structured trade or profession they may have a formal role giving them *legitimate* power over others. In the context of the ward round, however, unless they are in a private hospital with financial resources at their disposal, the *number* of staff encountered in a case conference is likely to overwhelm their usual access to social power. In this context the *expert* power of the professionals becomes another factor.

The case conference may be a place to address wounds (e.g. discussing the adverse effects of medication) or can be considered an arena where further wounding is to be suggested (e.g. a decision to administer ECT) or experienced by the patient in his or her loss of agency in the process. Although some research has indicated that patients prefer one-to-one meetings with their consultants due to the power of discharge held by the latter, a more normative rational is that one-to-one meetings are less threatening to the patient. As discussed earlier, one purpose of the psychiatric ward round is to further embed psychiatry within customary *medical* praxis. One-to-one meetings neither mimic the case conferences to be found in general hospitals nor give an opportunity to induct junior medical staff into the routine (a facet of their medical "education" in addition to learning diagnostic and treatment protocols).

My experiences in case conferences as a qualifying clinical psychologist were enlightening. I might be asked the occasional question about test results or, for outpatients more often than inpatients, asked if I would see the patient for individual therapy. In something of rescuer mode I would usually agree, naïvely thinking that medical staff would also agree to stop prescribing medication. If I offered an opinion based on discussions with patients – frequently about the circumstances of their lives beyond the hospital – the consultant would appear to listen, then increase or change the medication. My place in the hierarchy had been confirmed.

The experience is common and one which has led clinical psychologists to make claims for the superiority of their praxis over psychiatrists. For some the status and power of medical consultants has led to claims that clinical psychology is better placed to hold powers under the Mental Health Act or prescribe drugs (see chapters 6 and 10). For others, an old joke summarizes the key conflict: "What's the difference between a clinical psychologist and a psychiatrist? About US$50,000 per year." Or, in the words of Sir Van Morrison:

> Professional jealousy, started a rumour
> And then it extended, to be more abuse.
> What started as just, black propaganda
> Was one day seen to be, believed as truth.[6]

In these struggles for dominance, for the public, the title "Doctor" is a mark of power – the details within that mark are invisible; psychologists and psychiatrists become interchangeable. The profession itself does little to make a distinction. The positioning of the *Journal of Clinical Psychology* published since 1945 is made clear in its general statement of purpose which notes the journal is "a monthly peer-reviewed *medical* journal covering psychological research, assessment, and practice ... It covers research on *psychopathology*, psychodiagnostics, psychotherapy, psychological assessment and treatment matching, clinical outcomes, clinical health psychology, and behavioral medicine"[7] (my emphasis).

As noted in Chapter 8, however, psychology is everywhere; the psy lexis absorbs, and is absorbed by, public discourse, psychological research dictates the way supermarket shelves are stacked, occupational psychologists design questionnaires for employers; in education, psychologists assess children to determine whether families are entitled to state benefits. Military psychologists devise methods of torture for alleged terrorist detainees, clinical psychologists support psychiatry in the labelling and treatment of an increasing number of diagnosed individuals, while community psychologists attempt to influence social projects, and counselling psychologists research and intervene in individual distress. All this is underpinned by a growing academic discipline which includes developmental, social, experimental and neuropsychological branches. There is now an entire subdiscipline of critical psychology and the BPS includes counselling, clinical, educational and occupational divisions, and psychotherapy, philosophical, historical and health sections.

Conflicting interests

Conflicts of interest obtain within and between different aspects of the psy enterprise and between individuals and organizations bound up in the discourse of governmentality.

Perhaps the first area of identifiable conflicting interest is that *within* individuals – patients and psy professionals. Patients may present with self-identified difficulties knowing that the identified difficulties conflict with other aspects of the self or "selves".[8] The inscription of certain "problems" – for example, exhaustion due to overwork – is privileged over less socially acceptable aspects of the person's character, such as preferring work to family life. At first sight the presentation lends itself to talking the difficulties through with a friend, a simplistic therapy approach such as CBT or, perhaps, a family therapy perspective. Any of these options depend, however, on the person's willingness to reveal the internalized struggle – a struggle that needs to be contextualized with reference to societal pressure on the employed and internalized tropes relating to being a "good" parent.

Psy professionals are subject to the same disciplinary discourse as their patients. An overworking psychologist experiencing much the same struggle as the patient outlined above may not provide sufficient "space" for the patient's identified difficulties to be explored. Equally, the conflict of interests – family life and work – may so preoccupy the psychologist that he or she is consistently late for appointments or neglects note-keeping. This lack of a demanded "professional" stance may, in itself, be a conflict for the psychologist who – like the patient – must be willing to reveal the struggle if help is to be sought. The *ease* with which professional bodies and regulations make statements about professionals' ability to self-monitor to this extent is emblematic of their function within the gaze – turning the gaze inward is not seen as a particularly difficult process. As outlined below, *acting* differently as a consequence of the gaze is more difficult than professional guidelines would imply.

Conflicts of interest *between* patients and psy professionals are as common as conflicts of interest between any persons. One, for the purposes of a consultation designated a patient, may want to see the professional more or less often than the professional can accommodate or agree to. If a psy professional has more than one patient (as all do) then the professional must ignore requests for an inconvenient number or timing of appointments from any given patient in order to meet service targets, abide by regulations covering "safety" and other matters, and protect a life beyond employment. The situation obtains with friends who must face conflicting priorities in arranging to meet. For some patients the *appearance* of therapy as a form of friendship is quickly dispelled by therapists offering appointments at set intervals as dictated by manualized therapies or employers.

Other – possibly unstated – conflicts arise in relation to many factors within a therapeutic discourse. Gender, race, culture and age, for example, are supposedly irrelevant to newly qualified psy staff who agree to abide by the Geneva Declaration (see Chapter 10). Even a psy professional who could somehow obtain this ideal of untarnished beneficence will meet patients who have agreed to no such guiding principle. A patient presenting as racist, sexist and ageist will challenge any declaration signatory if these biases are seen as unrelated to the presenting problem. At the least they are a distraction, potentially offensive to the professional and potentially deleterious to the relationship. For the professional, signing the declaration will make no difference to views already held. For some professionals constrained by role, service demands or the need for sessional payments to see as many people referred as possible, their own prejudices are likely to impede any "therapeutic alliance" with patients viewed in stereotypically prejudicial ways. For others – for example, clinical psychologists in the NHS – with more autonomy, biases can only be inferred by reference to case-loads which may not be representative of local demography.

There may be conflicting interests for the professional in training who has been required or has opted to train in a particular form of therapeutics. A professional hoping to add to cultural capital by training in, say, family therapeutics will increase the number of families seen at the expense of seeing individuals. Although, from a systems perspective, families are inextricably involved in the identified problems of any patient, many patients prefer to experience one-to-one therapy; for the therapist training in systemic family approaches, these preferences will be ignored.

The list of possible intra- and interpersonal conflicting interests could go on. For the purposes of this chapter, however, the preceding paragraphs are a scene-setter for what follows: an analysis of the conflicting interests and power relations between and within professional groups, service user and recipient groups, the pharmaceutical complex and government.

Disciplines and discipline

Interdisciplinary struggles within psy have a long history. In the French courts of the mid-nineteenth century, alienists fought with both the emerging discipline of psychology and the judiciary for the right to speak with authority on the mentality of the accused.[9] In the early part of the twentieth century, Freud defended the right of non-medically qualified people to train as analysts.[10] By the 1940s, interdisciplinary tensions were the norm. In a return to the mid-eighteenth-century theories of Esquirol and others, Horney and Stack-Sullivan were emphasizing the importance of culture and familial context as their profession – psychiatry – struggled with neurology for dominance using increasingly physically invasive interventions with patients as one route to professional territorial advantage (see Chapter 5). In the 1950s, Eysenck (a psychologist) championed a scientific psychology, Winnicott (an analyst) was pursuing an essentially Kleinian intrapsychic agenda and John Bowlby was developing theories of pathology related to the mother–infant bond, research initially prompted by the number of children separated from their mothers due to mass evacuation from London during the Second World War. Eysenck's stance ultimately led to the formation of an entirely new profession of clinical psychology in the UK. With the formation of the Division of Clinical Psychology in 1965, the new profession would have explicitly excluded some of the founding member of the BPS Medical Section from membership as they held medical rather than psychological qualifications.[11]

Eysenck promoted the need for psychologists to stand apart from psychiatrists and develop a new praxis focused on research, the modification of specific behaviours and the study of personality rather than diagnosis and pseudomedical entities such as schizophrenia and depression. His work set the scene for a notional antagonism between psychiatry and clinical psychology that obtains today. Whatever the individual practice of clinical psychologists, the official stance of the Division of Clinical Psychology is, essentially, anti-psychiatric. The recourse to psychological formulation is the latest move by the profession to stay at the vanguard of other psy professions. This new branding follows phases where the profession self-identified as scientific-practitioner and reflective-practitioner, and coincides with the emasculation of the BPS as disciplinary body (albeit one where registration was voluntary) through the absorption of the BPS into the Health and Care Professions Council (HCPC).[12] The wider context of psy would suggest that psychological formulation will be as shortlived as the previous appeals to scientific and reflective practitioner status. The wider context includes the dominance of US-based psychological journals utilizing psychiatric nosologies, attempts by American psychologists to obtain prescribing privileges (to date there are three states where psychologists can prescribe medication) and the sheer *number* of clinical psychologists soon to emerge from China and the Indian subcontinent.

A typical professional(izing) territorial move by clinical psychology based on self-interest is illustrated by an event organized by the HIV & Sexual Health Faculty of the BPS Division of Clinical Psychology. The NICE publication *Prevention of Sexually Transmitted Infections and Under 18 Conceptions* was issued in February 2007. The HIV & Sexual Health Faculty held a "strategy day" two months later in order "to discuss how the guidance would affect services and what opportunities it would hold for psychologists".[13] The guidance recommended that health professionals should review individuals' sexual history in order to "identify individuals at high risk of STIs [sexually transmitted infections]" and that those individuals would have a variable number of 15–20 minute sessions with professionals "trained in health work" to improve self-efficacy and motivation to reduce risk. Targeted populations were to be men who have sex with men, those coming from areas of high HIV prevalence, drug and alcohol abusers, and people having unprotected sex with multiple partners. Other recommendations included how to help patients with an STI notify partners, and how to advise on unwanted pregnancies and contraception. Midwives and health visitors were advised to "regularly visit vulnerable women aged under 18 who are pregnant for discussion about pregnancy prevention, STI testing and referral to other agencies".[14]

The guidance was based on a "few American RCTs" – a factor that did not deter the HIV and Sexual Health Faculty, stating that it presented "considerable opportunities for psychologists…".[15] A "working party" was proposed to "ensure good practice" by providing workshops and documentation on behaviour change and risk assessment and to think about "how to promote psychology…" in relation to the guidance.[16]

Published in the DCP newsletter, the proposal for a working party does no more than what might be expected from a professional body. The majority of clinical psychologists in the UK are government (NHS) employees and *bound* to respond to NICE guidance. The proposal assumes the expertise of psy professionals; and the audience is almost exclusively clinical psychologists unlikely to argue with professional expansionism described as "opportunity". The proposal nests within the concept of governmentality. In less than 500 words it maintains tropes of risk, health and inscription with no reflection on the role of psychologists in maintaining socially divisive constructs. The gaze is to be extended to the sexual lives of consenting adults and the practice of other health professionals *despite* an acknowledgement that there are few scientific grounds for the NICE stance as represented by the guidelines. "Behaviour change" and "risk assessment" are positioned as aspects of psy expertise, thus giving psychologists authoritative power to act as "educators."[17]

From Szaszian and Foucauldian perspectives the proposal positions psy in a role deserving further analysis. For the former, the invasion of privacy – already condoned in the legal role of health visitors, now to be supported by psychologists – is an anti-libertarian move. If people wish to have unprotected sex or children as single parents, that should not be the business of the state.[18] For Foucault the proposal is both an example of governmentality and an extension of the gaze into the lives of new "targets" – homosexual men and those deemed "promiscuous". Promiscuity is here reinforced as undesirable (due to sexual health consequences) and abnormal by reference to "multiple" partners.[19]

To discover these features of young people requires inscription. People are to be designated “homosexual”, “at risk” or promiscuous, and their conduct and preferences codified and compared with a perceived norm.[20] No justification for this inscription is necessary as this codification is legitimized by fiat, though a particular form of justification – *expertise* – is required for psy professionals to be involved.

Competitive advocacy for psychotherapy in its numerous guises by psychologists, psychotherapists and psychiatrists is common. In noting, for example, the presence of 50 psychologists on the 30 task panels of the President’s Commission on Mental Health, Vandenbos and colleagues conclude: “Psychotherapists will be assured that the future mental health needs of the nation are met by staying involved in today’s public policy initiatives.”[21]

Advocates downplay the deleterious effects and exploitative elements of the praxis and, in the case of clinical psychologists, tend to ignore the major contributions of non-psychologists – frequently psychiatrists – to the field. Ex-chair of the DCP and now President of the BPS, Peter Kinderman, for example, suggests that empathy and relationship should be the “whole new approach” to healing, a suggestion echoing the ambitions of gurus from Jesus to Krishnamurti.[22] His thesis more directly reflects the view, expressed 25 years ago by psychiatrist Peter Breggin in his subtitle to *Toxic Psychiatry: Why Therapy, Empathy, and Love Must Replace the Drugs, Electroshock, and Biochemical theories of the “New Psychiatry”*. Both professionals are making a territorial claim, Kinderman from the position of external and Breggin the more radical internal critic of psychiatry.[23] Ostensibly not in conflict with each other, both are positioned as in conflict with other professions – counselling, art therapy and systemic approaches – which might lay greater claim to a historical praxis privileging relationship. Neither author explains why psy professionals might be in a better place to offer love and empathy. Chapters 6 and 7 might suggest that psy praxis is rooted in an historical tradition privileging control over love and coercion over empathy.

Within the discipline of clinical psychology there are continuing efforts to emphasize the professional nature of practice, rather than emphasizing love and empathy. The latter cannot be *taught*, though some critics have remarked that practitioners can be taught to *appear* empathic and concerned.[24] Prospective practitioners in the UK must obtain doctoral-level qualifications in clinical psychology. In the USA a practitioner psychologist requires only a doctorate in the parent discipline, psychology, for licensure. Like their American counterparts, Indian clinical psychologists remain “preoccupied with the Rorschach, and TAT”, and in both China and India, licensure is possible after a master’s-level degree (see Chapter 8). People can practice anywhere in the world privately as psychotherapists or counsellors with no formal qualifications. Within a disciplinary discourse this is regarded with suspicion, though there are arguments from both libertarian and emancipatory perspectives against the need for psy practitioners to obtain qualifications or register with a body such as HCPC.[25]

There are 30 clinical psychology doctoral courses in the UK. The overall failure/drop-out rate marginally increased between 2008 and 2013 from 0.62 per cent to 1.10 per cent. In 2013 this equated to 19 out of a total of 1,728 trainees.[26] Over 90 per cent of those qualifying are white women in their mid- to late 20s. The proportion reflects the entry criteria for clinical psychology training (an upper second-class degree in psychology) and the high proportion of women completing undergraduate psychology degrees. Those qualifying have little relationship to the patient demographic. A radical critic might suggest that every year 580 more bright young things are sent to oppress us, though a more reflective reading might examine this group in terms of potential conflicting interests (relationships, employment, career progression, research) with their patients (relationships, [un]employment, oppression, poverty, adverse effects of medication and trust in professional praxis).[27] Some critics from within the profession (many of whom psy professionals would see as also benefiting from the psy enterprise) “see us as part of the problem . . .”, adding that “psychology has facilitated the cause of injustice” by being “at best a technique for ignoring power inequalities and structural determinants of discrimination, at worst an overt legitimation of racism”.[28]

The BPS established a voluntary register in 1997 but efforts to make this a statutory implement (effectively a closed shop for psychologists wishing to work in the public sector) failed. The internal disciplinary praxis for clinical psychologists in the UK was taken over by the HCPC in 2009, and both clinical psychologists in training and qualified practitioners must register as practitioner psychologists. The HCPC website allows public examination of details of complaints and any subsequent disciplinary actions.[29] Clinical psychologists are grouped with other psy professions as “practitioner psychologists”, of whom 21,000 were registered by February 2015.

