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# Psychotherapy Section Review

No. 65 Winter 2020

**Covid Issue**

**Collaboration: Voices apart and together  
'Listening to the client'**

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# Introduction

## Collaboration: Voices apart and together

Erica Brostoff

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**T**HE ARTICLES in this issue are of exceptionally high quality.

Please make time to read these during your Christmas break, and establish a regular pattern of turning to the *Psychotherapy Section Review* for up-to-date accounts of thinking and research in our field. Over time, the Section committee hopes to increase the influence of the Section, and we can best do this by collaboration in various ways, as this issue aims to promote.

As Editor, I have gained a strong sense of a malaise affecting some aspects of psychotherapy, of ‘not listening to the client’ – the by-passing of painful experience in favour of labelling and routinisation. This is something I have experienced myself as a client, even outside the NHS, though not in the context of eating disorders as described here. It is intended to explore this topic of ‘not listening to the client’ in relation to

harm in psychotherapy in our future Issue on this topic.

Part 1 contains articles on eating disorders which are striking for their detailed approach to exploring below the superficial appearance of a clients’ problems.

Part 2 describes an exemplary collaboration between clinicians and researchers. A future agenda will include noting research developments for readers of the *Review*.

Part 3 invites collaboration with exciting developments in the field by our own members. Contact an author to share your views!

Enjoy your reading!

### **Note on Issue numbering**

Issue no. 64, Winter 2019: Group Psychotherapy was the most recent issue of the *Review*, edited by Terry Birchmore.

This Issue no. 65, Winter 2020 and other BPS publications have been delayed by Covid-19, and other unavoidable factors.

This Issue no. 65, contains several articles that Terry Birchmore commissioned from the Psychotherapy Section Conference on Eating Disorders held in October 2018. He was unable to complete an issue on this topic at the end of his six year tenure.

### **Future issues**

Issues 66 and 67 should appear in 2021 as the *Psychotherapy Section Review* should revert to two or three issues per year.

## Advance Invitation to Readers

# Editorial Committees

An editorial committee will be set up for the topic of the forthcoming issue on 'Improving Therapy and Avoiding Harm'.

You are invited to put your name forward now to join this committee. The aim is to identify the important themes for this topic, and to suggest the names of expert contributors.

Whether or not you wish to join this committee, please send your thoughts and experiences in any format, such as preliminary ideas, letters, commentary or articles to the Editors at:

[Psychotherapyreview@bps.org.uk](mailto:Psychotherapyreview@bps.org.uk)

This important topic is implicit in all the material that has been published in the Review over past years. This topic will be developed most successfully if views are freely shared.

Offers to join a committee to explore how we can effectively include research in psychotherapy research are also welcome.

# Letter from the Chair

Philip Cox

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## Our centenary year

**I**T NOW seems prescient that in the last letter from our outgoing Chair, Jo North wrote 'Life is always changing and sometimes we are challenged to keep up with the demands that this brings to us' (Winter 2019). In our centenary year, the tension between understating or overstating the impact of Covid-19 upon our lives feels very present. To balance the tension, the Psychotherapy Section is meeting the challenge by adapting how we will serve the Section's members and the field of psychotherapy.

## Personnel changes

Before outlining the committee's work, it comes to me as the new Chair to thank Jo North for her years of contribution, and to honour the friends and supporters who have retired or resigned from our executive committee. Susan Eppel, who spent 30-years working for the BPS and was our much respected and appreciated go-to person for all BPS-related queries has retired. Our new link person, Kate Brudenell, has already become a great asset. Terry Birchmore, who edited this *Review* for six years has resigned. The quality of the *Review* is a testament to Terry's years of commitment to the Section and (group) psychotherapy. The demands of *Review* editor are being met by Erica Brostoff, who is developing exciting new ideas. Ho Law continues to present consistently sold-out Psychotherapy and Mindfulness Workshops. I have the pleasure of welcoming many new committee members. Emma Tullet is our new e-letter editor and Nina Cioroboiu is our new Facebook page co-editor. Emma and Nina are inviting contributions and likes. We also welcome Juan Du, Nisha Gupta, Tara Taheri and

Jamie Giles. I am delighted to welcome Martin Pollecoff, the elected Chair of UKCP as an external representative to our committee. This is bridge building in action.

## New activities and objectives

The committee has been working hard across a range of areas. We have updated the Section's strategic aims and goals. A BPS strategic goal is to 'Promote the advancement in psychological knowledge and practice'. We are extending this to 'Promote equality and diversity in psychotherapy'. A key Section aim is 'To work closely with other Sections, Divisions and Special Groups of the society and to collaborate with external agencies and organisations'. A key Section objective is 'To actively reach out to marginalised and diverse groups and engage with a collaborative approach across people and communities to enhance the input of as many voices as possible'.

These aims and goals underpin the philosophy of the Section and my personal philosophy. These aims and goals are being actioned from multiple angles. Internationally, we have continued to fund the training place of a group psychotherapist in India. I'm delighted to report the students are now engaged with advanced training and living the philosophy of help one to help another... mentoring made easily accessible.

Nationally, the BPS has recently introduced a new mentoring scheme for all members, which offers the opportunity to support the development of another member/s. Anyone who seeks to benefit from the mentoring has only to join the Section for a nominal small fee. This will

operate across all geographical areas, trainings, modalities or professional bodies.

**Annual conference 2020 online**

This years' conference moved online with the topic of The Brave New World of Psychotherapy. We aim always to deliver a conference that will build upon the Section's strategic aims & goals by exploring the multidimensional inequality and diversity in psychotherapy. Covid-19 has thrown a broad beam of light on existing inequalities in society.

**Likely changes to future psychotherapy:  
Leading the debate**

Current social changes created by the impact of Covid-19 will change the landscape of psychotherapy. The NHS will increasingly develop online services. This will exacerbate the colonisation of therapy by IAPT and the ongoing closure of funded psychotherapy

services. Televised images beamed into homes across the world are highlighting how marginalised groups, with particular reference to the disparity in black and minority ethnic groups who are socially marginalised whilst providing care and dying to save the more privileged, are denied equal involvement in mainstream economic, political, cultural and social activities. This has implications for psychotherapeutic employment, practices, training, power-relations and so forth. In this Letter from the Chair, I suggest we psychotherapists join hands and take a lead in discussing and exploring such issues so that we can influence how the landscape changes.

**Philip Cox**, PhD, Chair 2019–2021 Psychotherapy Section

# Strategic Aims and Goals of the Section

Philip Cox

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**A**S ONE of the oldest specialist groups within the BPS, the Psychotherapy Section has a long and distinguished history as a meeting space for discussion of psychotherapy and related issues.

Over time, the landscape of issues around psychotherapy continues to develop – we face new challenges and welcome new voices to the discussions.

## **Strategic Goals of the BPS**

1. Promote the advancement in psychological knowledge and practice
2. Develop the psychological knowledge and professional skills of our members
3. Maximise the impact of psychology on public policy
4. Increase the visibility of psychology and public awareness of its contribution to society
5. Attract new members and broaden our membership
6. Develop our organisation to support change

## **Within the context of psychotherapy, these translate into the following aims (Strategic Goals) of the Psychotherapy Section:**

1. Promote the advancement in psychological knowledge and practice of psychotherapy
2. Develop the psychological knowledge and professional skills of our members within the context of psychotherapy
3. Maximise the impact of psychotherapy on public policy
4. Increase the visibility of psychotherapy and public awareness of its contribution to society
5. Attract new members and broaden our membership

6. Develop our Section to support change
7. Promote equality and diversity in psychotherapy (Strategic Goal 7 is not in the BPS Strategic Plan)

## **The aims of the Psychotherapy Section are:**

- To further psychological understanding of the personal, social and cultural issues; (Strategic Goal 1)
- To promote scientific investigation of psychotherapy which employs research paradigms appropriate to its subject matter; (Strategic Goal 1)
- To provide a forum for the discussion and exchange of ideas in relation to the above which avoids aligning itself with any school within the broad discipline of psychotherapy; (Strategic Goal 7)
- To work closely with other Sections, Divisions and Special Groups of the society in pursuit of these aims, and where appropriate, to collaborate with external agencies and organisations. (Strategic Goal 6)

## **The objectives of the Psychotherapy Section are:**

- To disseminate information about such new ideas and approaches by means of a Review, e-newsletter and Facebook page; (Strategic Goal 1)
- To explore and communicate issues of importance for the discipline of psychology which are especially highlighted within psychotherapy and which challenge more simplistic notions of science; (Strategic Goal 1)
- To make available information about psychotherapy within the society and to relevant external bodies; (Strategic Goal 1)
- To actively reach out to marginalised and diverse groups and engage with

a collaborative approach across people and communities to enhance the input of as many voices as possible; (Strategic Goal 7)

- To organise a varied and accessible annual programme of events, which promotes the discussion of new ideas and approaches within psychotherapy and are relevant to the Section's aims (Strategic Goal 1)
- To increase the numbers and breadth of our membership base; (Strategic Goal 5)

- To represent interests in psychotherapy and the psychology of psychotherapy on the Society's Council and Scientific Affairs Board; (Strategic Goal 6)
- To work towards becoming a Special Interest Group. (Strategic Goal 6)

**Philip Cox**, PhD, Chair 2019–2021 Psychotherapy Section

# Editor's Letter

Erica Brostoff

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## **The role of the Psychotherapy Section Review**

**T**HE *Psychotherapy Section Review* is an opinion periodical and is an exceptional means to exchange ideas and try new approaches. In the past there has been an editorial committee, a practice that may be revisited. Several Special Issues on particular themes are planned and already part-commissioned, as described below. There is plenty of space for additional articles from readers, on these and other topics. General plans for future editions are under consideration.

### **Future editors**

Erica Brostoff and Nina Cioroboiu will be future joint editors.

Dr Renaud Evrard, clinical psychologist at University of Lorraine, will be joint editor of the Special Issue on Clinical Parapsychology.

A conference on this topic is planned for May 14 and May 15, 2021, with a workshop on case histories. News on how to participate if this goes ahead will appear in the next Issue of the Review.

### **A view of the Editor's role: providing context**

Part of a periodical editor's role can be in providing context to contributors' articles. I have tried to do this here within the several limitations caused by the Covid pandemic. The ideal would be to provide more context so that themes could be followed up through other publications, seminars and conferences, and it is planned to do this more systematically in future issues.

### **'Collaboration' as the theme of this issue**

The need for collaboration of several kinds links the various articles into an overarching theme.

Part 1: the need for collaboration is explored, between internal voices within the client, between services and clients, and between individual psychotherapists and clients. Lip-service is often paid to a move away from 'one-person psychology' and towards a two-or-more interactive view of psychology, yet many would agree this is an aim still in progress. In practice, it is easy to fall back into the one-person, one-sided viewpoint, leading to stunted interactions and limited therapeutic success.

Part 2: collaboration between clinicians and researchers is explored, in the context of the recent work of leading psychotherapy researchers in the USA Chapter of Society for Psychotherapy Research.

Part 3: collaboration in networking between readers and authors is proposed; to give mutual support, exchange of ideas, and, in due course, reporting back to future issues of the *Review*. New formats for collaboration through letters, commentary or other innovations are possible, as well as continued publication of articles and reviews of books and events. Previous issues of the *Review* have contained abundant excellent articles on forward-looking themes. We can build upon these further over time, by active sharing and ideas about actionable plans.

### **Future issues of the Review**

Some articles already have been commissioned for future issues of the *Review*.

Readers are invited to contribute on these themes. Ideas for full-length articles or other formats can be discussed in advance with the editors at [psychotherapyreview@bps.org.uk](mailto:psychotherapyreview@bps.org.uk)

### **Future issue 66: The brave new world of psychotherapy**

Papers from the Annual Conference of the Section, October 2020.

### **Future special issue 67: clinical parapsychology**

This is not a topic likely to be familiar to therapists in the UK, but touches on our beliefs and practice around intersubjectivity.

This issue of the *Review* is well-advanced in terms of articles accepted, with articles from a network of specialists in EU countries and in the UK and USA. Thanks to Professor Ho Law, Editor of BPS *Transpersonal Review*, a companion issue of *Transpersonal Psychology* will appear. A notice about dates of publication and contents will appear in our e-letter.