In the first two years of its operation, one complaint concerning a clinical psychologist’s fitness to practice is recorded. The following year there were six, and a further five new cases appeared in both 2013 and

2014. In February 2015 alone, by comparison, there were 17 hearings featuring social workers (out of 87,000 registered members). The outcome of hearings (to which members of the public have free access) can include suspension or being removed from the register – "struck off." Accounts of accusations and outcomes fall within an expected disciplinary discourse. The social role of psy and its lexis remain unchallenged, and practitioners are consistently challenged to defend their "unprofessional" conduct. There are accounts of sexual assault accusations against clinical psychologists, deception, "inappropriate" use of test procedures and failure to keep "adequate" notes. This element of the gaze is critical to psy praxis: without note-keeping and inscription, psy loses a major disciplinary role in society. In one example within the complaints register, an ex-chair of the DCP was struck off the register *in absentia* for failure to keep notes (he sensibly also failed to attend the hearing).[30]

Half the clinical psychologists investigated by the HCPC are senior members of the profession. It might be speculated that, for example, "inadequate note-keeping" had pre-dated their membership of the HCPC by a number of years. There is no account of suggested "reasons" for the lack of notes – certainly there is no mention of voluntarily withdrawing on principle from the gaze, but the finding suggests a challenge likely to be faced by new registrants to the HCPC who have many years of particular praxis behind them. Changing the habit of a career lifetime (e.g. not keeping notes) will not come about simply by joining a registering body, even one which requires the regular auditing of patient records. Thus practitioner psychologists who have not been disciplined to maintain patient files will not do so simply because a disciplinary process (the gaze) is in place. It is like expecting people to keep to the speed limit when a new limit is put in place on a familiar stretch of road. As a *professionalizing* discourse the HCPC is not bound to consider contextual factors in a professional's conduct (in one example a complaint was made against a clinical psychologist due to his two-year waiting list – a *service* matter rather than a professional one). Rather, the process operates via "taxonomy to taxidermy". The accused are "mapped, measured, captured and stuffed".[31]

The ambitions of members of the Association of Humanistic Psychology (AHP) reflect a philosophy that "human beings are born fundamentally OK. We have innate capacities for giving and receiving love, understanding and being understood . . .".[32] In a critique of the moves towards statutory regulation of counsellors in the UK, Denis Postle, for many years a key figure in the humanist psychology movement, contrasts the humanistic position with that of psychoanalysis. The Freudian perspective is summarized thus: "People are innately aggressive."[33]

The AHP website defines humanistic psychology as follows: "It is broader than just a psychological discipline, and AHP is not just an organisation for psychologists, psychotherapists and counsellors; we are open to anyone who is interested in *how to be human.* It was founded by . . . people from many disciplines, such as history, poetry, philosophy and spirituality" (my emphasis). It goes on:

> Humanistic Psychology is not in itself a psychotherapeutic discipline; rather it is it is an umbrella term for a number of disciplines which put the person at the centre of their ways of working and strongly believe that the realisation of our own potential is crucial to creating a better world.[34]

Claims to knowing how to help people to be human or create a better world are bound up with a particular view of what the expressions mean. People are seen as "OK". Thus humanistic psychologists and their organization hope to counter a perceived psychoanalytic view that people are fundamentally aggressive. Being OK *and* aggressive does not appear to be an option within the AHP ideology, a fundamentally Christian stance (though members would recoil at the suggestion). Psychologists and others are here inscribing unpleasant people as "wounded" with their learning "distorted", as, by dint of circular logic, if people are "basically good" when they act in unpleasant ways it must be the outcome of some event that has impacted on their basic human nature. The vested interest in this position is clear – counsellors facing mean-ness, spite and anger shown by patients ("clients" in the fee-paying world of humanistic psy) may add to their capacity for tolerance by believing the patient is fundamentally loving rather than vitally abusive. Sessions can continue as the patients discover in their therapists pools of patience they – understandably – rarely encounter unless paying. For the analyst an opposite position may obtain as the search for the darker side of a patient's worldview can take some time if the patient is actually quite pleasant (if a little boring).

Postle's faith in the goodness (as he sees it) of people leads to his suggested method for ensuring standards of practice among counsellors in the Independent Practitioners' Network (IPN), a mutual counsellor support organization he founded in 1994. Small groups of fundamentally honest and good counsellors should meet regularly to discuss therapeutic praxis. The goal is one of mutual exchange in a trusting relationship, the model – peer supervision – derived from the cocounselling tradition. Cocounselling is based on reciprocal peer counselling. Time is shared equally and the essential requirement of the person taking their turn in the role of counsellor is to listen and give full attention to the other person. It is not a discussion; the aim is to support the person in the client role to "work through their own issues in a mainly self-directed way".[35] Cocounselling was originally formulated in the early 1950s by the American Harvey Jackins. A practitioner of dianetics – a personal development movement created by Ron Hubbard, founder of the Church of Scientology – Jackins died in 1999 having faced almost 20 years of criticism, including accusations of rape.

This type of peer support or peer supervision proposed by the IPN is practised throughout the psy world. Indeed, the NHS department of which I was director had several such groups and dyads. It represents a unique version of the gaze. Psy professionals voluntarily present versions of their praxis and other concerns for other psy professionals to comment upon. In their turn the other professionals in the room or in online Skype encounters do the same. The meeting can be represented as a figure of eight, the counsellors at the middle crossing point. The gaze is present in both circles (conveniently the whole resembles the NHS spectacles popularized by John Lennon). The gaze, however, is influenced in its turn. On the right-hand side, government, training bodies, training courses and professional bodies suggest what should be attended to by both participants. On the left-hand side, culture, family and personal histories, previous experiences of supervision and the meaning attached to previous or current training suggest relevant aspects of the encounter. The figure quickly becomes extremely complex if the interdependence between the aspects of governmentality on the right and left is recognized. This way of representing the supervision or cocounselling encounter applies equally to therapy dyads.

As noted above, the peer and cocounselling approaches depend on a particular view of human nature: in essence, people are doing their best to be "good". Postle himself offers contradictory evidence for this idealistic view of psy professionals (and people as a whole) when he quotes research that estimates rates of between 10 and 15 per cent of counsellors sexually abusing their patients.[36] Presumably those who assault or otherwise exploit their patients would severely censor what is revealed in supervision or cocounselling. Postle's plea for a more liberal and less sanctioned form of therapy organization would appear, at first glance, to be a mite too liberal for some. We know, however, that the estimates for sexual abuse in therapy are derived from surveys of *registered* practitioners, already bound by professional codes of conduct which they break at will. Postle's suggestion may be no worse than the system that currently obtains.

In any case, from the "scientific" perspective of professions such as clinical psychology there is no research demonstrating that supervision has any impact on therapy or therapy outcomes. In some forms of family therapy, supervision does have a direct influence via telephone or earpiece link-up between an observing team and the therapist; there is no research demonstrating that such supervision affects therapy outcome. The voluntary gaze of cocounselling repeats the self-justificatory professionalizing discourse that supervision is *necessary.* One response might be that for those professional bodies claiming that supervision is necessary, the figures on sexual abuse in therapy would indicate that it is not sufficient. This opens the door for demands for further training (or continual professional development) for psy professionals, a demand now met by over 1,000 counselling and psychotherapy training courses in the UK, excluding "personal development" and "coaching" courses. Psychotherapy training on offer ranges from mental aptitude patterning to suggestology via pet-facilitated psychotherapy. We appear to be reaching the point where the AHP goal for voluntary cocounselling as supervision will soon be met in some parts of the country (Hampstead and Chorlton-cum-Hardy in Manchester come to mind) merely by chatting to a neighbour, as the proportion of trained psy professionals begins to outweigh the proportion of non-counsellors among the general public.

Trading in misery

Arguments are frequently made that the psy industry has no vested interest in *curing* the numerous so-called conditions with which it inscribes the populace. Psychoanalysts are unusual in not suggesting a cure *per se*. Since Freud, the aim has been to return people to "ordinary misery". Other groups discuss "recovery" or, for those marked as disabled, "mature dependency" rather than independence. For the majority, however, service contracts with patients involve the idea of cure – or at least, for the people seen by UK IAPT practitioners, a change in scores in the desired direction on psychometric tests for depression.[37]

If no cure is forthcoming then less, more or different therapy and medication can be proposed in an endless dance. Therapists and drug manufacturers can't lose – for the latter the need for additional drugs to offset the adverse effects of prescribed medication guarantees an income.

Financial interest was paramount to Freud.[38] His income was entirely dependent on private patients for many years. In the UK, as in North America, the *number* of patients seen is more important than the *outcomes* for psy professional in both the public and private sectors. The former are paid no matter what the results of their practice, while the latter continue to advertise services whatever the results of theirs, and neither group systematically researches therapy outcome. For keepers of private clinics and madhouses the potential profits from human misery have been considerable. Treatment fees are only one element in a lucrative system of charges for food, additional therapies and medication, accommodation, domestic services, recreational and so on.

As noted in Chapter 3, distantiation as a technical praxis requires more than the fear and concern seen as motivating the establishment of leper and epileptic colonies 1,000 years ago. Removal to a therapeutics facility may only require concern that a relative is experiencing more than a tolerable degree of distress, which is simultaneously distressing to others. Such judgements are wholly subjective. The language of DSM maintains this subjectivity. Despite an apparently complex system of codes and diagnoses, the definitions of any given diagnosis rely on ordinary language. A person's conduct will be marked as exceptional and deserving of a psy inscription if the professional sees elements of, say, checking as extreme and therefore "obsessional", or quietude as "withdrawn" and thus "depressed". Similarly a teacher might ask for an assessment of possible ADHD if his or her attention is repeatedly drawn to a particular child rather than the others in the classroom. Formal distantiation requires several related processes: concern about a form of distress or abnormality, removal to a place of assessment or diagnosis, and treatment, which may involve incarceration.

The "trade in lunacy" was established in the eighteenth century.[39] It was a trade regarded as "shady" and "secretive".[40] Private madhouses were places to hide away eccentric, difficult or obstructive relatives, to resolve property disputes, and to banish difficult wives and daughters. They have left few traces for the historian, tending not to keep case books and destroying their records.[41] Porter describes them as "running sores of scandal" featuring extreme cruelty and deprivation.[42] Daniel Defoe described how the conditions in these institutions "clapped up, stripped, whipped, ill fed and worse used" was "sufficient to drive any soul stark-staring mad". He added: "All private Mad-Houses should be suppressed at once."[43]

By 1858, Forbes Winslow, editor of the *Journal of Psychological Medicine*, was complaining that asylums and their inmates could be "brought into the market and offered for sale, like a flock of sheep, to the highest bidder".[44] Upheavals in asylum management in Britain in the nineteenth century (in effect a "takeover" of public and private institutions by qualified medical personnel) were matched in India. The subcontinent had seen a form of institutional psychiatry even more blatantly based on the profit motive. Asylums in India were run by the East India Company, catering for European woman, soldiers and sailors, as well as the Indian and Eurasian insane. The latter were kept in conditions described as "abominable". The officials insisted on separation by race, class and gender, leading to considerably better living conditions for Europeans. By the turn of the century, an assistant surgeon (the company demanded neither proof of nor specific medical qualification), Valentine Connolly, ran a private madhouse in Madras while W. Dick owned Bengal's private asylum (for Europeans). By the 1840s the Madras asylum was structurally unsound, but not before Connolly had made a fortune from its sale (and, *de facto*, the sale of its inmates). In the Calcutta asylum the quality of provision was entirely based on social standing and racial background, a factor contributing to the potential for corrupt financial practices on the part of the superintendents and ward orderlies. For over 50 years the purchase and sale of asylums (and their inmates) in India made handsome profits for those in similar positions to Connolly.

Despite the conditions within the company's asylums, "cure rates" bear comparison with those claimed in England at the time. The lowest rate claimed, for example, for Calcutta in the 1840s was 12 per cent, while English and Welsh military and naval asylums were claiming 11. Mortality was a different matter: by 1850 the mortality for the Bengal asylum had reached 18 per cent whereas in England the rate was half that.[45] Conspicuous by its absence was any acknowledgement or use of Indian healing practices pre-dating European methods by several centuries. Europeans were the elite so, by definition, indigenous medicine was inferior.[46] *Exactly* the same colonialist view obtains in the Indian Psychological Association today (see Chapter 8).

The maze of colonial medical praxis in the nineteenth century invites analogies with modern psy. Psy remains class, gender and race biased. An individual psy practitioner may not identify with a twenty-first-century trade in lunacy, but the practice obtains. In the UK a "foundation trust" in the NHS may successfully bid for health-delivery contracts in an adjacent area. In effect that trust is buying the buildings, staff *and* patients from competitors. In the private sector, a company may lose the contract for service delivery to another company, which then takes responsibility for the "assets" of that company, foremost of which are patients. The service "wound" experienced in displacement and "trading" of this type can be described as discontinuity. There will be a loss of sense of control and agency for the person, who will experience discontinuities in places, possessions and relationships. The few relationships the person does gain are "bought". Wolfensberger uses the German construction "boughten", inviting the poor joke that service recipients are "boughten-sold". Relationships are thus dependent on governmentality inherent in professional mores, legal aspects of service provision and service factors, including career moves of paid carers.[47]

Who pays the piper?

As in any human endeavour involving monetary exchange, all areas of psy praxis are open to financial conflicts of interest. At government level, any committee overseeing aspects of health governance will have links with the pharmacology industry and take advice from professional groups, such as the Royal College of Psychiatrists. These professional groups also offer advice to bodies integral to the structure of psy – for example, the Health and Care Professions Council in the UK or the DSM Taskforce in the USA. A lattice of governance exists which, through use of different subcommittees and other nodes in the lattice, appears to be independent of vested and conflicted interests. These subcommittees, however, frequently consist of the *same* people, people representing the interests of a professional membership, patient group or commercial branch of the endeavour. Professional bodies (e.g. the Royal College of General Practitioners in the UK) are part-funded by the pharmaceutical industry, and patient/carer groups can be government funded. The National Resource Center on AD/HD (CHADD) in the USA, for example, receives funding from the federal government's Centers for Disease Control.[48]

CHADD's website provides an object lesson in the use of tropes vested with cultural capital to persuade a particular interest group – in this case potentially guilt-ridden parents. The first statement cannot be true due to the invalidity of the ADHD diagnosis. The paragraph begins "Research has demonstrated that AD/HD has a very strong neurobiological basis." It goes on: "Although precise causes have not yet been identified, there is little question that heredity makes the largest contribution ..." and "difficulties during pregnancy, prenatal exposure to alcohol and tobacco, premature delivery, significantly low birth weight, excessively high body lead levels, and postnatal injury to the prefrontal regions of the brain have all been found to contribute to the risk for AD/HD to varying degrees."

Finally, "Research does not support the popularly held views that AD/HD arises from excessive sugar intake, excessive television viewing, poor child management by parents, or social and environmental factors such as poverty or family chaos."[49]

The modern shibboleth "research" is used to give credence to a position countering the "popularly held views". Though true, the *expert* power implied by the word "research" would be reduced if it was preceded by the equally truthful "some". Overall, however, in a few sentences, parents are off the blame hook. As parents are held accountable for sugar intake, TV viewing and other home-based factors, the privileging of neurobiology, heredity and injuries as "causes" removes parents from the gaze and adds to CHADD's popularity. This is a potentially confusing strategy for some parents who *want* to take responsibility so that they might change things but are surrounded by publicity aimed at minimizing blame.[50]

Numerous theories compete with the raft of individualistic developmental and physical/genetic theories for any inscribed psy condition. As noted in earlier chapters, the nineteenth century was rich ground for those seeking to explain disorder by reference to the environment. This disordering environment might include poor housing and inadequate diet. As technology broadens its reach into daily lives, the public are familiarized with its vocabulary. Notions such as "normal", "excessive", "deficient" and "imbalance" have entered the discourse. We now *expect* to be told that nutrient deficiencies, endocrine imbalances and spending too much time on video games, cell phones or watching TV are causal factors in illness. Medicine has added to the list of possible causative agents by introducing so-called treatments which are soon found (or already known to be) toxic.[51]

The next section examines disciplinary structural moves by government in the psy domain, with particular emphasis on the pharmaceutical industry.

Governmentality, psy and government

There will be neurochemical correlates of many of a child's behaviours associated with a diagnosis of ADHD (just as there would be with the clinician's conduct of *diagnosing* ADHD). Correlation, however, does not imply cause. An outcome of a discourse privileging neurochemical "causes" is the exponential rise in drug treatments to counteract the supposed neurochemical disturbance (see also Chapter 6). Between 2000 and 2011, spending on drugs to treat ADHD by the tax-funded NHS rose by 938 per cent; a total cost of almost £50 million in 2011.[52] The government of the day is required to maintain gover*nance* via systems of inspection and control over the use of public funds.

As noted in Chapter 7, the role of the NICE in the UK is to assess evidence for treatments to be supported and recommended for state funding. The procedures of NICE committees are social rather than scientific; evidence is presented, followed by *discussion* and *persuasion*, processes governed by the speaker's command of rhetoric. In 2008, NICE commissioned a Guideline Development Committee (GDC) to write guidelines for ADHD treatment. Almost two-thirds of the GDC had financial affiliations with pharmaceutical companies as consultants, researchers receiving grants or by being funded to attend conferences. NICE guidelines continue to recommend psychostimulants as a primary treatment. In 2011 a review of the 2008 guidelines concluded there was no need for change or further review.[53]

The global pharmaceuticals market is worth US$300 billion a year, a figure expected to rise to US$400 billion within three years. The ten largest drug companies control over one-third of this market, several with sales of more than US$10 billion a year and profit margins of about 30 per cent. Six are based in the USA and four in Europe.[54]

The National Institute of Health (NIH) is the US government's centre for medical research on humans. Its studies can affect the commercial viability of new drugs and the stock prices of biomedical companies. A decision was made in 1995 by the NIH director to lift restrictions on NIH employees paid for outside consulting. NIH employees were authorized to accept company stock as compensation for consulting. It was later suggested that the NIH could adopt restrictions in place at the FDA, where employees are prohibited from owning stock in companies that may be affected by the agency's decisions.

In 2011 the chairman of the Appropriations Subcommittee on Labour, Health and Human Services and Education asked if ongoing consulting contracts for all NIH employees could be suspended. He noted that various policies and decisions exempted over 90 per cent of the NIH's highest-paid employees from having to publicly disclose payments from drug companies or other outside employers. Officials at the NIH stopped accepting consulting fees and stock options from drug companies later that year.[55]

Seven of the more than 70 pharmaceutical companies operating in the USA publish information concerning government efforts to censure their activities. On 15 January 2009, Eli Lilly and Company, for example, pleaded guilty to a violation of the Federal Food, Drug, and Cosmetic Act (FDCA) and agreed to pay US$1.415 billion to resolve criminal and civil suits arising from its promotion of Zyprexa for off-label treatment of non-psychotic conditions, such as dementia. The total paid included a US$515 million fine and asset forfeiture of US$100 million, the largest criminal fine imposed against an individual defendant in the history of the USA. Under the Corporate Integrity Agreement (CIA) between Lilly and the US Department of Health and Human Services, the parties agreed that Eli Lilly would not be placed on probation. However, the agreement imposed a strict compliance program to ensure that Lilly's criminal conduct – marketing off-label drugs – would not recur.[56]

It is not illegal to pay doctors for promotional work. ProPublica, an independent, non-profit newsroom producing "investigative journalism in the public interest …" compiled a list of 384 physicians (out of 17,700 individuals receiving payments) and health-care providers who earned more than US$100,000 each from one or more of the seven companies disclosing payments in 2009 and early 2010. Nearly all were physicians, 43 of whom were paid more than US$200,000, including 2 who were paid US$300,000.

There were 45 who earned in excess of US$100,000 but did not have board certification in any speciality, suggesting they had not completed advanced training. Some of those doctors and others also lacked published research, academic appointments or leadership roles in professional societies.[57]

Some doctors on the list faced disciplinary action, and others did not have the professional experience that would justify their use as an "expert" in the field – that is, discussing a company's research in the context of the entire research base. A review of physician licensing records in the 15 most populous states and 3 others found sanctions against more than 250 speakers, including some of the highest paid. Their misconduct included inappropriately prescribing drugs, providing poor care or having sex with patients. Some had lost their licences. More than 40 had received FDA warnings for research misconduct, lost hospital privileges or been convicted of crimes. At least 20 more had had two or more malpractice judgments or settlements. Of Eli Lilly's speakers, 88 have been sanctioned and 4 others have received FDA warnings.[58]

More psychiatrists are listed in the database than any other kind of specialist. Of the 384 physicians in the US$100,000 group, 116 are psychiatrists. A psychiatrist based in Chicago, Illinois, received US$203,936 from Eli Lilly, AstraZeneca, Johnson & Johnson and Pfizer, mostly for professional education programmes. A Michigan psychiatrist specializing in child and adolescent psychiatry and forensic psychiatry received over US$200,000, as did an Ohio psychiatrist specializing in addiction psychiatry, forensic psychiatry, geriatric psychiatry, pain medicine and psychosomatic medicine. Psychiatrists from most American states, including Texas, New York and Utah, feature on the list.[59]

There is an – admittedly lukewarm – debate about whether paying doctors to market drugs can influence what they prescribe. Gifts and payments, however, are likely to be *seen* to affect physician's attitudes in much the same way as politicians are regularly accused of financial conflicts of interest or corrupt practices.

In the UK, "payment" can be via conference fees and Pharma-funded meals featuring promotional films, computer equipment and other goods. Any visit to a GP surgery will reveal the overwhelming presence of drug company literature and other promotional material (e.g. the ubiquitous "drug company pens"). Patients seeking amelioration of distress may not be in the best position to make links between their concerns and the particular drug they are prescribed, even if they notice that the name of the drug manufacturer is emblazoned on the doctor's pen. Were a patient to make the link, the illness discourse governing the consultation makes it unlikely that anything other than a form of "illness" will be inscribed and a drug "treatment" prescribed.

To ensure that pharmaceutical companies maintain a dominant share in the health market, drug representatives are frequently the mediators between prescribers and the industry. The simple selling of drugs is seen to require a more sophisticated praxis where, by no means naïve, GPs and others are persuaded to choose one product over another. Firms use ideas drawn from social psychology to enable pharmaceutical representatives to gain a foothold with any potential prescriber. "Relationship marketing" is one such approach. It is described as, "first and foremost, a mindset that understands the importance of comprehensive customer knowledge for directing actions that can nudge customer behavior in a particular direction".[60] In short, get to know your customer. Appeals to referent power (see Chapter 6) can then be made by salespeople who have discovered something – parenthood, a favourite holiday destination or TV programme – they share with the prescriber.

In the USA, concerned members of Congress regularly pursue investigations into suspected cases of corruption within the pharmaceutical and psy industries. Based on the numbers of prescriptions by a Miami psychiatrist, for example, in 2010 the senator for Iowa pressured federal officials to investigate why some doctors write large numbers of prescriptions for tax-funded Medicare and Medicaid programmes. The senator's concern was triggered by a "Florida psychiatrist who wrote 96,685 prescriptions for mental health drugs in a 21-month period", twice as many prescriptions as the second highest Medicaid prescriber in the state. The psychiatrist claimed the drugs were "cutting-edge" treatments.

An investigation revealed that the psychiatrist wrote approximately 153 prescriptions daily. He sometimes prescribed four or five different drugs to the same patient and was the second highest prescriber in the USA for the generic form of Xanax.[61]

Psy prescriptions are not limited to adults. As noted in Chapter 6, hundreds of thousands of children are prescribed antidepressants and stimulants. Here the "off-label" prescribing has been investigated in relation to inappropriately targeting younger children, More than 10,000 American two- and three-years-old are being medicated for ADHD outside established paediatric guidelines. The Centers for Disease Control and Prevention found that toddlers covered by Medicaid are particularly prone to being put on medication such as Ritalin and Adderall.

The American Academy of Pediatrics' standard practice guidelines for ADHD do not address the diagnosis in children of three and younger, nor the use of stimulant medications. In 2014, a nationwide Center for Disease Control (CDC) survey found that 11 per cent of children aged 4–17 had received a diagnosis of the disorder, and that about one in five boys will get one during childhood.[62] The majority are put on medications such as methylphenidate (commonly known as Ritalin) or amphetamines such as Adderall. Only Adderall is approved by the FDA for children below six years old.[63]

An analysis of Georgia Medicaid claims found 1 in 225 toddlers being medicated for ADHD – that is, 760 cases. An additional 4,000 toddlers covered by private insurance were also being medicated for inscribed ADHD.[64]

Governments are involved, to differing degrees, in monitoring the production as well as the prescription of pharmaceuticals. Clinical trial data reveal positive and negative results of drug trials in contrast with published articles which have a bias towards positive results. In the USA it is already a requirement that all data – both positive and negative – are published. The World Medical Association's Declaration of

Helsinki outlines principles for research involving human subjects. The 7th revision was published in 2013 and contained a section entitled "Research registration and publication and dissemination of results". It notes that there is an ethical obligation to publish negative, positive and inconclusive findings in a complete and accurate manner, and requires researchers conducting a research study involving human subjects to register the study in a "publicly accessible database before recruitment of the first subject", give all medical research subjects the "option of being informed about the general outcome and results of the study", and report and disseminate the study's findings and conclusions.[65]

In June 2013, the European Medicines Agency (EMA) published for consultation its draft policy on publication and access to clinical trial data.[66] On 2 October 2014, after an 18-month consultation period, it decided to publish the clinical reports. The EMA adopted the new policy in the interests of "transparency" in February 2015.[67]

In the UK the Parliamentary Office of Science and Technology (POST) is accountable for reviewing European legislation in relation to health industry matters. In March 2014 it acknowledged the EMA consultation. It had not adopted the EMA policy as of February 2015.[68]

The POST does issue monthly updates to prescribers and the public with access to the Internet. The *time* required to read these updates (which can number over a thousand per bulletin) makes it unlikely that many will be read by prescribers *or* prospective patients. Governmentality is effectively invisible, though present – any prescriber failing to warn patients of newly published adverse effects will be held accountable. For example, in July 2014 the POST issued a safety update on the anti-anxiolytic medication falling into the benzodiazepine group (see Chapter 6). The guidance notes that the drug is potentially a danger to drivers as it causes drowsiness.[69]

Within this discursive network, governmentality shifts between the industry, individual practitioners and the government itself. A more direct use of psy as a form of governmentality will be described in the next section.

Terrorizing psy

In the UK the BPS includes various sections and divisions that consistently argue for a society role in public health policy, a position that includes the establishment of more posts for clinical and other psychologists. The International Society for Ethical Psychology and

Psychiatry (ISEPP) in the USA consistently advocates for the replacement of medication-based psychiatry by psychotherapy. Its members petition the US government in matters relating to the use of pharmaceuticals, and the society has strong links to the Law Project for Psychiatric Rights based in Alaska, MindFreedom International based in Eugene, Oregon, and WNUSP with delegates in Africa, Asia, Europe and the Americas.[70] One of ISEPP's founders, Peter Breggin, as Adjunct Professor of Conflict Analysis and Resolution at George Mason University, suggested in 1992 that psychological principles could be used to explain and eradicate sexism, racism, poverty and war.[71]

War as it affects the citizenry seems not to be on the agenda for UK psy. In March 2003, the UK and the USA invaded Iraq. Subsequent references to the invasion were couched in terms of a war rather than an invasion, specifically a "war against terrorism". A comparison of articles in response to the invasion published in *The Psychologist* and the *British Medical Journal* over the first 21 months following the invasion is indicative of the "silencing" of a particular discourse within the professional psy community. No articles appeared in *The Psychologist*, while 22 (covering malnutrition, the effects of radiation, civilian deaths and the withdrawal of aid agencies from Iraq, among others) appeared in the *British Medical Journal*. Some *119* articles appeared in *The Lancet*.[72] Another contrast between psychological and medical (psychiatric) positions on war is found in the different positions on torture taken by the American Psychological Association and the American Psychiatric Association. Although both psychologists and psychiatrists were involved in advising on interrogations at Abu Ghraib and Guantánamo Bay, it was the American Psychiatric Association that issued a statement declaring that no psychiatrists should be involved in interrogation, leaving the US Defence Department to rely on psychologists.[73]

Governments have used psychologists in military selection and propaganda activities for almost a century. Disciplinary theories from group analysis to mother–infant bonding have arisen from psy professionals working in the context of war.[74] The use of psychologists in interrogation and torture illustrates one way in which the notion of a professionalized psy discourse has become ubiquitous. People have tortured each other for millennia – it is the imprint of psy *expertise* that adds a scientistic gloss to acts as straightforward as half-drowning captives or isolating and hooding them.

In late 2014 it was revealed that a company founded by two former military psychologists and APA members who urged waterboarding and other coercive methods against suspects secretly imprisoned by the

Central Intelligence Agency and Department of Defense had been paid US$81 million for work with the agency's interrogation programme from 2005 until 2009.[75]

Ostensibly an example of disciplinary governmentality, the US government renders the information about the incident almost invisible by its comprehensiveness. The *summary* has 525 pages; the full report has 6,700.[76]

The publishing industry might again be regarded as complicit in this form of govermentality.

The *Military Psychologists' Desk Reference* includes 69 chapters about psychologists' involvement in war with few references to the ethics of such involvement.[77] War, it appears, is big business for psy – as providers of strategic advice, advice on torture and interrogation, medication to enable military personnel to function with less sleep, propaganda experts, and stress counsellors for *both* military personnel and civilian casualties.

In an interview with Victoria Moore, Sian Williams, a former BBC *Breakfast* TV presenter, "reveals what prompted her to study psychology". She was studying for an MSc specializing in PTSD at Westminster University. Moore was herself doing a part-time psychology degree. As a journalist, Williams had specialized in interviewing family survivors from disaster zones, an experience that left its mark with "Images, individuals. Smell." This last she describes as going "straight to the limbic system" and getting "locked in". She practises mindfulness and quotes a study showing that mindfulness students "had less grey matter in their amygdala (a part of the brain thought to be associated with fear levels)". Moore's summary of psychology as a subject is brief and masterly. It reduces the subject to a series of questions (e.g. What is stress? Is there a happy gene?) that fascinate people. She does not acknowledge that the discipline answers none of these questions.[78]

Resisting psy

The first editorial of the *Journal of Abnormal and Social Psychology* (founded in 1906) suggests that the most important aim of social psychology is socialization: "the fitting of the behaviour of the individual to the social order".