### **The relevance of this special issue on clinical parapsychology**

In the UK, clients with concerns about unusual/anomalous experiences, can approach various University departments or the Society for Psychical Research and similar bodies. This topic is well-represented clinically in EU countries, with a service funded by the German Department of Health in a clinic in Freiberg. Reports of widespread anomalistic/exceptional experiences in many cultures can be linked theoretically with unverballed and sometimes shared perceptual experience between people close to one another, also with early attachment experiences and with personal traits such as perceptual sensitivity. As such, there is continuity between unusual, sometimes troubling experiences, and everyday shared experience on the one hand, experiences in the consulting room, and even beyond these limits in certain circumstances. Potential links with everyday psychological processes are not necessarily obvious at first, but the more rewarding for deeper investigation.

### **Connection with mentalisation and theories of intuition**

I plan to emphasise in my own article, continuity between anticipation of events, as premonitions, and the familiar concept of mentalisation. Other articles will throw light on individuation versus enmeshment, adult or child conceptualisations, societal versus personal interpretations of experience and more. The topics should expand our thinking about intersubjective experiences in everyday psychotherapy, partially addressed by Freud and Jung among others. Potentially, these are now open to exploration by neuro psychoanalysis and other emerging disciplines. The topic is included as an issue in the *Review* not because of its dramatic aspects, but because of the potential light thrown on personal development and also therapeutic practice. Several University Departments in the UK have research into this field, see also future information in the Section e-letter.

### **Future issue 68: improving therapy and avoiding harm**

There is much to explore on this topic. Please send ideas and experiences, positive and negative especially, as these are less often explored, and themes for potential articles to the editors.

### **Future issue 69: special contexts for psychotherapy**

Articles by a prison psychotherapist and by a leading woman rabbi who is also a psychotherapist, have been promised in principle. All other suggestions welcome.

### **All future issues**

All ideas for future topics and future issues are welcomed by the Editors: Please contact us on [psychotherapyreview@bps.org.uk](mailto:psychotherapyreview@bps.org.uk)

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# Part one: Collaboration in meeting client needs

**M**ATTHEW Pugh's fascinating article on 'voices in eating disorders', draws attention to the many functions of internal voices, in an innovative approach to an aspect of eating disorders that is little explored, tendency towards 'splitting' of the self in eating disorders (and, indeed, more generally). To encourage these parts of the client's self to work together in collaboration towards survival and cohesion is the outcome desired by clinicians treating these clients.

Articles by John Adlam and client Joy Goodall explore the over-riding of clients' experiences and clients' voices in much standard treatment of eating disorders.

Helen Molden and client Jess Walling write a collaborative article on the careful approach to the client's engagement in psychotherapy.

The editor notes the pattern of 'split-

ting' of organisational needs and separation from the clients' lived experience, as early research has shown. 'Splitting' is likely to always be a tendency in a service dealing with strong emotions and painful experience, as described by Isabel Menzies Lyth in relation to nursing practices (Lyth, I.M., 1988, *Containing anxiety in institutions. Selected Essays Vol. 1*. Free Association Books, and other published articles.)

Recognition of 'experts by experience', an important and welcome initiative to counter this tendency is reflected in the recent recognition of clients as 'experts by experience' by the BPS Division of Clinical Psychology. This move includes the possibility of a fee paid to clients for advisory work, according to the circumstances. A step forward!

# Understanding 'Ed': A theoretical and empirical review of the internal eating disorder 'voice'

Matthew Pugh

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*Many individuals with eating disorders make reference to an internal eating disorder 'voice' or 'self' (EDV/S): a phenomenon which is poorly understood. This paper reviews conceptual and empirical literature relating to the EDV/S. Criticisms and controversies surrounding such experiences are also discussed with reference to current research. In order to clarify how and why internal voices contribute to disordered eating, four theoretical frameworks which help contextualise the EDV/S are presented: cognitive theories of voices; interpersonal theories of voices; trauma-based theories of voices; and dialogical self theory. The paper concludes by proposing a preliminary, multifactorial model of the EDV/S which is composed of four maintaining factors: EDV/S dialogical patterns, EDV/S appraisals, EDV/S relating styles, and early trauma and associated interpersonal schemata. Directions for treatment and future research are discussed.*

**Keywords:** Anorexic voice, dialogical self theory, eating disorders, eating disorder voice, voices.

## Introducing 'Ed'

IT IS STRIKING just how often individuals with eating disorders (EDs) describe an internal 'voice' of their disorder (Brousard, 2005; Tierney & Fox, 2010). For others, disordered eating is represented not so much by a voice, but rather a discrete component of personality: an anorexic or bulimic 'sub-self' which is composed of 'needs, feelings, perceptions, and behavior that has been dissociated from the patient's total self-experience' (Sands, 1991, p.37). References to the eating disorder 'voice' or 'self' (EDV/S) are apparent in early clinical descriptions of eating psychopathology (e.g. Bruch, 1978; Dym, 1985; Torem, 1987) and feature in personal accounts of recovery (e.g. Woolf, 2012). While the EDV/S has received some recognition within cognitive-behavioural (Mountford & Waller, 2006), psychodynamic (Davis, 1991), experiential (Dolhanty & Greenberg, 2009), and systemic treatments for EDs (Schwartz, 1987), these experiences are rarely a focus for treat-

ment. Moreover, direct investigations of this phenomenon have only emerged within the last decade. Albeit preliminary, this research has highlighted links between core features of disordered eating and various aspects of the EDV/S including its perceived power, hostility, and intensity (Noordenbos & Van Geest, 2017; Pugh & Waller, 2016, Scott et al., 2014)

## Nature of the EDV/S

Conceptual tensions surround the EDV/S, with some describing it as a metaphorical experience (Graham et al., 2019) and others suggesting that it reflects the multi-voiced nature of human personality (Pugh & Waller, 2018). The EDV/S has most recently been defined as a hostile internal dialogue (i.e. second- or third-person commentary) related to eating, shape, weight, and their implications for self-worth (Pugh, 2016). Single EDV/S are most frequently reported by individuals, although two or more voices

are not unusual (Noordenbos, 2017). Such experiences also appear to be relatively common across ED diagnoses, with an estimated incidence of around 75 per cent (Pugh et al., 2018). While most individuals recognise that the EDV/S is internally generated, it is usually described as alien to one's sense of self, possibly as a result of dissociative processes. This distinguishes the EDV/S from the auditory hallucinations found in psychosis to some degree, as well as the amnesic 'alters' described in dissociative identity disorder. However, given that EDs and psychosis appear to overlap in multiple ways (Rojo-Moreno et al., 2011; Solmi et al., 2018), it may be more accurate to hypothesise that EDV/S lies at varying points on a continuum between inner speech and auditory hallucinations for different individuals, at different points in time<sup>1</sup> (Pugh & Waller, 2018).

### **Relating to the EDV/S**

Individuals often describe meaningful relationships with their EDV/S – so meaningful, in fact, that it may represent a primary object relationship (Davis, 1991). Usually the EDV/S is seen as possessing some positive qualities such as being reassuring, offering companionship, and regulating distress, particularly during the early stages of illness (Tierney & Fox, 2010). Accordingly, it has been suggested that the EDV/S may partly function as a substitute system for fulfilling individuals' core emotional needs, particularly those which were unmet in early attachment relationships (Sands, 1991). It follows, then, that maintaining proximity to this alternate, seemingly positive attachment figure may limit motivation to change and contribute to the maintenance of ED symptoms (Mantilla et al., 2018b).

At the same time, most individuals describe the EDV/S as a highly critical, coercive, and controlling presence, particularly during the

later stages of illness; a toxic 'inner bully' which demands strict obedience and motivates increasingly destructive eating behaviours (Williams & Reid, 2012). Caught between these polarised experiences of the EDV/S, many individuals feel entrapped, defeated, and subordinate to the voice of their ED (Pugh & Waller, 2017). Consequently, attachments to this aspect of the self are often insecure (Mantilla et al., 2018b). Consistent with these findings, research suggests that changing the ways in which individuals perceive, relate, and respond to the EDV/S may play a role in recovery from disordered eating (Eaton, 2019).

### **The EDV/S over time**

Longitudinal research is yet to examine how the EDV/S changes over time. However, a recent synthesis of qualitative studies suggests that experiences of the EDV/S pass through a series of stages (Pugh et al., 2018) (Table 1). To summarise, the EDV/S is usually seen to enter individuals' lives during periods of insecurity and instability. For others, critical internal voices are present before the onset of disordered eating but intensify alongside the emergence of ED symptoms. Often a supportive presence at first, the EDV/S is observed to become hostile and demanding over time, resulting in an escalation in disordered eating behaviour. For some, submission to the EDV/S is gradually replaced by a desire to escape this relationship, motivating acts of rebellion and culminating in recovery. While the EDV/S often fades over time, it does not always disappear. Furthermore, new and unexpected challenges may accompany the process of emancipation: individuals may grieve the loss of their relationship with the EDV/S, while others fear that it will escalate in the future. Similar changes in how individuals relate to voices have been reported in other clinical groups (e.g. De Jager et al., 2016).

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<sup>1</sup> It has been suggested that experiences of childhood trauma and dissociation-proneness may be responsible for generating EDV/S which are experienced as more differentiated and 'split-off' from individuals' sense of self (Watkins, 1978).

Table 1: Time course of the EDV/S

Stage	Description
1. Direction	The EDV/S initially fulfills positive functions. Relating to the EDV/S is mainly affiliative, albeit contingent upon compliance, resulting in attachment. Internal dialogues are generally cooperative but increasingly monological. Positive EDV/S appraisals become established and motivation to change the relationship is often low. ED symptoms emerge.
2. Domination	The EDV/S is experienced as increasingly hostile and controlling. Relating to the EDV/S is characterised by dominance and coercion. Internal dialogues are increasingly imbalanced and hierarchical. Negative appraisals regarding the intent and relative power of EDV/S emerge. ED symptoms escalate, although motivation to change may remain limited.
3. Disempowerment	The EDV/S is experienced as punitive and overwhelming, generating submissive and defeated responses. The EDV/S dominates internal dialogues and undermines self-esteem and self-efficacy. Individuals are motivated to change their relationship with the EDV/S but may doubt their ability to do so. ED symptoms may continue to escalate.
4. Defiance	Individuals begin to oppose the EDV/S. Power differentials begin to shift, generating fervent EDV/S counter-attacks. Internal dialogues are conflictual and polarised. ED symptoms may begin to improve, although setbacks and periods of disempowerment still occur (see stage three).
5. Deliverance	Power differentials now favour the individual rather than the EDV/S. Individuals are better able to 'step back' and decentre from the EDV/S. Internal dialogues are less conflicted and more harmonious. More adaptive internal voices begin to emerge. ED symptoms continue to improve.
6. Disquiet	The EDV/S fades over time or is considerably less powerful. Recovery from disordered ED may be accompanied by feelings of anxiety or loss: individuals are vigilant to the EDV/S returning or miss its positive aspects. Intermittent 'skirmishes' with the EDV/S are not uncommon.

### Criticisms of 'Ed'

While the EDV/S appears to play a role in the maintenance of some EDs, this line of research has attracted a degree of criticism (Pugh, 2016). Some of the conceptual controversies surrounding the EDV/S are now discussed alongside alternative perspectives garnered from the literature.

### The EDV/S is a product of therapist socialisation

It has been suggested that the EDV/S may partly stem from therapists' use of 'externalising conversations' (White & Epston, 1990): an intervention originating from Narrative Therapy which aims to separate the person from the problem by placing it outside of the self. Indeed, externalisation techniques

have proved remarkably popular in treatments for AN (Treasure, 1997), particularly family-based therapies (Lock et al., 2002). However, two observations conflict with this argument. First, the EDV/S has been described by individuals who have not yet entered mental health services or talking therapies (Williams et al., 2016). Second, and more convincingly, references to the EDV/S predate use of externalisation techniques in psychotherapy (e.g. Bruch, 1978; Dym, 1985; Schwartz, 1987). This is not to say that EDV/S is never a product of therapeutic socialisation – sometimes it is. Rather, such experiences might also represent a legitimate feature of disordered eating for some individuals.

### **The EDV/S is indistinguishable from dysfunctional beliefs about eating**

Dysfunctional beliefs relating to the importance of shape, weight, and their control often play a role in the maintenance of EDs (e.g. Fairburn, 1997; Fairburn et al., 1999). Perhaps the EDV/S is simply another way of describing these cognitions. If so, near-perfect associations between measures of the EDV/S and negative attitudes towards eating would be expected. However, research indicates that this is not the case (Kay et al., in press; Pugh & Waller, 2016). Furthermore, many individuals distinguish the EDV/S from other patterns of negative thinking associated with EDs, such as self-criticism (Noordenbos et al., 2014).