Paris in the nineteenth century was one of the largest industrialized cities in Europe and was in the forefront of rising forces of anti-Semitism and far-right politics. Crowd psychology was established as a coherent discipline as the fledgling Third Republic was buffeted by clericalist agitation and populist movements. The French sociologist Tarde, the Italian lawyer and criminologist Sighele and the German sociologist Simmel established the discipline of crowd psychology, later to influence group psychological theories, in the late 1880s. Gustave Le Bon, a French anthropologist, published *La Psychologie des Foules* in 1895.[79] His book is said to be the most widely read psychology book of all time. Its readership included the doyen of public relations, Bernays (see Chapter 7), the group analyst, Wilfred Bion, and Hitler. Le Bon claimed that individuals, literally, lose their minds on becoming crowd members. They revert to a primitive racial unconscious and behave accordingly as a destructive force. The roots of populist psy have more to do with control than liberation, control that for Foucault and Rose is now vested in governmentality via the discourse of individual "responsibility". Pilgrim and Treacher summarize in relation to psy therapeutics: "psychological therapies, counselling and health education are examples, par excellence, of a new type of moral regulation favoured by government and public".[80]

Fully resisting psy is hampered by a relatively recent emphasis on interiority and individuality. Both concepts use the psy lexis extensively. Resistance against the psy industry, however, has a long history. Some of the most passionate activists in modern psychiatry are service survivors. An example is provided by the website for the European Network of Users and Survivors of Psychiatry. The webmaster was originally Peter Lehmann, publisher, writer and survivor. The site includes articles, links, commentaries and information generated by survivors on the various iatrogenic effects of psychiatry. The information appears in over 50 languages. The translations are provided by survivor activists around the world: one of my own contributions appeared in Japanese, Arabic and Finnish within days of it being posted. Many professionally run journals would be expected to take months to respond at all, without the translation. It seems unlikely that people have someone as creative and dynamic as Peter Lehmann in mind when they suggest consulting with a "service user".[81] Activists tend to term themselves survivors rather than users.[82] Many suggest that survivors of psychiatric services might prefer to set up their own support system.[83]

There are now hundreds of websites and Facebook pages devoted to psy. These are maintained by activists, pro- and anti-psy groups, survivors, carers, professionals, survivors and governments.[84] The scale of the Internet and available websites makes selectivity inevitable. Use of Web-based psy material is dictated by factors limiting any similar endeavour: interest, the availability of technology, and the time to devote to a reading of conflictual and contradictory knowledges. It might be argued that the resource best serves sociologists and academic members of psy wishing to add to their cultural capital via books such as this rather than any liberatory discourse. Reicher instead suggests a "guerrilla strategy" of "lending ourselves to those who feel themselves abused by psychology, turning up in schools, in courts, in the media and challenging what our colleagues are saying".[85]

The post-structuralist analysis of power relations involves questioning how certain discourses arise and are sustained while others are silenced. Foucault is not without his critics as his stance – in contrast, for example, to Deleuze and Guattari – is seen as apolitical: an analyst and commentator rather than activist.[86] In *Power and Knowledge*, however, he comes close to acknowledging the subversive potential of understanding the strategies of control within society: "The problem is . . . to acquire the rules of law, the management techniques and also the morality, the practice of the self, that will allow us to play these games of power with as little domination as possible."[87] This may be as close as Foucault ever came to approving of the tactics used by factory night-shift workers who have a well-earned rest between the hours of 1.00 and 3.00 a.m.

A form of resistance incorporating individual, societal, psy and legal perspectives is the "living will" or "advance directive". The first (self-) published example is that of Mary Ellen Redfield. In 1964, "Will for a living body" was drafted with doctors and lawyers, authorizing them to act as temporary guardians were she to become comatose or unsound of mind. *All* psychiatric treatment, including any yet to be invented, was to be refused.[88] The "will" exempted consensual psychotherapy. Had she had need of the document, Redfield might have been surprised by the ways in which psy overrides consent when it suits its own ends, though coercive psychotherapy is a relatively easy game to play for both parties.[89]

In 1983 the independent psychiatric survivor self-help organization Irren-Offensive (Lunatics' Offensive) received the article "The Psychiatric Will: A New Mechanism for Protecting Persons Against 'Psychosis' and Psychiatry" by Thomas Szasz, who proposed translating it into German.[90] He suggested that it should be possible to apply the mechanism of protecting a person's last will to involuntary psychiatric treatment. The idea had been put forward by Walter Block, an Austrian school economist, anarcholibertarian philosopher and professor of economics at Loyola University New Orleans.

Szasz's article was translated into German, and published and distributed as a booklet.[91] The booklet included a form, which had been discussed and developed with Berlin lawyer Hubertus Rolshoven.[92] The form included a legal instruction to psychiatric workers, space for personal data, different options, and space for referring to personal experiences to justify and strengthen the decisions about specific desired or rejected forms of treatment – especially specific psychotropic drugs or classes of psychotropic drugs. There was no law to cite except the criminal law, which defines each intrusion on bodily integrity as a criminal act, which loses its criminal character only if there is informed consent or if there is a life- and health-threatening emergency where people are unable to give consent and the psychiatrist believes that afterwards, when the person is in a rational state again, he or she would surely agree with the psychiatrist's decision. This legal construction is similar in most countries.

The idea was that if there is a statement written by the person while in a state of unquestioned rationality and the psychiatrist is aware of this statement (i.e. after it was handed over in the presence of a witness or sent by registered mail), it will be made absolutely clear to the psychiatrist that the person would not agree afterwards with the treatment without informed consent. Otherwise the psychiatrist could be subject to civil and criminal liability. In Germany, people who want effective legal protection from violation of their bodily integrity – usually through violent administration of psychiatric drugs – or even protection from unwanted psy examination can secure these protections by executing advance directives. A clinical psychologist inscribing a person via a psychological assessment would be acting illegally if that person had signed an advance directive (and foolishly if the psychologist had not checked before carrying out the assessment). In 2009, when the national guardianship law was reformed, it included a provision for advance directives for health care. Under the revised law, an adult considered capable of consent has the right to affirm in writing "independently of the type and stage of an illness" whether he or she "assents or disagrees with treatments, diagnostic procedures or medical interventions that are not immediately forthcoming at the time of this declaration." As noted above, psychological input is, to all intents and purposes, a medical intervention.[93]

Although an excellent example of an allied effort to resist the dominance of psy, the advanced directive is forced to use the same protocols (form filling, etc.) used within the wider system. The *energy* involved in obtaining changes in the law and praxis of psy should not be underestimated. Over 30 years have passed since the Irren-Offensive first received Szasz's article, and 50 since Redfield published hers.[94]

The Irren-Offensive worked with the psychiatrist Szsaz as an ally. Many similar organizations number psy professionals among their allies. For many of those whom psy professionals see as the benficiaries of the psy enterprise, however, psy professionals are part of the problem rather than solution. Psy is positioned as a set of technical procedures and lexis which ignore power inequalities and structural determinants of discrimination and oppression. It can be an overt legitimation of gender inequality and racism.[95] Via inscription and governmentality, psy helps construct the social order and disqualifies challenges to it.

I spy psy – the servants of power

To the extent that we are governed and govern ourselves by distal and proximal forces over which we have little control and power is the dominant discourse – discourse which has no reference point but itself – we are all servants of power.[96] The expression was first used to describe the impact of the social sciences on the workforce in US industry. If power is discursive, however, nested in the disciplinary lexis of individual struggle and resistance employed through governmentality, then it is power *in itself* that we serve rather than the more orthodox power represented by parents, employers and government.

It is not the aim of this volume to offer advice. If it is impossible to avoid the psy lexis and its inherent governmentality, however, *one* manoeuvre may be open to those hoping to avoid psy professions – think of them as spy professions.

Contextual note

A lifetime ago (1974) I joined about 60,000 other longhairs jiving to Crosby, Stills, Nash and Young at Wembley Stadium. This chapter was the last to be completed – cut, pasted, keyed in and edited from some 25,000 words over three weeks. There had been the usual mix of France Musique and the rest, but I needed a musical extravaganza to create some kind of closing mood. And then Crosby, Stills, Nash and Young's *1974* was released. Remember, "Only Love Can Break Your Heart".

10
So It Goes

"In these considerations there may be an entire philosophy for someone with the strength to draw conclusions. It won't be me."[1]

This chapter reviews conceptions of identity, professional and personal, and examines forms of resistance within psy. The role of "the author" in disciplinary praxis is explored via critique of a particular text. The critique invites the reader to reflect on the impossibility of "self" reflexivity and the place of analysology.[2]

Authoring the self

The Book of Disquiet, credited to Pessoa, was written over 20 years between 1913 and 1935, and it remained "unfinished and unfinishable".[3] A collection of 481 pieces varying in length from a sentence to seven pages, it is a "diary" – for its author(s): "A factless autobiography." It ends with "A disquiet anthology" – over 60 pages on everything from "Advice to unhappily married women" to "Funeral march for Ludwig II, king of Bavaria". Yet Pessoa, in the everyday sense, didn't exist. "He" wrote in Portuguese, English and French and had been a well-received poet publishing under the names of three "heteronyms" – Alberto Caeiro (supposedly a shepherd), Ricardo Reis and Álvaro de Campos – all of whom he invented, giving them "their own biographies, physiques, personalities, political views, religious attitudes and literary pursuits". Pessoa wrote under dozens of names, each heteronym having a biography identifying the invented author as in one case an astrologer, in another a hunchbacked woman and in another an unhappy nobleman (who committed suicide). "Charles Robert Anon" and "Alexander Search" wrote Pessoa's English poetry, "Jean Seul" the French. All three have accompanying invented biographies. An appendix to a recent translation of *The Book of Disquiet* contains letters written by Vicente Guedes (the original, fictional, author) and notes by Bernardo Soares (the fictional author of the second half). Pessoa's style was consistent with his philosophy that any individual is a profusion of selves, changing hour by hour according to context. This pre-dates Miller Mair's concept of the "community of selves" by almost a century.[4] It might also give psy professionals pause for thought about the concept "multiple personality disorder".

The 481 fragments of *The Book of Disquiet* are arranged as "texts" by the translator, Richard Zenith. The texts may *appear* to follow logically from each other, though this is the translator's ordering. Some cover a couple of pages, and some are effectively one- or two-line aphorisms dealing with philosophy, nihilism, religion and the nature of suffering. Many praise the virtues of sleep and dreaming above what we might understand by living a conscious life. Sleep, dreaming or both appear on every other page, sometimes more frequently.

The acquisition of cultural capital ensures that psy professionals will continue to publish under their given names rather than heteronyms. Pessoa's resistance to claiming personal credit is diametrically opposed to the way that psy authors struggle with whose name should take precedence in academic articles or, when writing accounts of patients for publication, anonymize them while ensuring their own names appear as author. This volume should really list multiple authorship (the names of all the people appearing in the Notes sections) addended with "Compiled by Craig Newnes (whoever 'they' might be)".

As an author I have toyed with non-existence. In 1988 I sent an interview to the then editor of *Changes*. It purported to be a discussion between myself and Alain Bragha, an invented psychotherapist about to tour the UK. Bragha's approach to therapy was that the therapist should constantly monitor for theoretical schemata he or she was imposing on the patient's utterances. These thoughts remove the therapist from the act of "being with" the patient and were alien to successful encounters. The position, termed "beyond method", bore comparison with Freud's "suspended attention". In the interview it was likened to the need to be aware of countertransference and not to act on it. Theories *were* countertransference. The editor liked Bragha but the piece – the lead article – didn't make it past the proof stage because I told her of the deception.

Similarly I have published book reviews of two books that don't exist, and in the early 1990s ran a series of advertisements in *Clinical Psychology Forum* for products such as the computer programme designed to generate *random* patient contact (Körner) data and inflatable psychologists for departments unable to fill advertised posts. I have had requests for the books and received two telephone calls requesting the Körner programme.

The problem, of course, is that psychology is beyond parody.

Clinical psychology in the UK has recently presented a professional face of "partnership" with service survivors. One reading of this position is that the rising tide of blogs, articles, TV programmes and campaigns against psychiatry represents an opportunity for clinical psychology to join with various allies to continue the supposed struggle against medical dominance. One example is the publication of a report by the Division of Clinical Psychology, *Understanding Psychosis and Schizophrenia: Why People Sometimes Hear Voices, Believe Things that Others Find Strange, or Appear Out of Touch with Reality, and What Can Help*.[5]

With no apparent sense of irony, the "Note on terminology" in the report includes the following: "Of course, much of what has been written previously in this area has used a clinical framework and has therefore used clinical or medical terminology. When describing this work we have sometimes used quotation marks round these terms."[6] As noted in Chapter 9, the general statement of purpose of the *Journal of Clinical Psychology* notes the journal is "a monthly peer-reviewed *medical* journal covering psychological research, assessment, and practice … It covers research on *psychopathology*, psychodiagnostics, psychotherapy, psychological assessment and treatment matching, clinical outcomes, clinical health psychology, and behavioral medicine"[7] (my emphasis). As a leading APA journal the *Journal of Clinical Psychology* attracts numerous UK psy researchers. As such it has for over 70 years published UK clinical psychologists who have used medical terminology without demur. There is a lack of reflexivity (or apology) in the DCP report, whose contributors include at least seven eminent clinical psychologists who have, similarly, consistently published academic papers using medical terminology in a *self-declared* medical journal in order to garner cultural capital.

As a profession, UK psychology has been loath to ally itself with the service survivor voice. This position has largely been taken by a few activists. Shropshire's Department of Psychological Therapies, for example, has paid service users as committee members and members of interview panels for over 20 years. In addition, people with a variety of psy diagnoses including schizophrenia gave presentations at local conferences and seminars as equal members of the organizing committee for training events. Over 15 years, events included "How does clinical psychology harm people?", "Empowerment and de-institutionalisation", "Alternatives to psychiatry", "Hurt, harm and clinical psychology" (at a 1992 BPS conference), "Gender issues and mental health", "Advocacy in action" and "Professional power".

Few, if any, NHS clinical psychology departments practise in similar ways and the majority use medical terminology in inscribing people in *exactly* the way that the DCP report decries.

The author as subject

Rather than further critique the DCP report, I should prefer here to offer a critique of an article pre-dating it by ten years. The article is a kind of call to arms for psychologists to respect labelled individuals as persons, a position outlined in some detail by the more recently published report. I shall also discuss the factors constraining the impact of either text.

At the time, the author was director of an NHS department of psychological therapies with a national reputation for attracting psy practitioners broadly sympathetic to the more emancipatory psy agenda. The department was renowned for publications critical of most aspects of clinical psychology. The director was a winner of a human rights award for speaking out about psy,[8] and responsible for commissioning a best-selling series of books critical of the psy enterprise.[9] More recently his co-editor for two of the volumes won the BPS Award for Distinguished Contribution to Psychology in Practice, a considerable achievement given that the winner has not been a BPS member for many years.[10]

"Psychology and psychotherapy's potential for countering the medicalization of everything" was published in 2004.[11] The abstract begins:

> This article examines the ways in which the professions of clinical psychology and psychotherapy have adopted the powerful discourses of eugenics and medicine. In so doing, they have acted in ways that oppress rather than liberate those who require their services. The article suggests that, through emphasizing connectedness with clients rather than difference from them, these professions might act in a more liberatory way.

So far, so rhetorical. Cultural capital is evident through the article's appearance in an APA-approved journal, one that regularly presents its subject matter as persons inscribed by the psy lexicon. That people "require" psy services is a moot point. It is generally powerful *others* that require services for their relatives or patients. The word "clients" was substituted by the journal editor conforming to editorial policy, a substitution the author didn't resist despite "patients" being the correct – and realistically disciplinary – terminology.[12]

The first paragraph includes the following:

> I slowly (and painfully) understood that my profession had few answers, was as corruptible and power-obsessed as psychiatrists could be, and, worse still, had singularly failed, in circumstances almost too good to be true, to provide a real alternative to the diagnostic and treatment excesses of traditional psychiatric practice. Indeed, it gradually dawned on me that it was psychiatry itself, rather than clinical psychology, that had done most to say something about the need for relationships rather than treatment, criticism rather than collusion, and modesty rather than self-congratulation. Many of the most inspirational psychotherapists had been psychiatrists, and most of the worst kinds of psychotherapy had been promulgated by psychologists.

The paragraph has the advantage of making clear that the author was not out to make friends with clinical psychology and psychotherapy peers. There is a naïvety about the opening sentence shrouded in an emotive rhetorical use of the word "painfully". It is hard to guess how painful it was for a long-standing and well-paid public servant who was also ex-chair of the BPS Psychotherapy Section to discover his profession was corruptible. Social historians have long reiterated Bernard Shaw's position on professions: they are a conspiracy against the laity. The author instead presents his position as a (sedate) Road to Damascus conversion. The circumstances "almost too good to be true" still obtain in the profession's almost unique position, as people *paid* to be trained to doctoral level for a job for life in the UK's NHS. The phrase avoids contextualizing the place of psychology in the wider system and there is no attempt to explain *why* the state might want to train psy experts at its own expense.