### **The EDV/S is a redundant feature of eating disorders**

While the EDV/S represents a feature of some EDs, such experiences might not be clinically relevant. Recent research would suggest otherwise. As already noted, significant associations exist between key dimensions of eating psychopathology (e.g. negative eating attitudes and duration of illness) and characteristics of the EDV/S (e.g. its power relative to the self) (Noordenbos et al., 2014; Pugh & Waller, 2016, 2017). Preliminary research also indicates that the EDV/S influences responses to psychotherapy, although the exact nature of these interactions requires clarification (Hormoz et al., 2019). Most importantly, many individuals with EDs identify the EDV/S as an important feature of their illness and one which warrants clinical attention (Tierney & Fox, 2010).

### **The EDV/S is not a 'True' perceptual experience**

It has been argued that because the EDV/S is not a 'true' hallucinatory experience, it does not represent a meaningful feature of psychopathology (for exceptions, see Rojo-Moreno et al., 2011). It is worth noting that attempts to differentiate types of voice experience (internal versus external voices; 'true' versus 'pseudo' hallucinations; voice hearing versus

voice experiencing) have failed in research settings (see Moskowitz & Corstens, 2007, for a review). Moreover, such distinctions offer little in terms of clinical utility. These points have led to the conclusion that voices might be best conceptualised as a dissociative, rather than psychotic, experience which is related to the multiple 'selves' and modes of information-processing which are common to all individuals (Moskowitz et al., 2012). As we shall see, experiences of self-multiplicity and dissociation-proneness are particularly relevant to EDs.

### **Making sense of 'Ed'**

Research indicates that the EDV/S plays a role in some EDs (Aya et al., 2019). However, several observations require exploration. First, a significant proportion of individuals who experience critical internal voices – including those related to eating, shape, and weight – do not experience ED symptoms (Noordenbos et al., 2014). Second, it appears that the EDV/S sometimes persists in individuals who have recovered from disordered eating (Bell, 2013; De Giacomi, 2019). Third, research indicates that conspicuous features of the EDV/S including its frequency and distressing nature are inconsistently related to eating psychopathology (Pugh et al., 2018). These findings beg the question: how, and why, does the EDV/S influence attitudes and behaviours related to eating, shape, and weight? Theories of voice-experiencing may provide some answers.

### **Dialogical self-theory**

Dialogical self-theory views the self as being composed of multiple, autonomous 'parts' or 'voices' which are capable of engaging in dialogical relationships with one another (Hermans, 2004). These voices are also believed to be subject to power dynamics, with some dominating or suppressing others. Dialogical self-theory suggests that psychological impairment stems from discordance between internal voices. Causes of such disharmony include the dominance of maladaptive voices (*tyrannical* internal dialogues),

limited numbers of voices (*uniform* internal dialogues), non-cooperation between voices (*conflictual* internal dialogues), rigid organisations of voices (*inflexible* internal dialogues), or chaotic interactions between voices (*disorganised* internal dialogues). In extreme cases, traumatic events may cause internal voices to become entirely dissociated and ‘split off’ from one another, resulting in a fragmented sense of self (Watkins, 1978).

Individuals with EDs describe an inner world which is often markedly multi-voiced and dialogical (Schwartz, 1987). These voices are often highly conflicted, with some encouraging disordered eating and others opposing it (*conflictual* dialogues) (Bruch, 1978; Tierney & Fox, 2010). Other individuals describe their EDV/S as overwhelmingly hostile and capable of ‘taking over’ their internal world during acute illness (*monolithic* dialogues) (Williams & Reid, 2012). In both cases, ED voices are characteristically repetitive, perseverative, and ruminatory (*inflexible* dialogues). Recovery from disordered eating also appears to be related to changes in the dialogical self. These include the strengthening of adaptive internal voices which counteract the EDV/S (e.g. ‘compassionate’, ‘healthy’, or ‘recovered-focused’ voices), distancing oneself from toxic statements arising from the EDV/S, and the emergence of higher-order meta-voices which enable decentred reflection on the EDV/S (Bell, 2003; Salvini et al., 2012).

In summary, accounts of the EDV/S are largely consistent with dialogical self-theory. More specifically, existent research suggests that the EDV/S influences eating pathology via hostile-monolithic, inflexible, and conflictual internal dialogues. Studies also suggest that decentring from the EDV/S, alongside the development of more functional internal voices, contributes to improvements in disordered eating.

### **Cognitive theory**

Researching exploring auditory hallucinations in community groups indicates that voice-related experiences are relatively

common (Beavan et al., 2011). Furthermore, not all voices result in distress or functional impairments (Lawrence et al., 2010). These observations suggest that factors other than the presence of internal voices contribute to the emergence of psychopathology. The cognitive model of auditory hallucinations (Chadwick & Birchwood, 1994) suggests that emotional and behavioural responses to voices are influenced by their appraisal. Specifically, voices that are perceived as omnipotent (all-knowing), malevolent (with hostile intent), and more powerful than the self tend to generate emotional distress and resistant responses. In contrast, individuals are more likely to engage with benevolent voices. That said, benign voices can also lead to social impairments as a result of preoccupation (Favrod et al., 2004). Birchwood and Chadwick (1997) have gone on to suggest that how individuals come to appraise voices may originate from their ‘core interpersonal schemata which... embody the individual’s past experiences of interpersonal relationships, particularly early relationships’ (p.1352).

Originally developed within the context of auditory hallucinations, the cognitive model also provides insights into how internal voices contribute to other disorders. In a series of studies, Pugh and colleagues explored relationships between EDV/S appraisals and aspects of eating psychopathology (Pugh & Waller, 2016, 2017; Pugh et al., 2018). Results indicated that voices perceived as more powerful than self were associated with negative eating attitudes across diagnoses (anorexia nervosa, bulimia nervosa, and ‘unspecified’ EDs), while positive beliefs about the EDV/S were linked to unhealthy food-related attitudes in two studies. Furthermore, individuals diagnosed with anorexia nervosa who reported a strong EDV/S tended to suffer from more severe EDs, characterised by longer durations of illness and greater use of compensatory behaviours (e.g. purging). Research is yet to determine whether EDV/S appraisals are related to maladaptive interpersonal schemas. However, such an association seems plausible

given that early maladaptive schemas are pronounced in EDs (Pugh, 2016).

EDV/S appraisals may account for the interactions between internal voices and disordered eating-related attitudes. Specifically, it appears that ED voices that are perceived to have the dual characteristics of being more powerful than the self (dominant) and with positive intent (benevolent) tend to exert the most deleterious effects upon attitudes towards shape, weight, and eating. Assessing, re-evaluating, and testing out appraisals about the EDV/S may, therefore, represent a target for psychological therapies. Positive beliefs about ED voices may also contribute to the high levels of ambivalence found in many EDs.

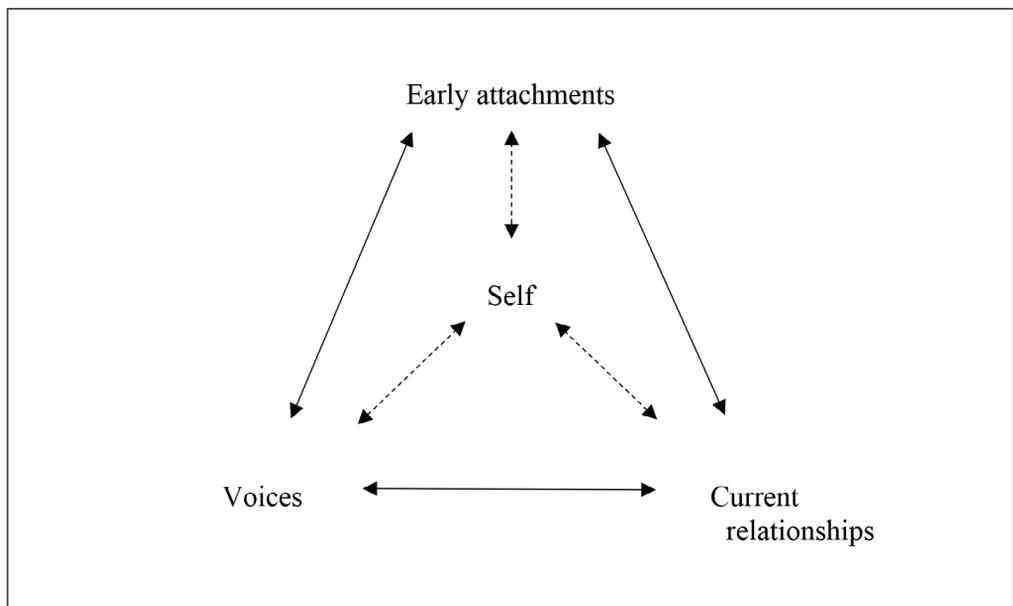
### **Interpersonal theory**

Many individuals describe coherent and personally meaningful relationships with internal voices. Interpersonal theories of voices such as Gilbert's (1989) social rank theory and Birtchnell's (1996) relating theory suggest that voices can be understood within relational frameworks. Specifically, interpersonal theories propose a bidirectional associ-

ation between interactive patterns in external relationships and relationships with voices (Figure 1). Perceptions of low social rank, for example, are likely to generate submissive responses within both social (self-other) relationships and internal (self-self) relationships. These patterns of interaction are also likely to be complimentary in that certain relational behaviours (e.g. domineering voices) tend to elicit reciprocal responses (e.g. obedience to voices) ('interpersonal complementarity') (Carson, 1969). Finally, attachment is believed to influence relating to voices insofar as one's experience of early relationships will inform how individuals treat themselves in later life ('interpersonal copy process') (Benjamin, 2003). Interpersonal theories of voice are supported by a growing body of research which highlights the overlap between social interactions and interactions with voices in psychosis (e.g. Hayward, 2003; Hayward, et al., 2011).

Individuals with EDs tend to perceive themselves as inferior and lower in rank compared to their EDV/S; a power differential that has been linked to increased ED symptomatology (Pugh & Waller, 2016; Pugh

Figure 1: Interpersonal model of voices



et al., 2018). Furthermore, responding to the EDV/S in subordinate ways (e.g. submitting or sulking) is associated with more significant ED symptoms (Mantilla et al., 2018a). Consistent with interpersonal theories of voices, these styles of relating to the EDV/S mirror the interpersonal patterns commonly found in ED groups. For example, individuals with EDs tend to view themselves as inferior to others and struggle to assert themselves in external relationships (Arcelus et al., 2013). Changing how individuals relate to the EDV/S also appears to play a role in recovery from disordered eating; however, research is mixed in terms of which styles of relating are most beneficial. Several studies suggest that learning to oppose and control the EDV/S contributes to reduced ED symptoms (Bell, 2013; Duncan et al., 2015; Jenkins & Ogden, 2012; Mantilla et al., 2018a), while other research has associated 'fighting' the EDV/S with more severe ED symptoms and emotional distress (De Giacomi, 2019; Pugh & Waller, 2017). These latter findings are consistent with research demonstrating that aggressive counter-responding (i.e. rejecting forms of anger) is not only an ineffective way of managing self-criticism, but also risks stimulating threat-focused affective systems and heightening attention towards voices (Gilbert, 2010; Kramer & Pascual-Leone, 2016; Pugh, 2016). Rather, responding to distressing internal voices with healthy assertiveness rather than maladaptive anger has proven effective in other voice-experiencing groups (Hayward et al., 2017) and may be more constructive in EDs. Alternatively, it may be that responding to the EDV/S from a distanced, rather than interactive, relational position is most advantageous (Bell, 2013; Pugh & Waller, 2017).

While EDV/S research is consistent with interpersonal theories of voices, studies are yet to directly explore the associations between relating to ED voices and relating to external individuals. Assuming that such a link exists, interpersonal theories have important implications for treatment. First, individuals may benefit from formulations

which situate the EDV/S in the context of past and present relationships. Second, treatments will need to address how individuals relate to ED voices: useful interventions might include limiting dysfunctional responses (e.g. submitting, complying) alongside the development of new functional ways of relating to the self and others (e.g. compassionate assertiveness). Third, if individuals are to give up their connection with the EDV/S, it seems important that the needs underlying this attachment are fulfilled within the therapeutic relationship, at least temporarily.

### **Trauma-related theory**

The trauma-dissociation model (TDM) of auditory hallucinations proposes that distressing internal voices reflect dissociated traumatic content arising from maltreatment (Longden et al., 2012). To illustrate, parental emotional abuse is likely to be internalised in the form of distressing images or introjected self-criticism. As a result of dissociative processes, however, these mental events are experienced as alien and 'voice-like'. Numerous studies have supported the trauma-dissociation model of voice experiencing, demonstrating that dissociation reliably mediates the relationship between childhood abuse and auditory hallucinations in psychosis (e.g. Perona-Garcelan et al., 2012).