The final statement is an attempt at a red rag to any bulls that might be reading the journal. The supposed conflict between clinical psychology and psychiatry (see Chapter 9) in the UK is so taken for granted that few explore the role of psychologists in relation to medicine *pace* Goldie. For example, behaviour therapy and psychotherapy were offered by clinical psychologists as scientifically validated alternatives or, more often, adjuncts to psychiatric treatment. This exemplifies Goldie's second position – eclecticism – a position embraced enthusiastically in the late 1960s and the decades following. The well-documented adverse and addictive effects of drugs such as Ritalin and Adderall have not led clinical psychologists to embrace the third of Goldie's positions – fight or flight – characterized by resisting the medical *zeitgeist*. Instead, clinical psychologists in child services have trained in family, systems and narrative therapies as part of an eclectic position.[13] The quotation's final statement serves as a further emotive marker aimed at arousing the reader.

Aligning the origins of psy with a, wholly contextual, ideology – that of euthanasia – positions the (Jewish) author as a provocative consciousness-raiser. The article thus continues by quoting Cattell, originator of the 16-PF personality questionnaire and well known to the majority of readers of the journal:

Writing on Beyondism, the eugenics movement he founded, Cattell claimed, "The vast majority of humans on the planet are 'obsolete' and... the earth will be choked with the more primitive forerunners unless a way is found to eliminate them... Clarity of discussion... would be greatly aided if genocide were reserved for a literal killing off of all living members of a people... and genthanasia for what has been above called 'phasing out,' in which a moribund culture is ended, by educational and birth control measures."[14]

The article continues:

> As the UK profession of clinical psychology moved into a phase of eclecticism, joining with psychotherapists in their attempts to change people, they maintained psychiatric nomenclature and its inscriptions of disorder. Few, with some notable exceptions, challenged either diagnostic validity or reliability.[15] Practitioners who retained the idea that people were inherently flawed, to be repaired by psychology and psychotherapy, did not dispute the diagnostic system. From even a cursory glance at the literature, it seems that the practice obtains. The best-selling What Works for Whom? is notable for the use of psychiatric diagnostic categories in its trawl through the literature to discover which approaches "work best" for people in distress – distress that is redefined as "conditions."[16]

The author consequently suggests:

> Far more of us need to embrace Goldie's third position: radical opposition. I believe we need to offer less of a balanced view on issues like diagnosis and the causes of distress and more of a balancing view. The

> vast machinery of capitalism, in league with self-interest, will always ensure more than enough voices that proclaim the need for technological solutions to change inherently flawed individuals. Only a few voices can be heard regularly challenging this view or promoting alternative understandings of distress.

Apparently at random, the author cites the work of Burstow as one such voice.[17]

We can see a gradual move from eugenic origins, via the almost uninhibited use of diagnostic categories, to the appeal for alignment with psychiatric survivors. This is a direct appeal to an assumed contemporary social consciousness on the part of the readership, a consciousness expressed to a degree by the journal's title – the *Journal of Humanistic Psychology*. The appeal is more based on hope than experience as, like any psychology journal, the readership is largely unknown to the contributors. The "red rag" is again thrown down, this time by reference to *What Works for Whom* – a book quoted in multiple psy texts. A lack of sociological perspective prevents the author from noting (as in Chapter 8) that the cultural capital and *necessity* of publication for the authors of the cited volume constrain them to particular forms of publication.

The challenge continues:

> For clinical psychologists in particular who claim to be scientists, we should be constantly prepared to critique assumptions, methodology, research conclusions, and so on. What appears to happen is that trainees in counselling, psychotherapy, clinical psychology, and some radical therapists are rarely introduced to their political role, the forces that have shaped their chosen profession, or even the possibility that they might do more harm than good. Instead, training is a process of socialization into the profession's mores and an enthusiastic presentation of the overwhelming desirability of one's calling.

It would be surprising if any profession trained its new arrivals in the ways implied by the above. People training in law, for example, may wish to use legal means in an emancipatory rather than oppressive agenda. One example is the Center for the Human Rights of Users and Survivors of Psychiatry (CHRUSP) based in New York. CHRUSP "provides strategic leadership in human rights advocacy, implementation and monitoring relevant to people experiencing madness, mental health problems or trauma" and "works for full legal capacity for all, an end to forced drugging, forced electroshock and psychiatric incarceration, and for support that respects individual integrity and free will".[18] Whether it reflexively examines the history of the legal system in promoting *oppressive* laws is unknown. As with clinical psychology, such an examination might lead prospective lawyers to abjure their profession. The quotation from the article uses a rhetorical device to prompt a degree of hesitation in those training clinical psychologists. Genuinely promoting an anti-psychology agenda for trainers seems, at best, naïve. As noted in Chapter 7, one such effort was quickly rejected.

The article continues:

> Another part of my own efforts to provide a space for critical analysis of the psy-complex has been a critical clinical psychology internship established in 1994. Clinical psychology trainees critically examine the psychiatric system and clinical psychology's place within it via reading, discussion, video material, research, supervision, and membership of our local psychiatric hospital's patients' council.[19] There is a thorough examination of the role that clinical psychology and psychotherapy play in the psy-complex and the policing of society.[20] The internship is only one aspect of local attempts to speak out about the mental health system. It is popular with trainees, but it is an exception and can hardly be judged at all by the usual criteria. The assessor's question, "Has the trainee developed assessment, formulation, and intervention skills?" is met with the response, "Thankfully not."

The quotation uses tropes – research and supervision – familiar to clinical psychology trainees. These are termed "interns" in the article for a predominantly US readership; arguably an attempt to join with a non-UK audience. The tropes are no less disciplinary for their use in a piece suggesting an anti-psychology stance than they are in the main body of psy literature. Research and supervision are *de facto* elements of psy training. Both are compulsory and both examined to ensure conformity with scientistic praxis. One feature of the trainees' contract – publication – is ignored in the article. The placement (internship) required trainees to publish two research articles over six months. Hidden to the readers of the article (and the local training course) was the justification for this contractual clause. Clinical psychologists have a median publication rate of *zero*.[21] *Ergo*, publication by trainees while training simultaneously positions the placement as unusual, appealing (to those seeking cultural capital) and disciplinary as an element of the profession's habitus. This contractual obligation was not (counter to the stated aim above) examined as part of the psy complex's policing role. Equally, psy publications are never Pessoa-esque. The closest instructions to contributors come to such an aim can be found in the last line of the "Aims and scope" section on the inside cover of the *Journal of Critical Psychology, Counselling and Psychotherapy*: "With a following wind, it will sometimes make you laugh out loud."[22]

As part of the author's non-scientistic agenda, the article notes:

> The British Psychological Society conference this year [2003] featured an entire division of clinical psychology seminar on "Computerised CBT for Anxiety and Depression" and another on "The Assessment and Prevalence of Personality Disorder in Primary and Secondary Care." Despite our academic background, there are no critical presentations on either issue. It should not be that difficult for more psychologists and psychotherapists to seek support in speaking out at case conferences, writing reports in ordinary English, or putting on more challenging conference presentations.

"Writing reports in ordinary English" would undermine the psy project to such a degree that readers who have paid for the report might reasonably conclude a variant of "I could have written that." The socialization process of clinical psychology training ensures that text is uncritically read to such an extent that, as noted in Chapter 8, invalid diagnostic terminology is a key aspect of professional discourse. The rite of passage at case conferences necessitates an uncritical acceptance of this discourse as members of other professions use inscriptions such as "borderline personality disorder". The prevalence of this terminology in psychology journals and other literature renders the use of "ordinary English" problematic for psy professionals seeking professional acceptance.

The suggestion that it should not be "that difficult" for psychologists and psychotherapists to seek support in speaking out ignores the factors that prevent protest of this type. These are a lack of allies, the hierarchical nature of case conferences and professional habitus. Further, the professional role within the nexus of governmentality demands the gaze and inscription of selves.[23] It is "that difficult" even assuming a member of a disciplinary profession would wish to reduce their professional status through speaking out. The article positions speaking out as a relatively straightforward matter and ignores the contradiction of a psy professional turning the gaze inward.

Further suggestions follow: "We might take a lead here from the consumer movement." The Madness Group website lists their priority areas for research as follows: "What are the longer term effects of forced interventions and coercive treatments? How does coercion affect compliance? Is there an increase in non-compliance after patients have been coerced? Is there an increase in treatment avoidance among people who have been coerced?"[24]

The article continues:

> Of course, the truth is that there is not that much research necessary. We know what hurts people: exploitation, humiliation, cruelty, inflexible ideologies, torture, starvation, and the substitution of hate for love. In fact, pretty much everything that is taken for granted in the English public school system should be banned in the real world to give people a greater chance in life.

The trope of research is used, the reference to the Madness Group website positioning the suggested praxis as part of an allied effort with oppressed others. There remains a contradiction: the Madness Group's agenda is one which might *support* psy interventions (e.g. treatment compliance) while questioning the coercive nature of psychiatry. This position is taken by contemporary ECT campaigners who may not object to the intervention *per se* (on the grounds it causes brain damage)[25] but concentrate efforts on banning its compulsory use.

We might conclude from the second quoted paragraph that the author is no supporter of public school education. The phrase "we know" positions the author as an authority with both expert and referent power.[26] The idea of "knowing" is, however, anathema to psy practitioners disciplined to disclaim knowledge (or reposition knowledge as "knowledges") in favour of extensively referenced "evidence".[27] "Hurt" is not defined in a list that includes physical and psychologizing (e.g. humiliation) "causes" of suffering. "Intention" to cause harm is neglected, leaving the author open to the accusation that the article might itself be positioned as harmful to the profession or the sensibilities of psy practitioners.

A list of further suggestions for emancipatory praxis follows:

> awareness comes from listening to people in trouble in some way. In our clinical work, we should remain attentive. We should constantly ask if we could cope with the families, jobs, childhoods, relationships, and classrooms we hear described. We should bear in

> mind the dispositional/situational attribution phenomenon; we tend to locate the causes of other people's distress in their dispositions and our own distress in our situations. The inclination is always to blame the victim – unless we are the victim. We should ask people who labeled them in particular ways, not label them ourselves. Hagan and Smail, in their work on power-mapping, suggest that we should help people identify sources of power and support in their lives.[28] It is no less important to help people identify the toxic powers in their lives including the drugs taken because their doctors say they will help.

The passage falls firmly within a Judeo-Christian frame of supporting our fellows via empathy and compassion. There is no reference to Szasz's views on the role of compassion in justifying involuntary treatment.[29] References to the widely recognized social psychology discourse of the "dispositional/situational attribution phenomenon..." and power-mapping add a scientistic gloss to the writing without reflexively questioning these knowledges.[30]

The paragraph maintains a subtle anti-psychiatry (and implied psychology-friendly stance) with its final reference to "doctors" telling patients that harmful medications "will help".

The author does not refer to the doctoral nature of clinical psychology training which might position the profession as part of the problem rather than the solution. Neither does the article make reference to the campaigns by British and American clinical psychologists to gain prescribing privileges:[31]

> Professionals need to learn more about advocacy and the user movement. We need to be clear about the role and rights of advocates and encourage speaking out whenever we can, even if that means speaking out about psychotherapy and psychology services. We need to get to know local advocates and promote structures that support advocacy. This might mean providing meeting rooms and other resources for advocates or user meetings. It may mean ensuring that clients know about the availability of local advocacy. We must be prepared to lose arguments with users and their advocates and use our knowledge of the system to help them through it. Psychology and psychotherapy should align themselves with the oppressed and speak out about injustice. There is room for comfort and clarification but no room for collaboration with the oppressor in theory or practice[32] ... We might then have some chance of helping people change the circumstances of their lives – lives that we would almost certainly find intolerable.

> Psychotherapists would do well to examine the manifesto for psychotherapy in *This is Madness Too*. It includes aims of collaborative power and the demand that we organize ourselves in challenging oppressive institutions.[33]

Advocacy within services takes several forms: peer, self and professional advocacy are all promoted. Advocacy by concerned relatives of those incarcerated in asylums has its origins in the Alleged Lunatics Friends Society of the mid-nineteenth century.[34] There are several UK advocacy groups for people marked as learning disabled – for example, People First. The article promotes advocacy on behalf of "the oppressed" without acknowledging that the disciplinary governmentality of clinical psychology makes the author's own profession an oppressor. There is a passing suggestion that the patients of clinical psychologists also require advocates and no reference (*pace* chapters 2 and 3) to the way that the language of psy contributes to the wounds of patients within the disciplinary machinery. This may be a rhetorical move to place the reader on the side of a constituency outlined as oppressed but takes no account of the probability that the *majority* of the article's readership is positioned on the side of the oppressor (while themselves governed by the psy discourse and its institutions).[35]

The wounds revisited and a modest proposal

As noted in Chapter 3, published psy research follows a scientistic format. Papers may be described as an hourglass, beginning with a justification for the research in terms of contemporary relevance, via a description of what was tried out with whom in a particular locale, to the need for further research to confirm the implications of the findings. Psy literature promoting new psy praxis follows a format whereby previous theories and methods are outlined before delineating the advantages of new theory and (frequently integrated) practice. Authors report greater "success" for their proselytized methods. The development of CBT, CAT and DBT can be seen in these terms. None of these therapies requires a complex theory and inscription of the self; they are popular, in part, because they reduce the complexity of conduct to apparently easy to manage cause-and-effect relations between assumed internal divisions of selves; thoughts and emotions are claimed to be mutually influencing and controllable aspects of persons.

This volume is one reading of the psy system and the factors constraining and promoting psy praxis. It is possible to speculate on a modest proposal following from the current reading, one that may be seen as a brief digression; the spirit behind it is more in line with the optimistic and naïve energy inferred from "Psychology and psychotherapy's potential for countering the medicalization of everything".[36]

Professional psy alignment with the system survivor movement can be read, as above, as an aspect of a continuing struggle between aspects of the psy complex – counselling, clinical psychology, psychiatry and so on. These moves might also be read as part of a human rights discourse wherein professionals and system survivors are to be seen as citizens with similar rights.[37] Such a reading is problematic as countries will have markedly different understandings of how different people – for example, those inscribed as mad – retain those rights.

The Human Rights Act 1998 came into force in the UK in October 2000. It is composed of a series of sections that have the effect of codifying the protections in the European Convention on Human Rights into UK law.

All public bodies (e.g. courts, police, local governments, hospitals and publicly funded schools) and other bodies carrying out public functions have to comply with the convention rights.[38]

The Declaration of Geneva attempts to ensure universal rights. It was amended by the World Medical Association in 1994. A further amendment was made in January 1995 by the Faculty of Medicine at Liverpool University, England. At graduation from Liverpool's doctoral programme, clinical psychologists must agree to abide by the amended declaration. The declaration includes several statements concerning allegiance to the profession and colleagues. For example, in addition to pledging a service to "humanity", newly qualified clinical psychologists must "give to teachers the respect and gratitude which is their due" and see colleagues as "my sisters and brothers". For patients, clinical psychologists declare that "The health of those in my care will be my first consideration" and agree that they "will not permit consideration of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation or social standing to intervene between my duty and my patient." Finally, "I will not use my specialist knowledge contrary to the laws of humanity."

Teachers retain a privileged status in the declaration while colleagues are "sisters and brothers". The implication is that these are valued sisters and brothers rather than irritating siblings. The challenge to value colleagues and simultaneously make those in the psychologists' care the "first consideration" decontextualizes, via a professionalizing discourse, the work settings of psychologists. As for any employees, it is a discourse that reduces the possibility of speaking out against colleagues seen as harmful to patients. The social nexus and need to preserve "good" working relationships with peers will lead to conflict if a worker attempts to put patients first in situations where exposing the conduct of peers to public scrutiny is considered (see Chapter 9 on case conferences).

The ritualistic rather than reflective nature of signing up to the declaration can be observed in the remarkable list of factors that the signatory agrees will not influence interactions with patients: "age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation or social standing". These considerations raise the signatory to a saint-like position of neutrality. The fact that newly qualified practitioners opt to work in particular services (e.g. for older people, children, people with learning disabilities or sexual health services) might be understood as a preference for certain service groupings. Such a preference – by definition – dictates the context in which practitioners will interact with patients. A preference, however, for, say, working with children will bring the practitioner face to face with parents who may be positioned as neglectful, abusive or overindulgent. Indeed, the theoretical constructs and legal responsibilities framing many interactions demand that parents are seen as "good" or "bad" influences (e.g. in the family court).