The TDM seems relevant to EDV/S for two reasons. First, disordered eating has been linked to multifarious forms of childhood abuse (Molendijk et al., 2017), most notably emotional abuse (Kent & Waller, 2000). Second, dissociation appears to be relatively common in ED groups (Dalle et al., 1996). To determine whether trauma and dissociation are related to ED voices, Pugh and colleagues (Pugh et al., 2018) explored associations between the perceived power of the EDV/S, dissociation proneness, and experiences of childhood trauma in a mixed ED group. Consistent with the TDM, ED voice power was found to be positively related to childhood emotional abuse,

but not other early traumas, and this association was partly mediated by dissociation. Albeit preliminary, these findings suggest that the EDV may reflect experiences of early maltreatment such as criticism and rejection. These findings have recently been corroborated by qualitative research highlighting the thematic links between the content of the EDV/S and the voices of critical caregivers (De Giacomi, 2019).

Regarding treatment implications, the TDM suggests that the EDV/S are partially memory-based and can be understood within a developmental-interpersonal framework. Situating the EDV/S within individuals' biography may help support meaning-making, therefore. The TDM also points towards the potential value of trauma-focused interventions when working with the EDV/S. These could include grounding techniques for managing trauma-related symptoms and experiential exercises for resolving attachment-related injuries related to internal voices (e.g. empty-chair confrontation of past abusers or imagery rescripting) (Arntz, 2012; Pugh, 2019).

### **A multi-factoral model of the EDV/S**

Studies exploring the EDV/S are consistent with several theoretical frameworks for making sense of voices. Based upon this research, a preliminary model of the EDV/S is now presented. This model takes the view that rather than being a purely metaphorical experience, the EDV/S reflects the multi-voiced internal worlds which are common to all individuals. It is also hoped that this model will generate testable hypotheses for future research and inform psychotherapeutic interventions for addressing the EDV/S.

In summary, existent research suggests that four inter-related factors play a role in perpetuating EDV/S-related experiences which in turn contribute to eating psychopathology: 1) characteristics of the internal dialogues linked to the EDV/S such as their rigid and monolithic quality; 2) dysfunctional appraisals of the EDV/S; 3) styles of

relating to the EDV/S; and 4) predisposing factors such as childhood trauma and, relatedly, negative interpersonal schemas. While support for some aspects of this model is reasonable (e.g. EDV/S-related appraisals and response styles), other components require further testing (e.g. the roles of childhood maltreatment and interpersonal schemas). Other biopsychosocial factors are also likely to contribute to EDV/S experiences. For example, starvation effects in anorexia nervosa will almost certainly exacerbate cognitive processes associated with distressing internal voices (e.g. repetitive, perseverative, and inflexible patterns of thinking), while the social isolation and withdrawal accompanying disordered eating is likely to increase preoccupation with the EDV/S.

### **Overview of the model**

It is hypothesised that vulnerability to the EDV/S is conferred by several interrelated factors including attachment-related difficulties, early trauma, dissociation proneness, and the development of maladaptive interpersonal schemas, alongside temperamental factors (e.g. perfectionistic and obsessive personality traits). Experiences of severe childhood abuse and a greater tendency towards dissociation are likely to give rise to an EDV/S which is experienced as more differentiated and disconnected from the self. For some, the EDV/S will emerge alongside the development of ED symptoms; for others, pre-existing critical-internal dialogues become orientated around eating, shape, and weight in response to critical life events (e.g. body-related bullying).

During the initial stages of illness, ED symptoms are positively reinforced by affiliative EDV/S responses (e.g. praise, reassurance) and associated emotional reactions (e.g. pride, gratitude). This has the effect of ameliorating aspects of psychological distress (e.g. down-regulating distressing emotions, distracting from low self-esteem), leading to the formation of positive appraisals regarding the functionality of the EDV/S ('my ED voice

is helpful'). Attachment to the EDV/S and, relatedly, positive EDV/S appraisals are likely to emerge at this point and contribute to ambivalence about change.

Gradually, and particularly during the later stages of illness, ED symptoms are negatively reinforced by hostile EDV/S responses regarding the individual's shape, weight, and eating (e.g. criticism, humiliation). In order to avoid or ameliorate the negative emotions accompanying EDV/S attacks (e.g. shame, anxiety), individuals will tend to adopt submissive counter-responses (e.g. compliance, appeasement) resulting in increased ED symptomatology. This subordinate style of relating has the effect of strengthening dysfunctional appraisals about the dominance and omnipotence of the EDV/S, prompting further capitulation and compounding feelings of defeat and entrapment.

The biopsychosocial effects of disordered eating are likely to become pronounced at this point. Isolation, interpersonal tensions, the abandonment of personal interests, cognitive changes, and difficulties adhering to the demands of the EDV/S all contribute to deteriorations in mood, self-esteem, and self-efficacy. This results in increased preoccupation with the EDV/S and an inner world that is monopolised by repetitive, critical, and distressing forms of dialogue. Furthermore, the negative consequences of disordered eating may be interpreted as indicating a greater need to adhere to EDV/S, prompting more extreme eating behaviour.

### **Treatment implications**

Current treatments for EDs have produced modest outcomes characterised by short-term symptomatic improvements, high rates of relapse, and significant levels of dropout. Psychological therapies for AN remain particularly dissatisfactory, with relatively low success rates reported across different forms of psychotherapy. In light of these findings, novel interventions for EDs are needed.

The EDV/S represents a fruitful direction for ED treatment. In particular, working

with EDV/S could provide therapists with a means to engage ambivalent individuals, address treatment-resistant EDs, and stand shoulder-to-shoulder with clients against a feature of disordered eating (Pugh, 2016). Appreciation for the EDV/S might also promote understanding for the lived experience of EDs amongst mental health professionals, as well as establishing a common language for treatment (Graham et al., 2019). Unfortunately, limited guidance exists as to how internal voices might be addressed in EDs. Based on this review, and informed by the EDV/S model presented earlier, several targets for working with the EDV/S seem relevant. These might include:

- Building motivation to change one's relationship with the EDV/S.
- Formulating the EDV/S with reference to past and present experiences in social relationships.
- Minimising biological factors which are likely to exacerbate the EDV/S (e.g. starvation) through improved nutrition.
- Clarifying the functions of the EDV/S through direct 'voice dialogue' (Stone & Stone, 1989) and identifying alternative ways to fulfill these needs.
- Re-evaluating and testing out maladaptive appraisals of EDV/S appraisals (e.g. its perceived power and benevolence).
- Developing more adaptive ways of responding to the EDV/S such as compassionate assertiveness.
- Establishing and investing in healthy, external relationships.
- Addressing underlying factors such as childhood trauma and associated schemata.

### **Future directions for research**

Additional studies are needed to elucidate the nature of the EDV/S, its interactions with disordered eating, and to test the components of the model presented here. It is hoped that continued research in this area will be buoyed by the development EDV/S specific measures (Gant, 2016), as well as adapted study designs and voice-related instruments

taken from other voice-experiencing groups (Pugh, 2016; Pugh & Waller, 2016). Important questions regarding the EDV/S which require exploration include the following:

- How does the EDV/S differ from the voices found in other disorders (e.g. psychosis and emotionally unstable personality disorder), if at all?
- Which longitudinal factors predispose individuals to experience an EDV/S?
- Is the EDV/S related to underlying interpersonal schemas?
- Are relationships with the EDV/S reflective of early attachments and external patterns of relating?
- Which ways of responding to the EDV/S are most problematic and which are helpful (e.g. 'fighting back' versus 'stepping back')?
- How does the EDV/S change during recovery from disordered eating?
- Do EDV/S characteristics influence responses to therapy and does working with the EDV/S improve treatment outcomes?

## Conclusions

Despite being a relatively common experience in EDs, studies exploring the

EDV/S have only just begun to emerge. This research, albeit preliminary, suggests that the EDV/S may contribute to the maintenance of some EDs. Theories of voice experiencing developed in other clinical grounds provide some insight into how eating psychopathology and the EDV/S interact. Based on these insights, the current research, and clinical experience, a preliminary multifactorial model of the EDV/S has been proposed. It is hoped that this will provide a useful framework for both formulating and working with the EDV/S. Additional studies are now needed to clarify the nature of the EDV/S, test its clinical significance, and evaluate components of the presented model.

## Matthew Pugh

Central and North West London NHS Foundation Trust

## Correspondence

### Matthew Pugh

Vincent Square Eating Disorders Service, Central and North West London NHS Foundation Trust, 1 Nightingale Place, London, SW10 9NG

Email: matthewpugh@nhs.net.uk

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## The over-riding of clients' voices – the need for collaboration

# Food practices, eating distress and the perils of bewildering interventions in 'eating disorders' treatment settings

John Adlam

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*'Mental health policies should address the "power imbalance" rather than "chemical imbalance" ... and abandon the predominant medical model that seeks to cure individuals by targeting "disorders".'* (UN Special Rapporteur, 2017, p.19)

*'Co-production requires give and take, an interaction in which participation is more likely to be welcomed and willingly entered into when the 'objects' exchanged are words, opinions, ideas, food for thought. However, when the 'matter in hand' becomes substantial, in the most literal sense of the word, an actual giving and receiving of food, ready co-operation may come far less easily ... To take what has been given, to accept the nourishment offered, is to acknowledge the existence of a need and recognise the legitimacy of the caregiver ... In more ways than one, accepting what is needed can be hard to swallow.'* (Anonymous expert by experience, from Adlam et al., 2016)

*'This has been a truly collaborative process (rather than the normal "token-istic" nod to Service User involvement). This is reparative and "bridging" – reaching across the chasm between Creon(s) and Antigone(s). I have felt seen, heard and respected (the antithesis, I feel, of my in-patient treatment). In this sense the author has/is practising the "hope" driving this project and creating the beginnings of the collaborative re-imagining he is advocating.'* (Anonymous expert by experience, from Adlam et al., 2014)

**I**N THIS ARTICLE I will set out a set of ideas concerning the phenomenology of eating distress which arose out of my experiences and observations – but also, I hope I may say, my listening – during my time running inpatient psychological therapies on an eating disorders inpatient unit. I presented this line of argument at the BPS Psychotherapy Section annual conference on 26 October 2018. If there was something of a polemic feel to my presentation at that event, then I make no apology and here I will attempt to replicate some of that feel in my writing. A visual diagrammatic representation of the

line of argument around food practices and eating distress is appended to this article.

I must begin by expressing my gratitude and respect to my colleague Joy Goodall-Leonard, who agreed to act as Respondent to my talk – in role as an expert from lived experience on eating distress and the treatment approaches of the system of care – and who co-facilitated with me the plenary large group that followed on from the end of our presentation. Joy has very generously agreed to offer a written piece in response and this follows on from this article. Without Joy and her survivor

comrades (some of whom are credited as authors here and some who must remain anonymous) this piece of writing would have been in no wise conceivable.

## **1. Introduction**

There are three conceptual issues that come together to form the foundation of this paper and which I wish to present by way of introduction.

The first arises from my increasing conviction that the existing diagnostic and treatment frame for 'eating disorders' is inadequate and needs to be challenged: in similar ways, and for similar reasons, to the continuing critical opposition to the contested diagnosis of 'personality disorder' (see e.g. Timoclea et al., 2018; for a sustained assault on all concepts of disorder and pathology in mental health and social care, see Watson, 2019). This proposition perhaps needs a whole book to develop, and I only have a few paragraphs spare; but a moment's reflection at least justifies the question being put.

It is well known that 'anorexia nervosa' is a misnomer predicated upon a very fundamental misunderstanding (the states connected with the diagnosis have nothing to do with loss or lack of hunger). It has no more intrinsic validity as a signifier than, say, 'moral insanity' or 'dementia praecox'. Dressing the idea up in Latin garments, doesn't make it any more of an identifiable illness entity. We continue to play 'hunt the biomarker' for all these concepts, but so far in vain.

'Bulimia nervosa', like 'Borderline personality disorder', is a diagnosis we've only had on the books since DSM-III codified it in 1980, at the very dawn of the neo-liberal turn. Moreover, DSM-III came with the significant disclaimer, which quickly disappeared from DSM-III-R, (having no doubt been perceived to be bad for business) that its system was so imprecise that it should never be used for forensic or insurance purposes (Van Der Kolk, 2015, p.29). More than half of all 'eating disorder' diag-

noses made under DSM-IV were 'EDNOS' ('Eating Disorder Not Otherwise Specified' – a non-diagnosis by any other name).

This statistic rather suggests that neither the 'specifying' nor the 'not specifying' is functioning under the existing classification system. To get that percentage down, DSM-5 has broadened its categories, so that 'anorexia' is now scarcely recognisable from its core criteria in DSM-III; a 'bulimia' diagnosis now requires a much less significant 'symptomatic' frequency and 'binge eating disorder' has now become a codified illness entity. Other new illness entities (Avoidant Restrictive Food Intake Disorder, anyone?) have also appeared.

Some of these changes may possibly be progressive (it's far too early to say, in 'clinical' terms) and some people may now feel better 'described' than they did before. Certainly, some treatments can now be accessed through health insurance schemes, that couldn't be accessed before. But my point is not to get lost in the endless fine-tuning of the DSM and ICD committees, as they negotiate their compromise formations with pressure groups and special interests both internal and external. Neither am I presuming to instruct anyone that they should not feel helped by being classified in particular ways. My point is simply to say that none of this appears clear enough, or has produced clear enough evidence bases for intervention, or has made sufficient inroads into the suffering that is 'out there', to have earned the right to go unquestioned in itself. My own suspicion is that there is too much bad science here; my own experience and observation tells me that far too many people have fallen into oblivion through the cracks in this crumbling edifice.

It partly follows from this that we don't make sense to the patients – an experience we push away, I think, by holding tight to the position that the patients don't make sense to us. On inpatient units in particular (because the whole encounter is more intense and claustrophobic), I have become convinced that our interventions

are *bewildering* as well as terrifying (and our non-interventions: to give one example, gatekeeping or triaging by BMI means that a given individual might be told their BMI is too high for inpatient treatment; might then feel that forcing their BMI further downwards is the only way to get help; and then be told that their BMI is too low for outpatient psychotherapy). ‘Why do you treat me this way?’ is the cry that goes up (on both sides of the staff-patient divide, in fact; see Scanlon & Adlam, 2009). In some sense, we who have worked in such places tend to take for granted our rationale for a range of interventions; and we somehow assume that the same unarticulated rationale is available to our patients. In this, I believe that we are entirely mistaken.

My second preliminary conceptual issue arises from the observation that ‘eating disorder’ services and the ‘eating disorders’ field in general are extremely reluctant to take their patients seriously in terms of asking them what troubles them: what they think is ‘the matter’. It is never quite said outright, but the tangled logic of the medical model, for ‘anorexia nervosa’ in particular, exits its own Gordian knot in the off-stage mutter: ‘they’re too ill to be asked’. I believe this is a central cause of the difficulties I have adduced under my first point.

The reader will note the anecdotal nature of this second point. But consider how the following discourses current in systems of care become intermingled and what might be the outcome: the psychiatric discourse of ‘over-valued ideas’, mixed in with the psychoanalytically-tinged usage of the term ‘psychotic thinking’ to signify loss of reality orientation; the determinism of ‘impaired cognition’ in starvation; the clinical and societal resistance towards, and sometimes downright hatred of, the patient with ‘complex co-morbidities’, and the concomitant clinical and societally located fearful forgetting of the possibility of hidden trauma in the history. All of these phenomena combine together in what I consider to be a damaging and perhaps even toxic ideological brew that

makes it a very uphill struggle indeed, in my observation and experience, to mobilise something resembling a practice of equality and a culture of open enquiry in the field, and on the ward; and mostly the endeavour is not even attempted.

The third issue arises from the comments of the UN Special Rapporteur on coercive psychiatry (United Nations, 2017) and its interdiction under the terms of the United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2006; for a critique of the ‘abolitionist’ position and the possible distinction between ‘non-consensual’ and ‘coercive’ interventions, see Martin & Gurbai, 2019; for the ‘abolitionist’ take on the Convention, see Minkowitz, 2007, 2010). I have looked at this issue in some detail in my previous piece in this *Review* (Adlam, 2019); for present purposes (i.e., in order to think about eating distress as a psychosocial disability) I propose to bypass some of the debates and legal and ethical controversies. I will therefore here simply accept the Special Rapporteur’s position and concern myself with what might follow from that acceptance. How then might we ‘dust off our ethics, reconsider our practices and shift our paradigms’ (Adlam 2019, p.9)?

## **2. Beyond the medical model: A ‘rainbow’ phenomenology**

These three conceptual issues come together in one specific although wide-ranging question. If we are to creatively re-imagine (Adlam, 2018) the whole field in line with the guidance of the Special Rapporteur, we would need to put the patient back at the centre of care planning and we would need to abandon not only coercive psychiatry/mental health care but also medicalised discourses around eating ‘disordered’ ‘symptoms’ and ‘pathology’ in favour of a new phenomenology (see Martin, 2017).

My question therefore looks something like this: *What would a phenomenology of eating distress look like if we took the testimonies of experts from lived experience as our evidence base – and*

*how might we develop non-coercive treatment possibilities using such an evidence base?*

In pursuit of a possible response, I am going to reverse the imbalance inherent in the 'clinical' literature (which almost entirely ignores the 'patient voice' and disparages survivor testimonies as 'grey literature') and, for this paper, as for my talk on which it is based, I am going, reciprocally and in return, to ignore that clinical literature in (almost) its entirety. I am also going to dispense altogether with the diagnostic framework upon which that literature is problematically predicated. I am going to make reference, here on in, only to the published work of experts from lived experience (which I prefer to term 'rainbow literature': see Adlam & Turner, 2017b) or to my own infant observation field notes. However, I do make reference to patient testimonies recorded, I believe faithfully and respectfully, by Hilde Bruch in *The Golden Cage* (1978) – and therefore make this one exception in the bibliography.

Most of the 'rainbow literature' references I am going to rely upon are taken from two edited collections, both available online and open access as of time of writing. The second (Adlam & Turner, 2017a) owes a great debt, which I now have the opportunity publicly to acknowledge, to the first (Pembroke, 1992), which latter is the original source for the term 'eating distress' – a term I am going now to prefer for the rest of this article. The blogosphere and Twitter-sphere are both replete with invaluable such testimony: I will mention just one weblog here, by way of excellent example: Emma's <https://progressnotperfection.co.uk/>. There are also many powerful survivor testimonies in book form (see e.g. Sister Marie Therese of the Cross, 2008; Allison, 2009).

One last point before I offer my hypothesis: I note and mark the obvious difficulty here, that I am at risk of being seen to be writing 'on behalf of' people who have not in fact authorised me to ventriloquise them. How can I advocate deployment of this 'rainbow' literature and the ethos of

emancipatory research in a written piece when I am not speaking from my own lived experience of the difficulties I am trying to describe and map here? How far might I be at risk of being seen here to adopt some kind of colonial move or Bolshevik-style 'intellectual vanguard' posture? These are pitfalls I may not be entirely able to avoid – but I am looking out for them, and I will do my best in what follows to foreground other voices and present them unfiltered.

### **3. Food practices**

A foundational term, then, to begin with, and to conjure with: 'food practices'. My focus in this article is on *food practices* and on *eating distress*. By the latter term, I mean to denote that distress that can be either causative of or consequent upon, or simply contingent with, what it feels like when anyone's food practices get into (often, are forced into) a tangle of some kind – when the offering of food (by the self or by another) and the receiving of food come together in a process that somehow goes awry.

What do I mean by the former term, food practices? The term comes from sociology, where food studies is a sub-discipline all of its own (and the writing team from our 'Offering food – receiving food' project presented a symposium at the British Sociological Association Food Studies Group biennial conference in 2017). We all have practices around food. And so intensely affect-loaded and life-essential is the consuming of foodstuffs, that practices very quickly form and become habitual.

Consider this material excerpted (with permission of both mother and baby (who is now in her twenties)) from my contemporaneous notes of the first half-year of the two-year, once-weekly infant observation which I undertook for my training as a group psychotherapist in the late 1990s.

*Mum fetches B's bib and puts it on her. She brings in the bowl of baby food and B immediately reaches out for it on the little table of the high chair, tipping it over although*

*it does not spill. Mum makes an 'uh-uh' noise to indicate that B should not do this and places it just out of reach while she fetches a stool for herself. B protests at this, using her new language of sounds, but Mum has now got everything ready and she starts to offer B the baby food on a plastic spoon. B wrinkles up her nose at the first nibble and expels it onto her bib, but readily accepts the second.*

*Mum gently talks to her as she feeds her, wondering if really she does like the food or whether she finds it as unappealing as Mum does and is thinking to herself why Mummy is dishing out such unpalatable fare. B does seem to be unsure whether she likes the food, but she is definitely in to the process of eating it, eagerly reaching out for the spoon as it approaches her lips and gazing intently at her mother.*

*After a while Mum can no longer bear to continue with this particular food and opens up a can of cherry flavoured something which goes down much better. After the first mouthful of this it is clear that B likes it better, and she becomes eager, almost impatient for the next mouthful and happily voicing her approval. Mum wonders if she would like some water and she comes back with a cup, having been unable to find the beaker. B again reaches for the bowl and Mum again makes the 'uh-uh' noise to signify she will not allow B to do this. She offers the cup gently to her lips. B takes a gulp of the water, reaching for the cup with both hands.*

*At the second offering B becomes distressed and gives out a wail, because in her eagerness to drink she tries to do it over the handle, which doesn't work for her and she can't get at the liquid. Mum calmly says that there is no need for her to become flustered and presents the cup so that she can drink and then mother and baby sit there together, both with their hands around the cup, as B slurps her way through the drink. B is very focused on her and also looks over at me from time to time over the rim of the cup.*

I want to let this material speak for itself to the reader (I have used it in teaching a number of times now and everyone sees different things in the scenes described). I hope that it gives context for and some illustration of my broad opening proposition that our food practices emerge developmentally with our very early attachments and social interactions and that a complex range of influences go into their formation, including the possibility of genetic inheritance but also, more simply and observably, the food practices and patterns of affect regulation in our familial, systemic, societal and cultural heritages (see Appendix, Figure 1).

#### **4. Food practices, adversity and eating distress**

Here is another scene of a 'family meal', equally replete with examples of food practices both established and emergent, but an experience perhaps of a very different kind to the one co-produced by the feeding pair in the infant observation (different, but note the resonances – in both stories there is a feeding pair, and an audience that is witness to the transaction; there is someone (in both these cases, as it happens, the figure of mother) in the would-be offerer role, and whose own food practices are strongly bound up in the offer; in both stories there are threads and flashes of disgust).

*We've finished our cheese on toast and Mum brings out the pudding. It's light brown and speckled and, however lightly you breathe, you can't get away from the stink. ...*

*'What's that?' says Fran.*

*'Prune fool,' says Mum. 'Come on, try a bit.'*

*I feel like my talking doll. Someone's pulling the string in my back and it's the pause before one of the recorded phrases comes out. Thank you Mummy. It looks nice. Please may I leave the table. But nothing comes out. Only silence. I take a tiny mouthful and my tummy jumps in, sending a sick taste up into my mouth.*

*I swallow the sick back down. Mum's watching me and all of a sudden her face looks like the woman on the front of Dad's Picasso book. She's very still and tears are falling down her cheeks in slow motion. Tears are running down my face too. She takes my bowl, and standing with her back to me she slowly eats the rest of my fool. I keep still, so still, not knowing what to do.*

*Dan stares ahead frowning. He pushes his bowl away a fraction of an inch.*

*'But it's yucky,' says Fran, pulling a face.*

*'Oh, for goodness sake. Get out, all of you,' says Mum. 'Be unhealthy, see if I care.'*  
(Nott, 2017, pp.107–108)

We none of us can help but have food practices, around which habit and pattern form and expand in ever-increasing circles. How we source, store, prepare, consume, metabolise and discard our foodstuffs – in all such matters, individually as well as in groups, families, communities and societies, we have our food practices, they are distinctive and personal blends of countless influential other practices, but only in certain circumstances are these going to become connected to experiences of eating distress and only in certain further and consequential circumstances will such distress also be caught up in and become entrenched within the habit and pattern of these practices.

Whereas the infant observation material sits at the nexus of an infinity of possible futures and is predictive of no one of these futures over another, Nott's fictionalised autobiographical writing brings us to a pivotal moment, which may be captured in the question: what happens to emergent food practices when adversity is encountered?

Now, it must at once be allowed that, whether in the geneticist or the sociological (or even the psychiatric) narratives, adversity may begin in the womb and innate vulnerabilities or phenomena associated with the transgenerational transmission of trauma

entail that food practices emerge out of a preconditional adversity. I do not favour quite so deterministic a meta-narrative myself; however, my hypothesis aims at inclusivity, for (social) exclusion is the ailment which precisely it is aimed at, so I will say here that adversity is always located in more than one nodal point. To say that it did not pre-exist and then suddenly it presented itself is always a schematised and stylised way of seeing things. Without further preamble, though, let us hear from two further voices of lived experience.