Practitioners are wholly influenced by cultural and personal factors bearing on their interventions. As noted in Chapter 8, psy professionals are influenced and affected by media stereotypes. Patients can reveal a great deal to psy professionals apparently unrelated to the factors that have brought them to the consultation. Those revelations might include the fact that the patient approves of private education, fox hunting or capital punishment. The patient might present as intolerant, racist or politically passive. Any opinions expressed are culturally located and must relate to "creed, ethnic origin, gender ... political affiliation ... or social standing". To not be influenced by these factors in interactions with patients would require the psy professional to ignore the likelihood (in psy's own terms) that the patient's every utterance is influenced by them.

Equally, signing the declaration may have a paradoxical effect on patient–expert interactions. Citing Michael Rose's *Industrial Behaviour*, Nikolas Rose remarks: "employees could gain as much satisfaction at work by defiance of managerial rules as by involvement with them".[39] In this light the declaration might be viewed as an *invitation* to allow creed, gender and so on to influence interactions. The position is reminiscent of several factory jobs I had when younger. Various socially aware friends who were attending college would sympathize with my oppression as a working man – the long hours, the lack of breaks, oppressive management and so forth. I could only reassure them that I spent many hours with my workmates *sleeping* on night shift at the Birds Eye cold store. Management strictures and declarations, like any rules, are there to be broken.

I shall outline below further internal contradictions for clinical psychologists in signing up to the declaration by reference to a "modest proposal" for psy professionals. The proposal is constrained within parameters summarized by Richards: "Forms of liberation are necessarily conditioned by those of oppression."[40] The proposal is framed by a legal rather than psy discourse and requires allies – service survivors, non-psy professionals, the legal profession – frequently neglected by members of psy whose essentially individualistic position leaves them unwilling or contextually poorly placed to seek allies beyond the psy complex.

For Wolfensberger, a legitimate aim of allies of service recipients is compensation for the wounds suffered within the service system. The position is familiar to legal representatives and lawmakers, and frequently taken in the context of medical injury claims or class action suits against pharmaceutical companies (see Chapter 9).

Some members of psy are already active within a rights discourse. Though not explicitly using Wolfensberger's concept of wounds, they actively seek compensation or protection for their clients.[41]

Legal efforts to gain compensation tend to operate in isolation. Insurance policies, for example, will offer agreed amounts for injury or death due to traffic accidents or other harmful events. In this system a severed finger due to an injury at work is likely to result in a smaller payment for the injured party than catastrophic medical negligence on the part of, say, an anaesthetist deemed to have resulted in permanent brain damage to the claimant.

As noted throughout this volume, the psy system is interconnected to such an extent that separating specific causative factors in a wounding praxis is a task that falls to the courts. An elderly person diagnosed with dementia assaulted in an older person's residential facility may receive some recompense and the assailant charged with assault. Legal procedures of this type have been a feature of various "scandals" and public enquiries in UK hospitals since the foundation of the Bethlem Hospital. Assault by staff was one reason for the formation of the Alleged Lunatics Friends Society over 150 years ago (see previous section).

Psy practitioners and their institutions are linked via networks of professions, praxis and governmentality to such an extent that the majority will be – often unconsciously – linked to wounding events. Wounding practice often starts when a person is "marked" (labelled in ways not valued by the wider society and thus more likely to be confused with others with similar, frequently poorly defined and stigmatizing, labels). As noted in chapters 7 and 8, this inscription of the self is integral to psy praxis – research, assessment, therapeutics and publication. *Without* some form of inscription, modern discourse could not function. The particular form taken within the psy discourse, however, is frequently the beginning of physical and psychological treatments that harm persons.

A clinical psychologist using one of Hogrefe's ADHD rating scales described in Chapter 8 may confirm a diagnosis of ADHD. Subsequent pharmacological treatment may harm the child[42] or lead to addictive drug use.[43] If the child or family is referred for psychotherapy, the success rates of therapeutic interventions do not inspire confidence that harm will be avoided.[44] A psychological assessment ("marking") resulting in a diagnosis of depression in a child or person over 60 can lead to ECT (see Chapter 5). A simplistic account of the chain of accountability for subsequent brain damage would suggest that the assessing psychologist – as in the previous examples – should be considered an accessory to harm.

Members of the medical and psy professions are protected by the defence of "best practice" in legal cases. If it can be agreed that assessment followed by diagnosis and physically or psychologically damaging treatment has followed "best practice" then the professional will not face censure. The last sentence in the Geneva Declaration offers a more challenging reading of the psy professional's culpability. Agreeing not to use "specialist knowledge contrary to the laws of humanity" places clinical psychologists in an invidious position. "Specialist knowledge" should include knowledge of critical accounts of the psy industry and the harm claimed by service recipients. Those accounts may position psychiatry as the dominant (and more harmful) profession but clinical psychologists should find no defence in the stance "Psychiatrists are worse than us." Specialist knowledge requires specialist learning, reading and experiences (training, supervision, etc.). At present, clinical psychology training in the UK does not require trainees to be exposed to critical ideology and critical placements no longer exist.[45] A clinical psychologist contributing to a service wound by assessment or therapeutics performed in ignorance of the potential harmful consequences can be seen to be in a chain of accountability that begins with the training course and BPS structures for accrediting courses.

The mechanics of apportioning accountability for harm in such a chain increase the likelihood that any legal attempts to gain compensation for victims would continue to focus on the proximal factors in distress: a physical assault by a therapist or the adverse effects of a drug. The modest proposal presented here is that members of psy professions not directly involved in the administration of physical treatments or psychotherapeutics may reasonably be held to account for *complying* with wounding praxis, either through marking individuals ("contrary to the laws of humanity") or by not speaking out about the known ill effects of the psy complex.[46] Clinical psychologists who *legitimately assess individuals as part of their professional discourse* should be construed as accomplices and held to account according to the Geneva Declaration.

The reader might, at this point, conclude that the proposal is not so modest after all.

Other wounds to psy recipients include rejection and exclusion (to service centres without easy access to valued people), being moved within and between services, being associated with devaluing imagery, losing relationships with valued others, isolation and congregation with people similarly devalued. Service recipients may lack security and control, become poor(er), be blamed (e.g. for "resisting" treatment), subjected to case conferences, invaded without consent (e.g. with PRN medication) or referred without consent, denied help (e.g. when an invalid diagnosis such as ADHD is substituted for an investigation of physical causes of a particular difficulty). People may be given aversive or useless "treatments." As suggested in Chapter 2, for many, these wounds are an inevitable feature of the psy enterprise rather than a byproduct.

Being verbally abused or physically assaulted by other than treatments in institutions are, however, both contextual features of institutional life and already illegal. The notion of a "vandalizing environment" was first proposed by sociologists in the 1960s. Rather than individualizing vandalism with the idea of corrupt interiority, some saw the environment as corrupting individuals – in the same way that modern bankers can be seen as being drawn into a culture of greed and corruption, and youths on underprivileged housing estates or the banlieues of Paris are invaded by a culture of graffiti, fear and poorly lit sidestreets with no areas to play safely. Recently, community psychologists have joined with a political consensus that regards environmental change as necessary.[47] *Staff* in closed institutions may have the freedom to leave after a day's shift (and hold the keys) but they are subject to a similar panopticon regime as patients (see Chapter 7).

Despite caveats around the unconsciousness nature of the wounding process and the last paragraph's sympathy towards the equivalence of patients and staff, the loss of person-hood and potential for bodily harm in this, by no means exhaustive list, for Wolfensberger made the service recipient dead in body or spirit.[48]

Nor should we forget that inscriptions of the self posthumously continue. We are remembered – or celebrated in obituaries – with the same descriptors we have accrued throughout life. Colleagues, family and friends may continue to use these individualized descriptors (brave, weak, foolish, a "good" father or "intelligent" person, etc.) long after our physical death. To this extent "we" are "each other" bound in a mutual attempt to locate the soul via a governing language. For those inscribed by psy, their mark as a "schizophrenic" may long outlive descriptors such as "dad", "electrician" or "sister". Obituarists consistently prefer the eye-catching over the mundane. Marie José de la Barre d'Erquelinnes (later Lady Villiers) died on 1 February 2015 aged 98. A Belgian aristocrat and member of the Belgian Resistance, she might be remembered for any number of adventures. As evidence for her "daring", however, readers unfamiliar with her life will discover that while "attending the Convent of the Assumption at Mons . . . she upset several of the nuns by putting a frog in the lavatory bowl". The sentence simultaneously locates the young Lady Villiers as daring and invites readers to ponder the archaic use of "lavatory bowl". This kind of inscription in death is equivalent to "schizophrenic" in that the *opinion* of one writer has marked Lady Villiers in the same way that opinions of diagnosticians mark the mad.[49]

The modest proposal to link labelling with subsequent harm with the aim of future compensation incorporating the psychologist's culpability faces numerous challenges. Some – the "best practice" defence, the lack of critical input to psy training courses, the tendency of courts to focus on proximal events – are outlined above. More complex still is the system of state benefits that render psy labels desirable for individuals, especially those wishing to avoid responsibility for their conduct or gain financial help. Other service recipients are rewarded in a way that further demonstrates the double-edged nature of the psy lexicon. In 2015, Jan Burns received an OBE for her work with people marked as learning disabled. She has written extensively on how, for potential paralympic competitors, being marked as *more* disabled is, due to the compensatory points system, a much sought-after advantage to the young athletes.[50]

The technical use of the psy lexicon is thus to be found in efforts to create a more egalitarian society as well as inscribing people with marks that can lead to service wounds. Wounds are not inevitable: a Benthamite would ask whether psy praxis leads to the greatest benefit for the greatest number. This would require balancing the unknown (but vast) numbers of psy recipients who have suffered wounds with the number who claim to have been helped. Added to the equation must be the millions of people employed in the psy complex, and the publishing and related industries that benefit from psy.

The next section discusses resistance in the context of the all-embracing discourse of individualism and language.

"Resistance" trapped by discourse

One form of resistance to psy professions is common on the Internet. *Alphabet Kids: Diagnosis in the Classroom* is a documentary film directed by Andrew Thibault that is available on YouTube.[51] The film depicts a trend in Florida public schools to request a mental illness evaluation for underperforming students. The "evaluation" has all the hallmarks of psy inscription first demonstrated by Gesell (see Chapter 8). A teacher in the documentary describes directives from school administrators to teachers to harass parents who are reluctant or refuse to take their child to a paediatrician for a diagnosis, to fudge answers on behaviour-rating scales to obtain a desired diagnosis, and to threaten parents that their child will be placed in a behavioural unit for emotionally disabled children if they refuse to medicate. These strategies are employed for teachers struggling to adapt to new demands placed on them by the introduction of performance-based pay in the public school system.

A parent tells of how Florida school officials and child protective services coerced him to put his son back on ADHD medication despite the multiple adverse effects already suffered. The father complied with the authorities after being threatened with losing custody. The child died soon after with an enlarged heart, a symptom associated with stimulant use. The documentary was sponsored by Parents Against Pharmaceutical Abuse, a parent movement combating the diagnosis and medication of children.[52]

There are hundreds of similar organization, some country-specific – for example, We Shall Overcome, based in Oslo.[53] An example of alliances is provided by the Tokyo Center for Mental Health and Human Rights, a legal advocacy organization for mental health service users in Tokyo. It was established in March 1986 by a coalition of lawyers, psy professionals, community workers, patients and families. It offers a hotline service, visits to psychiatric hospitals in order to resolve problems of inpatients, and publication of human rights literature.[54]

The psychiatric survivors movement arose in the late 1960s and early 1970s. The key text in the intellectual development of the survivor movement, at least in the USA, was by Judi Chamberlain, co-founder of the Mental Patients' Liberation Front.[55] Coalescing around the ex-patient newsletter *Dendron*, in late 1988 leaders from several of the main national and grassroots psychiatric survivor groups suggested the formation of an independent, human rights coalition focused on problems in the mental health system. That year the Support Coalition International (SCI) was formed. The SCI's first public action was to stage a counter-conference and protest in New York City, in May 1990, at the same time as (and directly outside) the American Psychiatric Association's annual meeting. In 2005 the SCI changed its name to Mind Freedom International.

In the USA the number of mental health mutual support groups, self-help organizations (run by and for mental health consumers and/or family members) and consumer-operated services was estimated almost 15 years ago to be 7,467.[56]

In the UK, in Liverpool alone there are 20 advocacy organizations. The Knowsley Council for Voluntary Service Mental Health Advocacy Project offers a "free confidential and independent service to anyone with a mental health problem".[57]

The Family Refugee Support Project uses "therapeutic horticulture to protect the mental health of refugees and asylum seekers",[58] and First Step Merseyside offers "Small business trading with the community staffed by people with mental health problems".[59]

As noted in Chapter 9, there are also European-wide organizations (European Network of (ex)Users and Survivors of Psychiatry) and a global network of psy survivors (WNUSP).

A leading alliance of psy professionals and learning disabled people in the UK was the Community and Mental Handicap Education and Research Association (CMHERA). It was CMHERA that organized visits to the UK by Wolf Wolfensberger to teach first on normalization and later on social role valorization (SRV). Over a period of 15 years (1979–1984) the organization introduced hundreds of professionals to the principles of normalization and SRV via PASS (Program Analysis of

Service Sytems) and PASSING (P.A.S.S.Implementation of Normalization Goals) seminars.[60]

People First is a self-advocacy organization for people marked as learning disabled. It has branches all over the UK, including in Bradford, Manchester and Cumbria.[61]

Ouch, a monthly Internet radio and blog service, reports that since 2010 many young people inscribed as disabled have used videos and interviews broadcast on YouTube. The format is the same – someone talking into a camera about what life is like for a young disabled person. The "share" facility on the BBC News page allows reports of the various posts (from the UK to Australia) to be accessed on Twitter and Facebook accounts.[62]

Members of psy have grouped to form "resistance" against the broader social ills that assail us. This is despite the intrinsic contradictions of such a stance as "Scientific description does not imply ethical prescription ... The scientific project is only meaningful in that we have *already identified* the goals worthy of pursuit."[63] As an essentially moral endeavour – concerned with how we relate to each other – movement toward social advocacy is seen by some commentators as "inevitable".[64] Psychologists maintaining the tropes of science and scientists in order to preserve their cultural capital while being paid as public servants already have goals identified (publication targets, patient numbers seen, etc.). In order to follow an emancipatory project (e.g. equality of gender, income or race), psy professionals first have to demonstrate that these factors are relevant to their existing projects (therapy or research). In the UK, some psychologists have moved towards a position of influencing government policy in relation to, for example, poverty, and the BPS regularly produces briefing papers for ministers concerned with social demography.

Formed in 1982, Psychologists for Social Responsibility (PsySR) is based in Chicago and describes itself as "an engaged community of members and supporters who work to advance peace and social justice through the ethical use of psychological knowledge, research, and practice". It represents "a variety of cultural and disciplinary perspectives ..." that "recognize diversity as a valuable resource in ... efforts to address economic, racial, and gender-based injustices and other forms of oppression".[65]

How far the formal practice of clinical psychology is from an emancipatory discourse can be gauged by reference to two key modern texts. *The Oxford Handbook of Clinical Psychology* has over 900 pages. There are no chapters on critical psychology and, in a large section devoted to treatments, it includes chapters on schizophrenia, bipolar disorder and "the bipolar spectrum", OCD, eating disorders and the "spectrum" of personality disorders.[66] Inscription followed by intervention is the natural order for the majority of authors.