*I think I probably lost my ability to control my eating from an early age. I have always had a feeling of panic and desperation when I am hungry, as if I am afraid I am going to starve, which may be the result of the advice to mothers of the 1940s and 1950s to leave their babies to cry if it wasn't time for the four hourly feed.*

*I think poverty was another cause of my eating problems. My father had a low paid job and his wages never seemed to last the whole week. By mid-week there wasn't much to eat, so when pay day came, my sister and I would binge on fish and chips, sweets and fruit. Eating was comforting, pleasurable, an attempt to make up for everything I didn't have. The worse things became for me out in the world, the more I ate for comfort, or to tranquillise myself, and the more I ate, the more the other children called me Fatty and the more freakish and rejected I felt. It was a vicious circle that took me over thirty years to begin to break.*

*...on bad days I still feel like the pits, the bottom of the heap, the one everyone else looks down on from their security as part of a group.*  
(Jan, 1992, p.20)

*At the age of 12 I became the victim of multiple perpetrator rape and spent the next ten years making use of my spiritual framework and ascetic ideals to try to make sense of my traumatic experience. I entered the mental health system at the age of 17 after a voice instructed me to attempt suicide. ...*

*The belief that my body was a shell, a mere vessel, enabled me to give meaning to my experience of sexual violence and focus on maintaining the unblemished innocence and purity of consciousness that was me, dissociated from the shell. (Timoclea, 2017, pp.94–96)*

Adversity, then, would seem to mean psychosocial adversity, and it floods or percolates into people's lives under many different flags, from the debilitating consequences of poverty and social exclusion to moments of unimaginable traumatic intrusion and violation. For purposes of this line of argument, it is important to note that adversity does not necessarily impact upon food practices. When it does, then, if enough protective factors are in place – and here I do NOT mean 'resilience' – if the individual has a strong enough sense of themselves, their qualities and values and resources – and if this is marked and validated by attachment figures who are able to bear witness to adversity and not turn away from, deny or replicate it – if resistance can be sufficiently mobilised – then it may still be that, whatever other harm ensues, food practices survive and continue to develop (see Appendix, Figure 1).

This is not to dismiss other 'harms' as less harmful – not by any means – but this article is looking at food practices and eating distress, not at trauma theory in the more general sense. And it is eating distress that follows on from the meeting point of food practices and adversity, if protective function in the system around the individual is for whatever reason insufficient.

In order to understand the usage of the term 'eating distress' more clearly, let's hear again from 'Fran':

*'What's that stuff?' says Fran. After several weeks of usual food, Mum's spooning something green and slimy into our bowls at dinner time.*

*'It's stinging nettle soup,' says Mum. Fran's mouth is a big letter O. 'Don't worry.*

*The cooking takes the sting out.' I don't believe her. 'You need to try it. Only a mouthful. It's full of minerals.'*

*I pick up the bowl in both hands, hold it high in the air and throw it with all my might. It smashes down onto the black and white lino squares. The bowl breaks and the soup oozes out over the floor. Some splashes up the wall and runs down the pine panelling like pale green tears.*

*Except I don't. I couldn't. The feeling got stuck. It came roaring up from my tummy, through my chest and into my arms and here it is, trapped. My arms are as still as stone. The feeling's fizzing between my shoulders and elbows, between the skin and the bone. No thinking, no words, no running out. Just the tiny pin pricks, buzzing in my arms. From high up in the corner where two walls meet the ceiling, I watch the me below. (Nott, 2017, pp.108–109)*

All the testimonies adduced in evidence in this article have to do with eating distress. Here I shall limit myself to the comment that an emergent phenomenology of eating distress (considering the distress discretely, without reaching yet too far into the question as to what practices and survival strategies may then emerge) would seem possible to map under four broad headings (but this list is not intended to be exclusive, as though some other form of distress would not 'count').

These headings are (broadly) *arousal* (agitation, anxiety, panic, terror, dread, rage); *melancholy* (for my extensive joint exploration of this theme with an anonymous group of experts by experience, see Adlam, 2015); *withdrawal* and *dissociation*. These last two do of course start to shade into explicit survival strategies in themselves, as Nott (2017) so vividly and starkly evokes; and the first two can implicitly also be understood in such terms.

As was noted in relation to the schematised 'advent of adversity', so too with the

emergence of eating distress, it is important to eschew determinism and to say that food practices could yet come back into their previous trajectory of development and creativity, if enough resources can be mobilised both internally and within familial systems and other networks; but the direction of travel, so to speak, from emergent food practices encountering adversity and eating distress manifesting itself, represents a gathering momentum, with ominous future consequences, and will otherwise propel the individual sufferer into (and here I introduce some carefully constructed language) *emergent practices of starving and experiences of malnutrition* (see Appendix, Figure 1).

### **5. Practices of starving and experiences of malnutrition**

What becomes of language if we imagine abandoning the whole idea of 'eating disorder'? One thing that I think can be readily perceived is that inpatient 'eating disorder' units, and by extension the whole pathway that they sit at the end of, exist in the context of carer and system anxiety (sometimes, but not always, patient anxiety) about malnutrition and starvation and their physical consequences but also the ways of being that lead to this bodily states. Low potassium; low sodium; low body mass index; low haemoglobin; postural drop; osteoporosis and many besides – these are symptoms, properly understood, of malnutrition or starvation and related food practices. We don't need the framework of 'eating disorder' to start to think about these practices – we could listen to those who are and/or have been caught up in them. Here are two testimonies – they speak for their selves...

*In some ways, and I speak for myself here, in a paradoxical way, starving myself was the only thing that was keeping me alive – my search for my Self, even though I nearly destroyed myself in the quest. Much of that search was a looking within, trying to locate an identity for myself, something that was*

*particular to me only, a woman within society, but equally one with her own standing.*

*There was a great fear that if I gave up my struggles I would be sucked into the collective, I would be forced to conform to the **norm** of womanhood. Like the two faces of Eve, I would be forced to play both femme fatale and the housewife and child rearer – all smiles and sweetness, never expressing any of my feelings of anger, desperation or fully realising my power. If I became sucked into that, for me it would be synonymous with death, indeed it would be death of the self, and of my spirit. I would have failed my higher self, the part who knew there was more to life than role-play; and such a thought was almost more terrifying than starving. (Rosalind, 1992, p.16)*

*My thought processes became very unrealistic. I felt I had to do something I didn't want to do for a higher purpose. That took over my life ... I created a new image for myself and disciplined myself to a new way of life. My body became the visual symbol of pure ascetic and aesthetics, of being sort of untouchable in terms of criticism. Everything became very intense ... Being hungry has the same effect as a drug, and you feel outside your body. You are truly beside yourself – and then you are in a different state of consciousness ... That's what I did with hunger. I knew it was there ... but at that time I did not feel pain. ('Gertrude' from Bruch, 1978, pp.17–18)*

### **6. Rigidity and chaos**

To recap: food practices emerging out of all the complexity of social life and human development have met with adversity and eating distress has emerged and evolved into practices of starving and experiences of malnutrition. At this stage in our timeline a number of feedback loops start to further complicate matters for the individual in pursuit of what by now are safety or survival practices laden with intense affect. The first feedback loop, or 'double arrow' in Figure 1 (see Appendix, is that these emergent practices of starvation and experiences of malnu-

trition do not eliminate eating distress (or only do so transiently); they tend rather to complicate and add to the tension needing somehow to be held and to reinforce the eating distress (remember the list roughly stated above – arousal, melancholy, withdrawal, dissociation).

*I started dieting in a bid to lose weight. It began as healthy eating but it became an obsession: my sole focus was restricting and losing weight. ... I lost around 8.5 stone in 10 months as I reached a low healthy weight for myself through restricting more and more. However, the bingeing returned as my body was starved of nutrients and needed food. I understand that in hindsight but I couldn't see it at the time; I was terrified of gaining weight so I began to vomit. The more I binged and vomited, the more I felt I needed to binge and vomit, both physically and psychologically. When I was in this mode I binged and vomited constantly and then I could stop for a few days where I would restrict myself to 500–800 calories a day. In my mind when I binged I was being bad and when I starved myself I was being good. Bingeing was loss of control, and vomiting and starving were my furious attempt to fix past mistakes. My life revolved around my eating disorder. I rarely slept; I had damage to my car that I couldn't account for as I had lost consciousness while driving. I also struggled to maintain friendships. I recall going to the cinema with friends and leaving during the film because I had eaten something I considered bad and felt I had to go and vomit. (Goodall, 2017, p.40)*

As Goodall's testimony suggests, there are in broad essence only two directions in which to turn in pursuit of resolution of the mutually reinforcing and amplifying feedback loop between eating distress and practices of starving.

One set of moves takes the individual towards positions of greater rigidity, in pursuit of experiences of control or mastery over often very narrowly defined areas of human existence that may (have) become

all-important. Another set of moves (and it's evidently not either/or) takes the individual towards chaos ('dysregulation' in some other languages – 'multi-impulsivity' in one particular system-of-care dialect, no longer much spoken). Chaos and control – perhaps the oscillation between these two territories is the essence of the human condition. When food practices get caught up in this oscillation (or tilt definitively one way or the other), it can then be as if the whole system gets caught up in the resonant frequency. Whatever may have been the original or originating anxieties, the anxiety about whether one has just made the right move in the right direction now comes to the fore.

## **7. Agonies of deliberation; habit and pattern; safety practices and terrifying interventions**

*It is as if you create a robot and then you can't control what it is thinking. After a certain point, I really felt full. And then you get tormented by this awful guilt feeling after you have eaten any food. I became tense and unhappy, all joy and spontaneity had gone out of my life. I felt as though a slavedriver were whipping me from one activity to the other. ('Helga', from Bruch, 1978, pp.19–20)*

*...I could not eat the food that they ate. It was too much: too oily; too rich; too sweet... too unknown. Too early; too late; too expensive; I really just fancied a drink. I was like Goldilocks but everything was wrong. Plates cleared, I seized my moment, came in from the cold where I'd stood looking in – waiting, watchful – persona non grata while the others took their fill. Taking up my place with a flurry of distracting greetings, I batted away the reasons I hadn't 'made it' for the meal. Traffic. Work. Family. (There are two Ryvita in my bag and I can't stop thinking about them.) These people might linger for hours yet, replete with the glow of companionship, the bonhomie from sharing that extra pudding ('Diet starts tomorrow!') while I sit here and*

*starve. I could not eat their food, had to stand outside waiting for them to finish – and now they insist on my presence here: these people are cruel. I am being denied access to those plain, dry crackers which I'd packed in a plastic bag to eat furtively, in a far corner of the tube station, or dark street corner – wherever I might hide my squirrel-like nibbling and finally experience the long-delayed relief of the longed-for food ... I need to leave. Work. Traffic. Family. (Ryvita in my bag, and more in the packet at home). (Beth, 2017, p.24)*

Here is where the developmental line which I have been mapping, through these various testimonies, reaches its own precariously self-sustaining conclusion. It is not that there is no way out, although I think that this is why the mortality rate is so high. But because the agonies of deliberation, second-guessing and self-reproach further intensify the oscillation between rigidity and chaos and accentuate the eating distress, the terrified subject becomes entrenched in the reflexes, the habit and pattern of his or her safety practices. Here is where the nonsense of 'you could just snap out of it and eat something' – the neo-liberal 'on your bike' of the system's frustration with the individual who declines to be a 'happy consumer' – is made painfully stark. Here there are very few choices, in the sense of a psychic 'fork in the road', where one can consider the pros and cons of taking either path and come to a decision one can sit with. In this self state or way of being, the neural pathways light up each time the shortest path from terror to safety practice.

Now, I know it's easy enough to critique existing systems of care and tough to reinvent new ones – but here, sadly, is where the system of care, in all kinds of ways, makes the opposite moves to those that might be indicated. Here is where a range of ever more powerful and potentially intrusive medico-legal technologies are deployed – from Community Treatment Orders to Mental Health Act detention, from enforced bed rest and nursing observations through

to naso-gastric tube feeding under restraint to PEG (Percutaneous Endoscopic Gastrostomy) feeding. Here is where the Mental Capacity Act will be restrictively invoked to exclude the possibility of building care planning around the patient's own experience, just in case anyone is tempted to be so audacious as to suggest this. All of this, let's remember, in arguable violation of the obligations of States Parties to the United Nation Convention on the Rights of Persons with Disabilities.

Here also is where, instead of structure and flexibility, treatment models and systems veer off into their own oscillations between chaos and rigidity (see Appendix, Figure 1). Here is where the system in its own version of panic, fires bewildering interventions *at* the patient's 'symptoms' instead of working through *with* the patient's distress. Here, where choice and agency has existentially collapsed, is where hostile attributions of intent into the patient are intensified: 'it's behavioural' (whatever on earth that is supposed to mean); 'she's doing it deliberately'; 'he's splitting the team' – and so on. Here, when asylum and respite might be supposed to be just the thing, is where 'hostile environment' practices are consciously implemented on inpatient units to deter the 'complex patient' from getting too 'comfortable' or 'dependent'. Here, lastly, in the moment when terror has become the patient's universe, is when we somehow find ourselves least likely to understand terror as the key factor driving safety practices.

It's easy to critique and so it is worth also recognising that it's not easy to do this work. No work of engagement with extreme distress and suffering is easy. This the 'patients' also know – 'they' can be more patient with 'us', then sometimes 'we' are with 'them':

*How can you keep offering, in the face of such hollow-eyed and relentless refusal of all the good that you would seek to instil? How do you not, sometimes, feel the rejection of the food to be a symbolic refusal of your best attempts*

*to care, support, deliver what you were able... or not occasionally feel irritation with the person who hurls the meal you've meticulously measured out (at the optimum temperature, as per individual preferences, in the 'right' cup, without a single speck of 'dirt' – and just one, clean tissue – because you know the details matter) to the floor, all because you forgot to use the agreed wording when you handed it over...? (Beth, 2017, pp.27–28)*

## 7. Conclusion

*Coercion in psychiatry perpetuates power imbalances in care relationships, causes mistrust, exacerbates stigma and discrimination and has made many turn away, fearful of seeking help within mainstream mental health services ... Immediate action is required to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement ... States must not permit substitute decision-makers to provide consent on behalf of persons with disabilities on decisions that concern their physical or mental integrity; instead, support should be provided at all times for them to make decisions, including in emergency and crisis situations ... There is shared agreement about the unacceptably high prevalence of human rights violations within mental health settings and that change is necessary. Instead of using legal or ethical arguments to justify the status quo, concerted efforts are needed to abandon it. Failure to take immediate measures towards such a change is no longer acceptable. (UN Special Rapporteur, 2017, p.15)*

I am sure that as we have gone along, there have been many mutterings or exclamations of 'yes, but...' or 'hang on a second...' ringing out. As I write, and indeed each time that I try to work through this line of thought, I catch myself doing the same thing. Have we really got it so wrong? Do these things really happen? Surely sometimes the end justifies the means? And so on. I recognise the force of these objections, just as does the Special Rapporteur – and I quote again, just above,

from his report, by way of conclusion, just so we're clear that I'm not just off on one on my own and that the system of care would right now be facing a real and immediate challenge to its very foundations – if only it would face it!

I also trust that the testimonies I have brought together here may successfully and perhaps even powerfully anticipate the criticism that I have nothing to propose in place of what presently happens and how things are presently understood. We could very easily, in fact, obey the first instruction of the Special Rapporteur, and abandon all talk of 'mental disorders' – in this or any other field. We could discard the arcane and pathologising language of 'eating disorder' – who would mourn it? – and we could start to think in terms of food practices and eating distress – and to see how thinking like this might change our thinking more deeply. We could be much, much better at asking the patients what happened to them, what's going on for them, what the matter is and what might help. We could abstain from dismissing their responses as evidence of 'incapacity' and we could get a whole lot better at what the law already says we should be doing, which is to say, supporting the patient in his or her decision-making and not deciding for them.

In my previous piece for this *Review*, I noted that the Special Rapporteur observes that we lack the clinical tools to try non-coercive options. I asked there, and I ask again: 'What if the increasing power and potency and even sophistication of our medico-legal technologies ... has deskilled us in some simpler forms of intervention? Suppose our coercive muscles are so well developed, that our engagement skills have become rather flaccid and feeble with disuse?' (Adlam (2019), p.8). We could use the outline I have sketched here as the foundation of a new evidence base, located in a different set of values about what constitutes 'acceptable evidence' (and thus in the process break the stranglehold which Big Pharma and the old medical guilds still exert

upon our own capacity to think our own thoughts). We could then avoid the hidden pitfalls of the bewildering intervention, because we wouldn't be having to translate (or choosing to abstain from translating) our

own thoughts into 'a language patients can understand' – we'd be speaking in kindred tongues, from a practice of respectful equality and a cherishing of our shared humanity.

**Appendix: Eating distress –  
A phenomenological description**

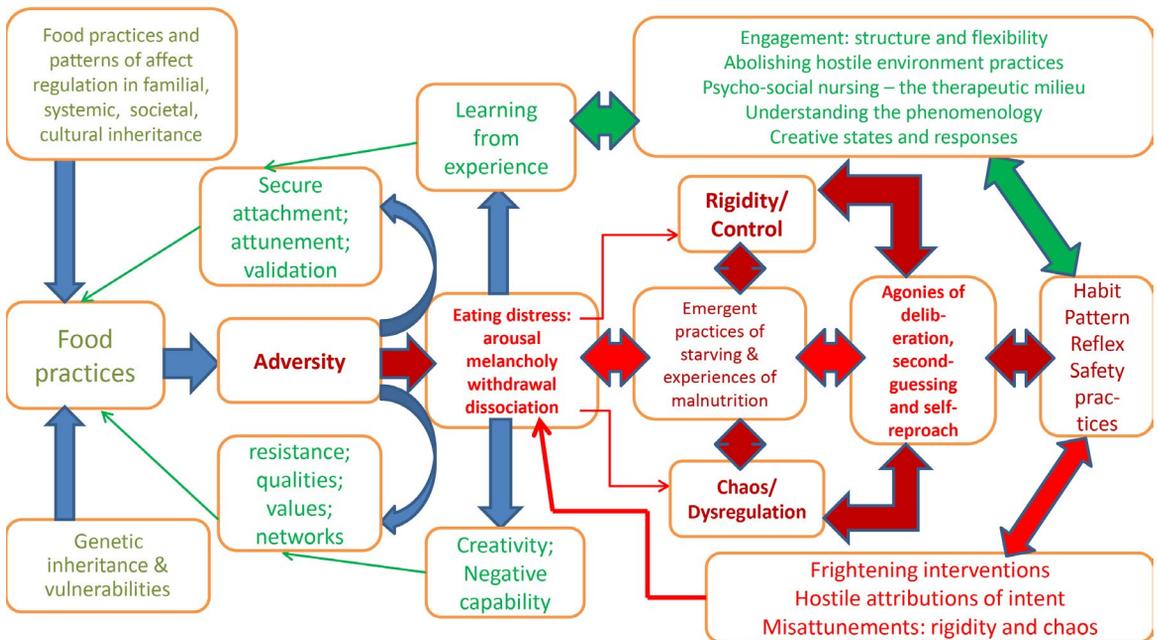
I have attempted to render the developmental trajectory of eating distress in diagrammatic form below (Figure One). The central line begins with food practices and moves through to the force of habit, pattern, reflex and safety practices. Red elements indicate threat; green elements signify protective or ameliorative factors;

'core' elements are represented in blue.

Correspondence on this or any other aspect of this paper is very welcome via [john.adlam1@btinternet.com](mailto:john.adlam1@btinternet.com).

**John Adlam**

Figure 1



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# The client's experience of coercive treatment

Joy Goodall-Leonard

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*This article is a response to John Adlam's Food Practices, eating distress and the perils of bewildering interventions in "eating disorders" treatment settings'. This response was first presented in the form of a talk at the BPS Psychotherapy Section Conference on 26 October 2018. I am writing in the capacity of a survivor researcher, an expert through lived experience. In the spirit of disclosure I must acknowledge that I also work within the mental health system, in the role of a mental health support worker, and while I endeavor to use my experience to inform my practice, there are times when these dual identities can come into conflict with each other.*

**O**VER THE course of my life I have received a number of differing diagnoses. The first came at aged 13 when I was diagnosed with PTSD, at 16 came the label of depression. By 22 I was told I suffered from Bulimia (multi impulsive) which then became reclassified as EDNOS when I didn't fit neatly enough into the diagnostic criteria and finally the stigmatising diagnosis of borderline personality disorder followed at 23. In 2006 after years of struggling with my mental health as a result of trauma I experienced at a young age, and falling between the cracks after being discharged from CAMHS at 18, the deterioration in my mental health came to be severe enough to warrant the attention of Adult Mental Health services, who admitted me to an acute admissions ward for assessment. Within a few days of my admission to the ward it was decided that my primary problem was that I had an 'eating disorder' which required treatment. I was considered unsuitable (too sick) for outpatient 'eating disorder treatment and with no inpatient or day patient options in Northern Ireland, they sent me to London for treatment.

My experience with treatment was coercive from the beginning. This is not something I realised at the time because I was so desperate for help. My first engagement with treatment before I was sent to London was an acute admissions ward. When my weight continued to drop while an inpatient,

treatment in London and the possibility of me losing the opportunity to receive this treatment was used as a way to control my behaviour. I was told that if I didn't stop losing weight, I wouldn't get the help that I so desperately wanted.

When I arrived for treatment in London, I was presented with a standardised treatment plan (keep in mind that this is my interpretation of the treatment plan) –

- Stop all 'eating disorder behaviours'.
- Eat and Drink what we have prescribed you.
- Pass our admissions test – basically make the right noises about treatment, follow the rules or you will lose your opportunity of treatment.
- Go to the groups and therapies we have prescribed.
- Follow all ward rules – how you eat your food, what condiments you can use and rules on when you can use the bathroom.
- There were also some accepted rules that you picked up pretty quickly. For example, we will allow you a couple of f\*\*k ups but any more than that and you're out. Time out was used as a punishment for these indiscretions.
- If you don't follow these rules then we can't help you, we will have to let you go back to where you were.

Not once was the question put to me; What is the matter? What might help. Yes, I was in treatment voluntarily but that fails to recog-

nise the huge power imbalance which exists. To receive treatment, I was expected to hand over all responsibility for my most basic needs to a stranger. I was given an outline of the treatment plan and the ward rules which I had to agree to, or I would not receive treatment, I was desperate for help, I would have agreed to anything. I was expected to accept the treatment offered without question and I would argue that this is not informed consent. One might say that it was in my best interests but was it? The threat of how terrible things would be if I did not agree and conform to the treatment offered was often used as a tool to facilitate compliance. I feel that my diagnosis of mental illness, in this case 'eating disorder' was used as a licence to use coercive and restrictive practices. In fact, many of the restrictive practices used were employed because it was easier to apply them to the group. However, restrictive practices should not be enacted because it is more convenient to staff or applied to a group as a whole because it is easier, the focus should be person centred care.

Examples of Coercion and restrictive practice I experienced:

- Being coerced to things I was not prescribed because the nurse believed my diet plan was different. This was the result of a culture of the nurse is always right and the patient is being deceptive because of their 'eating disorder'.
- Being accused of eating outside of my meal plan when I wasn't and being told that I must have blanked it out because it was too distressing for me to remember. This made me feel like I was losing my mind and that I could not trust my own memory. This is 'Gaslighting' and again was a result of the belief that the nurse was always right.
- I was subject to strict rules, many of them restrictive practices that were applied to all.
- Assumptions were made about why I presented with an eating disorder without proper consultation with myself. The patient should be considered an active participant in their own treatment.

Many of these may seem minor taken in isolation, but it created an overall unhealthy culture of fear and mistrust. It gave me the impression that I was imprisoned with no control over my life, when I should have been in a supportive environment to help me regain healthy control over my life. I struggled at various points during my treatment with 'eating disorder' practices but felt unable to confide in any of my care providers because of fear that I would be got rid of because of my indiscretions. I suffered in silence and was made to believe that their treatment was my only option.

### **What changed?**

I completed my treatment programme and returned to the outpatient's service in Northern Ireland. I was supposed to go to a follow-on support group facilitated by liaison nurse from the treatment team in London but was denied entry to it because I wasn't 'behaviour' free. I was told if I didn't cease my 'behaviours' they would have to let me go back to the way I had been prior to treatment; they wouldn't help me. Fortunately, I had encountered a kind and compassionate consultant in the outpatient team who offered to take me on as a patient and assured me that they would support me even if I was still struggling with 'eating disorder' practices. This was probably the first time in my treatment that I was given a choice. Having this choice gave me the strength to tell the treatment team in London that I no longer wanted their involvement in my care. It wasn't a straight road to recovery, but I did recover.

In John Adlam's article he suggests asking the question that is often not asked what the matter is and what might help to those experiencing eating distress. I have answered these questions below with the benefit of hindsight of one in recovery.