The Handbook of Clinical Psychology (Volume 1; Adults) is another 900-page tome. In a section on theory, only three theoretical models are covered: psychodynamic and cognitive theory are included due to their relevance to fee-paying individuals inscribed by various diagnoses. Seven chapters follow on diagnosis and evaluation; then nine on treatment. Gestalt therapy and brief therapy are included, as is an entire chapter on "*Psychopharmacology* as practised by psychologists" (my emphasis). As psychologists in only Guam, New Mexico and Louisiana had the right to prescribe drugs at the time of publication, the chapter seems somewhat premature, though it may mark the ambitions of the authors.[67] In a sardonic comment on the topic, Tom Greening, editor of the *Journal of Humanistic Psychology*, has added: "I expect that we will see thorough discussion of the merits of chemical, surgical, radiation and electrical interventions by psychologists and campaigns by psychologists favouring prescription privileges to obtain comparable lobotomy, radiation and electroshock privileges."

Psychotherapists and Counsellors for Social Responsibility (PCSR) in the UK has over 700 members, almost all of whom had signed a petition to "end homo/trans/bi phobia and racist discrimination in therapy organisations and training courses" by March 2015. An objective is to increase the number of trainees identifying with such groupings. The organization's conference for 2015 was advertised as Reaching Out: Therapy in Unconventional Settings. Its aim was to "explore the difficulties that therapists have in providing therapy outside their protected office environments so that more people can access therapy"; in short, to increase the psy project in terms of an individualist rather than collective agenda.[68]

This is, I think, more typical of the psy endeavour in relation to "advocacy". Clinical psychologists might be prepared to help people advocate *against* psychiatry while counsellors and psychotherapists might advocate for their own services in favour of psychologists.[69] All are involved in the kind of interdisciplinary contests outlined in Chapter 9 and all will use patients to further their cause. A Google search of "clinical psychology", "advocacy" and related words retrieved *no* sites specifically dedicated to helping people speak out about clinical psychology and very few (e.g. POPAN; see Chapter 7) helping those who feel harmed by psychotherapy.

Writing psy

Kurt Vonnegut had a tendency to use throwaway phrases in his novels ("so it goes" is a favourite), frequently at the point – a death, murder, disaster or similar – where it was the last thing the reader expected. J.P. Donleavy would end paragraphs with curiously centred triplets

something like
this.[70]

This final section has a flavour of "so it goes" to it. There is overall no resolution to the kind of challenges some might see as set by the psy enterprise. The universal acceptance of a psy discourse of interiority governed via language is, perhaps, better viewed as a context-specific phase for humanity, a phase that shows no sign of decreasing in public and professional discourse.

Beloff despaired of the exalted position psy finds itself in. For him, "Psychology has yet to establish a *single* fact about human behaviour." As a science, psychology has failed; but as an unchallenged discourse it reigns supreme.[71] Weber had a pessimistic view of science itself: "Science is meaningless because it gives no answers to our question, the only question important for us: 'What shall we do and how shall we live?' "[72]

Lasch suggests that our narcissistic culture and preoccupation with the self arise from the way bureaucracy has wrested from us many tasks and identities previously associated with the home.[73] Thus managerialism has overtaken the worker's wisdom, educationalists replace parents, psy specialists replace the need for quiet contemplation with a friend, and so on. It is possible to counter that the ubiquity of televized "reality shows", blogs, gossip columns and celebrity-focused magazines (to say nothing of the numerous – remaindered – autobiographies by pop stars) suggests that the majority are preoccupied with *others*. It is the media that self-fixates while the rest of us get on with life and chat about the latest celebrity revelation.

Rose inverts Lasch's nostalgic view of the modern search for a private self in harmony with the world as it once was. He suggests:

> The relations between psychotherapeutics and political power reveal not the devastation of the psychic autonomy and security of the self, but the fabrication of the autonomous self as a key term in analyses of social ills and cures, as the subject of expert knowledge, as the target of systems of moral orthopaedics.[74]

The self, and the trials and tribulations of living, are thus entwined in a lexis claiming the former exists as an inscribable entity while the latter can be ameliorated by focus on that inscribed self. Moral orthopaedics are integrated into our processes of governmentality, in the way we speak about ourselves and others, and the political processes that demand tropes such as "personal responsibility" and "personal choice".

For Miller Mair this lexis is fundamental to modern life. In his final book he suggests that we all live in "conversational ecologies". In these ecologies the strong and simple forms of the psy lexis can destroy other forms around them. In this way a "monoculture" is established. This "impoverished environment" will feed the demands of "a particular sectional interest".[75]

For most of us the "strong and simple forms of life" in the conversational ecology include the psy lexicon. Subtlety of expression and use of particular language (language that includes facial expression, vocal inflection, posture and the rest) is reduced to a short-hand borrowed from the psy discourse. An agitated, verbose and tearful avowal of misery becomes "depression". For the speaker, too, it is simpler to respond "I'm depressed" to any enquiries about how the person is doing. Here a personal conversational ecology is evident, the respondent filtering from the community of selves in favour of one form of language.[76] The "monoculture" of simplistic responses (disguised as *explanations*) comes to choke out other voices and, as detailed in previous chapters, serves any number of sectional interests. Those interests are further served by the construction of selves as individuals, demanding that they be recognized *as* individuals rather than fellow travellers only distinguished by the perpetual marks of inscription.

If the writing self in my community of selves were to try to describe this community, it might suggest the cold in my fingers is the strongest sensation, then a curious tingling in my back. A feeling of the chair not being quite the right height for the writing posture – a sensation that lifts me back to earlier writing selves: on buses, railway stations, in the shed (surely too cold today); or perhaps sitting at tables as various invigilators stared down as I scrawled answers to examination papers. Already the writing self has taken another self and introduced it to selves from the past; all me, all still around if I just sit for only a few moments.

This writing self is disciplined, urgent at times, reluctant at others. Right now it resists a different writing self – the one that must return to the final chapter and excise, edit and reference. A thorough examination of this writing self would have to pose the question of whether it *writes* very much. This chapter has included references to websites, academic research, sociological inquiry and summaries of each. It has (I have) cut and pasted quotations and passages from my own work, and many of the references are cut and pasted from my curriculum vitae. Writing now must involve a degree of dexterity on a laptop and familiarity with the mechanics of a Word document. This is all a far cry from the painstaking use of typewriters in the early twentieth century, or the pen and ink of the nineteenth. *Righting* writing via deletion or use of the spellchecker is, on the face of it, so much easier. But conveying meaning, a meaning that shapes the reader's experience, is as difficult as it ever was. For that the poet must "imagine what you are writing about . . . Do not think it up laboriously . . . the words look after themselves like magic. You will read back through what you have written and you will get a shock. You will have captured a spirit . . .".[77] If only. It is tempting to add a familiar codicil to the effect that this author acknowledges the help of various others and any errors are all my own. I prefer to suggest that any errors, misreadings or misunderstandings are all the reader's own trapped in a context over which he or she has no control. So it goes.

Contextual note

Unusually, the majority of this chapter was put together in silence.

Notes

Introduction

1. Illich, I. (1977) *Disabling Professions*. London: Marion Boyars.
2. Magaro, P.A. (1978) *The Mental Health Industry: A Cultural Phenomenon*. New York: Wiley & Sons, p.104.
3. Szasz, T. (1994) *Cruel Compassion: Psychiatric Control of Society's Unwanted*. Chichester: John Wiley & Sons, p.60.
4. See Chapter 9.
5. Wolfensberger, W. (1987) *The New Genocide of Handicapped and Afflicted People*. New York: University of Syracuse. "Death-making" refers to human service practices causing spiritual or physical harm (including hastening death) to their recipients. Notably, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) lists neuroleptic-induced brain disorders such as tardive dyskinesia as "mental disorders" rather than iatrogenic assaults.
6. Gruenberg, E. (1966) *Evaluating the Effectiveness of Community Mental Health Services*. New York: Milbank Publishers.
7. See, for example, Newnes, C. (2011) Toxic psychology. In M. Rapley, J. Moncrieff and J. Dillon (eds), *De-medicalizing Misery: Psychiatry, Psychology and the Human Condition*. Basingstoke: Palgrave Macmillan, pp.211–225; Newnes, C. (2014) *Clinical Psychology: A Critical Examination*. Ross-on-Wye: PCCS Books.
8. The Psy complex is Rose's term for the financial/professional/linguistic disciplinary apparatus governing us all.
9. Wolfensberger, W. (1998) *A Brief Introduction to Social Role Valorization*: *A High-Order Concept for Addressing the Plight of Societally Devalued People, and for Structuring Human Services* (3rd edn). Syracuse, NY: Training Institute for Human Service Planning, Leadership and Change Agentry (Syracuse University).
10. Foucault, M. (1972) *Histoire de la Folie à l'Âge Classique*. Paris: Gallimard; Rose, N. (1989) *Governing the Soul: The Shaping of the Private Self*. London: Routledge.
11. Zappa, F. (1991) "Make a Jazz Noise Here". California, USA: Barking Pumpkin Records.

1 Thou Shalt Not Kill

1. For example, Erchak, G.M. (1992) *The Anthropology of Self and Behaviour.* New Brunswick: Rutgers University Press; Casemore, R. (ed.) (2001) *Surviving Complaints Against Counsellors and Psychotherapists: Towards Understanding and Healing*. Ross-on-Wye: PCCS Books; Ross, C.A. and Pam, A. (1995)

Pseudoscience in Biological Psychiatry: Blaming the Body. Chichester: John Wiley & Sons; McDonald, M. and Wearing, S. (2013) *Social Psychology and Theories of Consumer Culture: A Political Economy Perspective.* Hove: Routledge.

2. Bishop, B. (2013) *Unexpected Lessons in Love.* London: John Murray; Elton, B. (1998) *Blast from the Past.* London: Black Swan.
3. Bailey, J. (2003) *The Iris Trilogy.* London: Abacus.
4. These include Miller, E. and Morris, R. (1993) *The Psychology of Dementia.* Chichester: Wiley & Sons; Kline, P. (1993) *Handbook of Psychological Testing.* London: Routledge; Neisser, U. (1967) *Cognitive Psychology.* Englewood Cliffs, NJ: Prentice-Hall.
5. Marshall, J.R. (1996) Science, "schizophrenia" and genetics: The creation of myths. *Clinical Psychology Forum*, 95, 5–13.
6. Newnes, C. (2014) *Clinical Psychology: A Critical Examination.* Ross-on-Wye: PCCS Books.
7. Scull, A. (ed.) (1991) *The Asylum as Utopia: W.A.F. Browne and the Mid-nineteenth Century Consolidation of Psychiatry.* London: Routledge.
8. Insanity and Madhouses. *Quarterly Review*, 1816, 15, 402. Quoted in Scull, op. cit.
9. Morison, A. (1848) *Lectures on Insanity.* Edinburgh: Lizars, pp.35–37. Quoted in Scull, op. cit.
10. Neville, W. (1836) *On Insanity: Its Nature, Causes and Cure*. London: Longman, Rees, Orme, Brown, Green & Longman, p.18.
11. Russell, B. (1921/1992) *The Analysis of Mind.* London: Routledge.
12. Scull, A. (ed.) (1991) *The Asylum as Utopia: W.A.F. Browne and the Mid-nineteenth Century Consolidation of Psychiatry.* London: Routledge, p.xvi.
13. Newnes, C. (1996) The development of clinical psychology and its values. *Clinical Psychology Forum*, 95, 29–34, 33.
14. *Ibid.*, p.34.
15. Wolfensberger, W. (1987) *The New Genocide of Handicapped and Afflicted People.* New York: University of Syracuse.
16. Bailey, op. cit., p.337.
17. Bishop, op. cit.
18. Newnes, *Clinical Psychology*.
19. Gardner, B. and Harley, N. (2014) Gipsy site worries may have driven suicide husband to kill his terminally-ill wife. *Daily Telegraph*, 14 August, p.5.
20. Bailey, op. cit., p.337.
21. British Medical Association/Royal Pharmaceutical Society of Great Britain (2014) *British National Formulary.* London: BMA, p.168.
22. Bucknall, O. and Holmes, G. (2001) Relatives and carers. In C. Newnes, G. Holmes and C. Dunn (eds), *This is Madness Too: Critical Perspectives on Mental Health Services*. Ross-on-Wye: PCCS Books, pp.127–134.
23. Newnes, C. (1995) One hundred and forty-five years of madness: Salop County Lunatic Asylum, 1845–1990. Unpublished PhD thesis, Keele University.
24. Weindling, P. (1999) *Health, Race and German Politics between National Unification and Nazism, 1870–1945*. Cambridge: Cambridge University Press.
25. Valenstein, E. (1986) *Great and Desperate Cures: The Rise and Decline of Psychosurgery and Other Radical Treatments for Mental Illness*. New York: Basic Books.

26. For a full account of the costs of the IAPT scheme, see NHS (2011) Improving access to psychological therapies: programme review December 2011. London: NHS, p.5, examined in Newnes, *Clinical Psychology*, p.214.
27. This was one remark made to me during many hours of supervision. Equally memorably, Dorothy (a contributor to the *Journal of Philosophy* as well as author of a dozen books and numerous academic papers) once commented: "*Everyone* is a philosopher."
28. Collison, R. (compiler) (1962) *Newnes Dictionary of Dates*. London: Newnes.
29. Holmes, G. (2003) An audit: Do the people I see get better? *Clinical Psychology*, 24, 47–50.
30. *Happy Valley* (1999) London: BBC Productions.
31. See, for example, Masson, J. (1999) *Against Therapy*. London: Collins; Dineen, T. (1999) *Manufacturing Victims: What the Psychology Industry Is Doing to People*. London: Constable; Stein, D. (2012) *The Psychology Industry Under the Microscope!* Plymouth, UK: University Press of America Inc.
32. Horowitzz, W.A., Poaltin, P., Kolb, L.C. and Hoch, P. (1958) A study of cases of schizophrenia treated by "direct analysis." *American Journal of Psychiatry*, 114, 780–783.
33. Masson, op. cit., Jung among the Nazis, pp.134–163.
34. Jung, C.G. (1963) *Memories, Dreams, Reflections*. London: Routledge & Kegan Paul, p.363.
35. Advertising methods in the hair products industry are a good analogy for similar psy endeavour. Hair can be described in ill-defined ways as "normal", "greasy", "fine" and so forth. Products will then restore or thicken hair along similar dimensions. For psy, equivalent terms might be "anxious", "depressed" and "bipolar". With the application of scientifically supported therapies or unguents, the user can hope to achieve "normality".

2 The "Service Wounds"

1. Foucault, M. (1975) *Discipline and Punish: The Birth of the Prison*. New York: Random House.
2. Wolfensberger, W. (1987) *The New Genocide of Handicapped and Afflicted People*. New York: University of Syracuse. See also Wolfensberger, W. (1998) *A Brief Introduction to Social Role Valorization: A Higher-Order Concept for Addressing the Plight of Societally Devalued People, and for Structuring Human Services*. Syracuse, NY: Training Institute for Human Service Planning, Leadership & Change Agentry (Syracuse University). A list of the 18 wounds is available at http://ccsw2012.weebly.com/uploads/1/1/5/4/11542142/wolfensberger_woundings.pdf. Retrieved 20 February 2015.
3. Szasz, T. (1994) *Cruel Compassion: Psychiatric Control of Society's Unwanted*. Chichester: John Wiley & Sons, p.60. The passage is interesting in coming so close to Wolfensberger's position on death-making: I have yet to come across any reference to Wolfensberger by Szasz. In bibliographies that include Oscar Wilde, van Gogh, Nietzsche and Shakespeare, Wolfensberger, like Foucault, is absent. Much the same can be said of Wolfensberger himself in relation to Szasz or, for that matter, Peter Breggin, who quotes neither of them while finding space for Masson, Marx and Tolstoy. See, for example, Breggin,

P.R. (1992) *Beyond Conflict: From Self-Help and Psychotherapy to Peace-Making.* New York: St Martin's Press.

4. See, for example, Smail, D.(1987) *Taking Care – An Alternative to Therapy.* London: Constable Revised: 1998
5. Newnes. H. (2010) A warning unheeded: Consumerism in the House of Mirth and Nana. *The Journal of Critical Psychology, Counselling and Psychotherapy*, 10, 2, 111–118.
6. Wolfensberger, W. (1998) *A Brief Introduction to Social Role Valorization: A High-Order Concept for Addressing the Plight of Societally Devalued People and for Structuring Human Services.* 3rd edn. Syracuse, NY: Training Institute for Human Service Planning, Leadership & Change Agentry (Syracuse University).
7. Schiller, von F. (1794/1967) *The Æsthetic Education of Man in a Series of Letters*. Trans. E.M. Wilkinson and C.A. Willoughby. Oxford: Oxford University Press. Quoted in Hansen, S., McHoul, A. and Rapley, M. (2003) *Beyond Help: A Consumer's Guide to Psychology.* Ross-on-Wye: PCCS Books, p.230. Newnes, C. (2014) *Clinical Psychology: A Critical Examination.* Ross-on-Wye: PCCS Books.
8. Newnes, *Ibid.*
9. Hunter, R. and Macalpine, I. (1963) *Three Hundred Years of Psychiatry: 1535–1860.* London: Oxford University Press. Quoted in Stone, M.H. (1998) *Healing the Mind: A History of Psychiatry from Antiquity to the Present*. London: Pimlico.
10. Szasz, op. cit.
11. *Ibid.*, p.48.
12. Graham, G. (2014) Elderly in care "must be given home comforts." *Daily Telegraph,* 18 August, p.1.
13. The Alzheimer's Show (advertisement) *Daily Telegraph*, 6 May 2014, p.8. The first Alzheimer's Show, "the UK's only event dedicated to people dealing with DEMENTIA on a daily basis", took place in London on 16 and 17 May 2014. Coinciding with my mother's 85th birthday seemed apposite. My mother drank too much surrounded by a riotous collection of grandchildren and friends in my brother's back garden. She had expressed no interest in the goings-on 70 miles away.
14. Porter, R. (1988) *Illustrations of Madness*. London: Routledge. Introduction, p.xxviii.
15. Post, F. (1994) Creativity and psychopathology: A study of 291 world-famous men. *British Journal of Psychiatry*, 165, 22–34.
16. http://www.behaviourlibrary.com/strengths.php. Retrieved 3 July 2013.
17. Kealey, E.J. (1981) *Medieval Medicus: A Social History of Anglo-Norman Medicine*. Baltimore, MD: Johns Hopkins University Press.
18. *Ibid.*
19. Rubin, M. (1989) Development and change in English hospitals, 1100–1500. In L. Granshaw and R. Porter (eds), *The Hospital in History.* London: Routledge, pp.41–59.
20. Carlin, M. (1989) Medieval hospitals. In L. Granshaw and R. Porter (eds), *The Hospital in History.* London: Routledge, pp.21–39.
21. Wedhe, U. (1992) The Runaway-house: Human support instead of inhuman psychiatric treatment. *Changes: An International Journal of Psychology and Psychotherapy*, 10, 2, 154–160.

22. Hölling, I. (1999) Three years of antipsychiatric practice at the Berlin Runaway-house. *Changes: An International Journal of Psychology and Psychotherapy*, 17, 4, 278–288.
23. Smail, D. (1987) *Taking Care: An Alternative to Therapy.* London: Dent.
24. The impress of power and self-interest is explicated by Smail himself in Smail, D. (2005) *Power, Interest and Psychology: Elements of a Social Materialist Understanding of Distress*. Ross-on-Wye: PCCS Books.
25. See Newnes, C. (2014) *Clinical Psychology: A Critical Examination.* Ross-on-Wye: PCCS Books. Chapter 1: The nature of clinical psychology, pp.5–28.
26. Forsyth, R. (1988) *From Here to Humanity – A Manifesto for Survival.* Nottingham: Pathway Publications.

3 Labelling and Languaging the Other

1. Young, N. (1970) *After the Goldrush*. Atlantic Records.
2. See Newnes, C. (2004) Psychology and psychotherapy's potential for countering the medicalization of everything. *The Journal of Humanistic Psychology*, 44, 3, 358–376; Newnes, C. (2011) Toxic psychology. In M. Rapley, J. Moncrieff and J. Dillon (eds) *De-medicalizing Misery: Psychiatry, Psychology and the Human Condition*. Basingstoke: Palgrave Macmillan, pp.211–225.
3. Goldie, N. (1977) The division of labour among the mental health professions. In M. Stacey, M. Reid, C. Heath and R. Dingwall (eds) *Health and the Division of Labour.* London: Croom Helm, pp.141–161.
4. Stein, D. (2012) *The Psychology Industry Under the Microscope!* Plymouth, UK: University Press of America.
5. Newnes, C. (2007) Are we all mad? *The Journal of Critical Psychology, Counselling and Psychotherapy*, 7, 3, 191–194.
6. Haslam, J. (1810) *Illustrations of Madness, Exhibiting a Singular Case of Insanity, and a No Less Remarkable Difference of Medical Opinion: Developing the Nature of Assailment, and the Manner of Working Events; with a Description of the Tortures Experienced by Bomb-Bursting, Lobster-Cracking and Lengthening the Brain, Embellished with a Curious Plate.* London: Rivingtons, Robinsons, Callow, Murray & Greenland.
7. Porter, R. (1988) *Illustrations of Madness*. London: Routledge. Introduction, p.xxviii.
8. Haslam, op. cit., p.15.
9. Berrios, G.E. (1996) *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century.* Cambridge: Cambridge University Press, p.34.
10. Hill, C.G. (1907) quoted in Grob, G.N. (1991) Origins of DSM-I: A study in appearance and reality. *American Journal of Psychiatry*, 148, 4, 421–431.
11. Levy, D.A. (2010) A proposed category for the Diagnostic and Statistical Manual of Mental Disorders (DSM): Pervasive labeling disorder. *Journal of Critical Psychology, Counselling and Psychotherapy*, 10, 4, 121–125.
12. Grob, G.N. (1991) Origins of DSM-I: A study in appearance and reality. *American Journal of Psychiatry*, 148, 4, 421–431.
13. *Ibid.*, p.421.

14. In similar vein, Moncrieff sees the promotion of *treatable* psychiatric disorders such as depression as arising in factors outside scientific (or clinical) work. Instead, corralling depression was (and continues to be) a political act – psychiatry's attempt to integrate with general medicine and improve its status while disengaging from the power base of the asylum. Moncrieff, J. (2011) The myth of the antidepressant: An historical analysis. In M. Rapley, J. Moncrieff and J. Dillon (eds). *De-medicalizing Misery: Psychiatry, Psychology and the Human Condition.* Basingstoke: Palgrave Macmillan, 174–188. For a history emphasizing scientific progress, the reader is directed to Michael Stone's (1998) *Healing the Mind: A History of Psychiatry from Antiquity to the Present.* London: Pimlico. This charts the inexorable progress of psychiatry towards ameliorating the suffering of those who are diagnosed in increasingly precise ways before being treated by more and more refined technologies. Debates are duly reported and Stone locates the rationales for progress in praxis within brief autobiographical sketches of leaders in the field. A critical stance – indeed, *any* genuine analysis – is avoided, leaving the likes of Rosen unscathed, Bettleheim avoided, Masson unmentioned and Laing's "experiment" dismissed as a "dismal failure" (p.216). In a work of over 500 pages it must rate as something of an achievement to mention neither Foucault *nor* Thomas Szasz.
15. Isaac Ray, *A Treatise on the Medical Jurisprudence of Insanity* (1838), quoted in Grob, op. cit.
16. Grob, op. cit.
17. Valenstein, E. (1986) *Great and Desperate Cures: The Rise and Decline of Psychosurgery and Other Radical Treatments for Mental Illness*. New York: Basic Books.
18. Smail, D. (1996) *How to Survive Without Psychotherapy.* London: Constable.
19. Katz (1983), quoted in Szasz, T. (1987) *Insanity: The Idea and Its Consequences.* Chichester: John Wiley & Sons.
20. American Psychiatric Association (APA) (2013) *Diagnostic and Statistical Manual of Mental Disorders-5*. Washington, DC: American Psychiatric Association.
21. Bourdieu, P. (1990) *The Logic of Practice.* London: Polity Press.
22. Jackson S.W. (1986) *Melancholia and Depression.* New Haven, CT: Yale University Press.
23. *Ibid.*, p.5.
24. Bourdieu, P. (1986) The forms of capital. In J. Richardson (ed.) *Handbook of Theory and Research for the Sociology of Education.* New York: Greenwood, pp.241–258.
25. An example of a common reaction (and rejection) to being faced by this kind of expertise might be illustrated by the response of my brother (Andy, who is a groundsman) to public statements by psy experts – "Not another bloody 'ologist."
26. Cromby, J. (2004) Depression: Embodying social inequality. *Journal of Critical Psychology, Counselling and Psychotherapy*, 4, 3, 176–186, p.177.
27. Wiener, M. and Marcus, D. (1994) A sociocultural construction of depression. In T.R. Sarbin and J.L. Kitsuse (eds) *Constructing the Social.* London: Sage Publications, pp.213–231, p.217.
28. Cromby, op. cit., p.184.

29. Flaskerud, J.H. (1986) The effects of culture-compatible intervention on the utilization of mental health services by minority clients. *Community Mental Health Journal*, 22, 2, 127–141.
30. Mays, V.M. and Albee, G.W. (1992) Psychotherapy and ethnic minorities. In D.K. Freedheim (ed.) *History of Psychotherapy: A Century of Change*. Washington, DC: American Psychological Association, pp.552–570, pp.553–559.
31. http://apps.bps.org.uk/_publicationfiles/consultation-responses/DSM-5%20 2011%20-%20BPS%20response.pdf.
32. The majority of articles in the *British Journal of Clinical Psychology* use diagnostic terminology without demur. See, for example, Lomax, C.L. and Lam, D. (2011) An investigation into activation of dysfunctional schemas in euthymic bipolar disorder following positive mood induction. *British Journal of Clinical Psychology*, 50, 2, 115–127; Morris, E., Milner, P., Trower, P. and Peters, E. (2011) Clinical presentation and early care relationships in “poor me” and “bad me” paranoia. *British Journal of Clinical Psychology*, 50, 2, Brief Reports 211–216; Jacobsen, P., Freeman, D. and Salkovskis, P. (2012) Reasoning bias and belief conviction in obsessive compulsive disorder and delusions: Jumping to conclusions across disorders? *British Journal of Clinical Psychology*, 51, 1, 84–89; and Whitton, A.E. and Henry J.D. (2013) The relationship between sub-clinical obsessive-compulsive symptoms and social cognition in chronic schizophrenia. *British Journal of Clinical Psychology*, 52, 115–128.
33. Hawks, T. (2006) *A Piano in the Pyrenees*. London: Ebury Press, p.7.
34. Baker, E. and Newnes, C. (2005) The discourse of responsibility. In C. Newnes and N. Radcliffe (eds) *Making and Breaking Children’s Lives*. Ross-on-Wye: PCCS Books, pp.30–40.
35. http://www.elsevier.com/wps/find/intro.cws_home/ataglance.
36. I am grateful for the authors’ permission to use their work as this basis for this paragraph. See Fryer, D. and Duckett, P. (2014) Community psychology. In T. Teo (ed.) *Encyclopedia of Critical Psychology*. New York: Springer, pp.284–290
37. For a historical critique of scientism in a wide range of disciplines, see Boyle, D. (2000) *The Tyranny of Numbers: Why Counting Can’t Make Us Happy*. London: HarperCollins.
38. For a critique of attempts to reflexively analyse data, see Fryer, D. and Easpaig, B.N.G. (2013) Critical analysology: The critical theorising of analysis. *Journal of Critical Psychology, Counselling and Psychotherapy*, 13, 2, 67–72.
39. Newnes, C. (1995) On note taking. *Clinical Psychology Forum*, 80, 31–36.
40. Division of Clinical Psychology (2011) *Good Practice Guidelines on the Use of Psychological Formulation*. Leicester: British Psychological Society. For a critique of psychological formulation, see Newnes, C. (2014) A psychological formulation of psychological formulation. Can we still be friends? *Journal of Critical Psychology, Counselling and Psychotherapy*, 14, 1, 30–36.
41. Foucault, M. (1975) *Discipline and Punish: The Birth of the Prison*. New York: Random House.
42. Burton, M. (2013) A second psychology of liberation? Valuing and moving beyond the Latin American. *Journal of Critical Psychology, Counselling and Psychotherapy*, 13, 2, 96–107.

43. Kraepelin, E. (1902) *Clinical Psychiatry* (6th edn). New York: Macmillan.
44. Post, F. (1994) Creativity and psychopathology: A study of 291 world-famous men. *British Journal of Psychiatry*, 165, 22–34.
45. Newnes, C. (1995) Histories of clinical psychology forum. *Clinical Psychology Forum*, 84, 39–42.
46. Newnes, C. (2002) The rhetoric of evidence-based practice. *Ethical Human Sciences and Services*, 4, 2, 121–130.
47. http://dcp.bps.org.uk/dcp/dcp-publications/clinical- psychology-forum/guidelines-for-contributors.cfm. Retrieved 8 July 2013.
48. The following websites are a sample of the numerous self-diagnosis sites available (all accessed January 2015): Asperger's http://iautistic.com/test_AS.php, Autistic Spectrum http://www.wired.com/wired/archive/9.12/aqtest.html, Depression (Pfizer and NHS Direct), http://www.nhs.uk/Tools/Pages/depression.aspx, ADHD http://www.dore.co.uk/learning-difficulties/adhd/?gclid=CM-N9N2Xv7ICFUEMfAodiR4Ang, Alzheimer's http://www.telegraph.co.uk/health/healthnews/9059568/Alzheimers-test-shows-who-is-at-risk-take-the-quiz-now.html, and Schizophrenia http://psychcentral.com/quizzes/schizophrenia.htm.
49. Eberstadt, F. (2006) *Little Money Street: In Search of Gypsies and their Music in the South of France*. New York: Alfred Knopf, p.67.
50. Douglas, C. (1994) *Kazimir Malevich,* London: Thames and Hudson. Quoted in Chadwick, P. (2014) How do creative artists cope on The Edge? *Journal of Critical Psychology, Counselling and Psychotherapy*, 14, 2, 70–74.
51. *Ibid.*, p.71.
52. Rose, J. (2014) *Women in Dark Times*. London: Bloomsbury.

4 Rejection: Exclusion and Incarceration

1. Bucknall, O. and Holmes, G. (2001) Relatives and carers. In C. Newnes, G. Holmes and C. Dunn (eds), *This Is Madness Too: Critical Perspectives on Mental Health Services*. Ross-on-Wye: PCCS Books, pp.127–134.
2. Wolfensbrerger, W. (1998) *A Brief Introduction to Social Role Valorization*: *A High-Order Concept for Addressing the Plight of Societally Devalued People, and for Structuring Human Services* (3rd edn). Sracuse, NY: Training Institute for Human Service Planning, Leadership and Change Agentry (Syracuse University).
3. Kealey, E.J. (1981) *Medieval Medicus: A Social History of Anglo-Norman Medicine*. Baltimore, MD: Johns Hopkins University Press.
4. Foucault, M. (1972) *Histoire de la Folie à l'Âge Classique*. Paris: Gallimard.
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5 Assault as Treatment

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7 A Mouthful of Air: Talking Therapies and the Emperor's New Clothes

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> We are parents, lovers, partners, children, men and women as well as psychologists. We will have loved, lost, betrayed, envied, suffered and survived. We have all used the health service. We are gendered and politicised. We will have used, or love people, who use services like the ones we offer. We may have been diagnosed. We are all oppressed. We can hurt others deeply and wish our children ill. We may have been criminals, miserable or hopelessly out of touch with what others call reality. We may be single parents or children of single parents. Our parents may be happy, divorced, adoptive or dead. Our sexuality, consumption of alcohol or use of drugs may be regarded as deviant or excessive ... We may be considered mean or may think ourselves shy. We may hear voices or believe in the risen god; may struggle in relationships or live contentedly alone. We may be moved by the doctors Dre, Faustus or Doolittle; by Prokoviev, Picasso or the Pixies and prefer Lucien to Sigmund in the Freud family. We may have been born on farms, live on council estates or in deepest suburbia. We may have learned that dishonesty and the willingness to run away are important to survival.

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Name Index

Subject Index