### **What was the matter?**

- I have used disordered food practices from childhood as a way of coping with the deep unhappiness I've felt from

a young age. Food was a way to cope with the trauma of my family and the sexual assault I experienced at age 13.

- I came from a dysfunctional family environment in which my mother used bingeing as a way to self-medicate to cope with her own trauma. My mum controlled the food the whole family ate. She passed these practices on to her daughters. When I tried to be assertive and take control back my mum refused to support my wish to eat healthier and continued to provide only unhealthy food. I see this as a form of coercive control.
- I lost a large amount of weight between the age of 21 and 22 in a bid to take back control but I only switched the method in which I used food to help me cope with my unhappiness and feelings of powerlessness.
- Restriction was an attempt to have control. Bingeing represented the loss of control and vomiting was the furious attempts to fix past mistakes and regain control – damage limitation.
- Food is an addiction for me, used like a drug to temporarily provide relief from emotional distress.

### What helped?

- Being accepted at where I was in my recovery journey. Knowing that someone had my back and that they wouldn't give up on me even when I sometimes did.
- Not having treatment and the threat of its removal as a tool to coerce compliance.
- Person centred care – a treatment plan individual to my needs.
- When I was ready – Group psychotherapy.
- Photography – Through my degree in media studies with photography. I used my photography projects as an opportunity to explore my relationship with my body, my fear of my own femininity and my desire to erase any sign of my sexuality from my body.
- NEXUS – specific counselling in relation to the sexual assault I experienced.

It was always the elephant in the room throughout all treatment I received because I was afraid to talk about it or when I was being coerced to talk about it when I wasn't ready.

Of course, it is hard to speculate how one's recovery may have been different had the approach taken by professionals been the one Adlam suggests. However, I do believe that had I been asked what the matter was and what might help from the outset, my experience of treatment may have been more positive and beneficial. I imagine my answers may not have been as articulate at the time, but just asking me those questions may have helped me think beyond the 'eating disorder' practices I was using and be curious as to why I was using them. I believe that the people involved in my care were doing what they thought would help me recover. I too have been in the position where I have found myself guilty of feeling paternalistic need to swoop in and save someone from their psychological distress without asking them what the matter is and what might help, but I still believe they are important questions to ask.

### Joy Goodall-Leonard

#### Note:

John Adlam elsewhere refers to the important conclusions of a report by the UN Human Rights Council. The future Issue on Improvement in Psychotherapy and Avoiding Harm, will refer to this.

In 2017 the UN Human Rights Council published the 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (UN, 2017). The secretariat prefaces the report by observing the Rapporteur's call 'for a shift in the paradigm, based on the recurrence of human rights violations in mental health settings, all too often affecting persons with intellectual, cognitive and psychosocial disabilities' (UN 2017, p.1).

Another article title by John Adlam The story of Janeway and Seven of Nine: coercive psychiatry and human rights in 'eating disorders' inpatient units. This article is based upon and adapted from a blog which I published on 18/2/18 under the handle

'Barrelman'. The original blog can be found at <https://barrelblog.org/2018/02/18/janeways-dilemma-coercive-treatment-and-human-rights-in-eating-disorders-inpatient-units/>

# How did I get here? A narrative exploration of arriving at talking therapy in a neuro-rehabilitation setting, co-written by a young adult patient and her therapist

Jess Walling & Helen Molden

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*Aims:* This narrative case study explores some of the themes and process behind the referral process in a neuro-rehabilitation multidisciplinary team (MDT) outpatient setting. It aims to give a central focus to the patient experience, in this case, Jess, one of the co-authors, who at 19, experienced a life-changing spinal injury causing paralysis and pain in January 2017 while she was in her first year at university. Jess is doing well with her recovery, back at work part-time, and started back at university in September 2019. *Methodology:* The data was gathered through two interviews held to reflect specifically on what life was like in the run up to coming to talking therapy services as an outpatient and the impact of that first session. The interviews were facilitated by, Helen the other co-author, a counselling psychologist and integrative psychotherapist, and the participants were Jess, and her referring physiotherapist and occupational therapist. The data was then analysed thematically by Jess and Helen.

*Findings & Discussion:* Five themes were identified: 1) The point when ... I knew that I needed a bit of extra help, even though I didn't really want to... 2) How this 'different kind of conversation' might fit in with the rest of rehabilitation, 3) Could this be the right time 'to open the box ...?' 4) The moment when it felt like talking therapy might be OK and 5) How starting talking therapy began to change things. Jess's experience and reflections provide a client-centred view as to the added value psychotherapy can bring within a physical healthcare MDT setting. The findings also support existing evidence that it is less the therapeutic approach or modality that is paramount, but the fit of the therapeutic relationship that counts (Norcross, 2002; Cook et al., 2017). The authors offer this piece of work for wider discussion within the context of practice-based research, promoting the voice of the client experience within talking therapy discourse. It also fits with the wider objectives of embedding co-production with the BPS Experts by Experience initiative. The authors present a summary with reflections and learning points in the conclusion.

## Introduction

THIS IS a co-written narrative exploration by Jess, a young woman (20) who loves Nandos fries and *Love Island*, and Helen (43) a counselling psychologist and integrative psychotherapist with a passion for supporting people towards better integrated healthcare and getting outdoors whatever the weather (and also loves a good Nandos). They worked together with fortnightly psychotherapy sessions for just over a year starting in June 2017, while Jess has been making progress in her recovery from a life-changing neurological injury in

January 2017. Jess explains what happened that year:

*'Whilst on the way to university for the start of my second term there, in January 2017, I was overcome with a burning sensation that started in my neck and quickly spread to my left hand. My boyfriend of the time told me to pull over in the nearby road which is when the burning started to spread around my body. When we eventually got to our uni flat the burning pins and needles sensations made me sick and I ultimately collapsed. I was taken*

*into hospital with a suspected migraine. How wrong they were.*

*I went into what felt like thousands of machines and blood tests; doctors came to examine me, all confused by why I was so ill. Initially they told me I had a spinal stroke at C2 level, which meant everything from my neck down was paralysed and they didn't expect anything to recover. Me being stubborn, I refused to accept this news and soon after I proved doctors wrong leading them to conduct more studies. Eventually, I was diagnosed with idiopathic longitudinal extensive transverse myelitis, an autoimmune disorder that causes the white blood cells to attack the spinal chord. I was placed on high dose steroids and went through five rounds of plasma exchange to clean my blood.*

*After two months in a busy hospital environment, I was transferred to a spinal unit where I continued to recover and gain movement. Hospital for me was a complete mixture of emotional turmoil, due to medication, being away from my family and being surrounded by people that were in a similar situation to me. I struggled mentally to come to terms with what had just happened. In the acute hospital environment that I look back on now with fond memories, my family were with me constantly, my nurses became my friends due to being so young and chatty, and I genuinely had the best stay. I'm not saying that there weren't times where I cried myself to sleep, I screamed and also felt extremely vulnerable but the staff were honestly the most professional best friends I could have ever wished for.*

*The spinal unit was completely different; I felt*

*scared, alone and, quite honestly was the hardest part of my journey so far. It was such a different environment to my previous hospital that I struggled to recover my mental state all while my body was improving. Eventually, I came to outpatient care, with me back at home, balancing the demands of physiotherapy, occupational therapy, medical appointments, everyday life and then psychology ...'*

One of the aims of this collaborative piece is to explore some of the aspects that played a part in establishing a good working alliance (as defined by Clarkson 1995, and later added to by Murphy and Gilbert's model, 2000), specifically in the first and second stages; 1) whether it's possible to work together, the first meeting and assessment and 2) building trust through the working alliance.

The title of this piece was inspired by an in vivo quote from Jess' assessment session, and illustrates something of the psychogeography of the client arriving at the beginning of talking therapy in recovery from a serious illness.<sup>1</sup> During her recovery, Jess has been keen to take part in research where her voice and experience can be recognised within the field of neuro-rehabilitation and beyond. She has frequently taken part in neuro-physiotherapy demonstrations, and continuing professional development sessions for practitioners in the neuro-rehabilitation field.

This article is part of that process, with the aim of looking at some of the explicit and implicit co-constructed processes on coming to psychological support from the patient's perspective (something we believe is under-represented in the

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<sup>1</sup> Helen considers this to be reminiscent of Sontag's (1978) seminal quotation at the beginning of her book *Illness as Metaphor*, an exploration of the socially constructed nature of illness: 'illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.' Arriving as a 'citizen of that other place' happens both suddenly in its acute form as described above, and episodically, over the course of loss, adaptation and recovery, as Jess' experience will testify.

literature<sup>2</sup>). As part of preparing for this article, we had a discussion outside of the therapy room, based on what the experience of arriving at therapy was like, and involved Jess's physiotherapist and occupational therapist also in that discussion. Our approach to our subject is based on narrative theory, applied with a postmodern paradigm (Bruner 1990; Griffith & Griffith 1994). Within this epistemological framework, personal experience and reality are viewed as constructions created through the process of telling stories, to our own self or others. Reality is not fixed but rather co-constructed. Sense making, or meaning, is negotiated within the social context.

As Weingarten and Weingarten-Worthen (1991, 1997) have highlighted in their work on understanding the experience of illness, from this perspective, the self continually creates itself through narratives that include other people who are reciprocally woven into these narratives. The meaning-making aspect of this piece of work has been in the creation of a narrative of self in relation to Jess' illness and our joint understanding of that at the recovery stage represented in this article. What follows are some of the themes and reflections that arose during our interviews:

**The point when... I knew that I needed a bit of extra help, even though I didn't really want to...**

Jess had been attending treatment at the outpatient neuro-rehabilitation facility for about two months when she realised that 'I had got into a really horribly dark place'. Working several times a week with her physiotherapist (PT) and occupational therapist (OT), she had been making progress and was still well engaged in her therapeutic goals, but both therapists noticed independently that Jess was increasingly less chatty, although 'usually a bubbly person'. As Jess

describes it, 'I felt really like shut off from everything, and like, really like just down constantly, and I'd go home and I'd be crying all the time, and a lot of the time my mum had to like... try and calm me down and I think it started getting to a point where everyone was just arguing at home because of me being really really upset all the time.' This underlines the fact that recovery from a serious neurological health condition impacts not just the young person but changes the relationships for that person systemically, across family, friends and their wider support system. Exploring the changes across those relationships forms a key part of the work, so in Jess' case that meant university, and work as well as her close family support, boyfriend and friends.

Recognising that Jess was tearful in much of their recent sessions, her OT raised the possible idea of seeing Helen for a talking therapy assessment, based at the outpatient neuro-rehabilitation centre. Helen's focus as a counselling psychologist and integrative psychotherapist is to work with the patient (and their therapeutic team) to maximise their wellbeing, using evidence-based practice such as Acceptance and Commitment Therapy (ACT) and systemic therapy. In the therapeutic space, she works with patients exploring issues such as adjusting to living with a chronic health condition, changes in family relationships, impact of stress around medical or surgical interventions, loss of confidence and issues around appearance or visible/invisible difference. Helen's theoretical framework has a central focus on attachment theory, trauma and developmental disruption with an existential underpinning, essential when working in the healthcare sector with the key tasks of adaptation, adjusting to loss and reaching an understanding of an evolving embodied identity.

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<sup>2</sup> It has been hard to find similarly collaboratively written articles in the neuro-rehabilitation or even healthcare sector, though it is a growing area within the field of narrative therapy research (Denborough, 2008; Young & Cooper, 2008). The DCP publication *The Child and Family Clinical Psychology Review*, No. 6 Autumn 2018 also focuses on participatory practice with all the articles written in collaboration with children, young people and families engaged in the projects.

One of the challenges for Jess's outpatient team who were keen to involve psychological services, seeing Jess 'as less bubbly and now beginning to voice her difficulties around adjustment to her injury, mainly fatigue management and relationships in the family', was that Jess 'already had preconceptions of psychology.' She had had a strongly negative previous experience which, understandably, made her feel considerably less like reaching out for help now. As Jess says, 'I had a psychologist in a previous in-patient setting, and I didn't get anything out of it because I was so like het up, and it was done in a personal space, in my hospital room, so I felt like I could never escape...'

Although Jess recognised that 'a lot was spilling out into my OT sessions' and that it might be a good idea to seek professional counselling help and not just rely on her PT and OT, she was extremely nervous and resistant about going to see a psychologist, even just for the one-off initial session suggested by her OT. 'I'm really not sure how it's going to go, like I don't know if I'm going to feel comfortable...'

The anxiety that Jess was experiencing at the time of coming to therapy proved a considerable barrier to getting help for how she was feeling, plus the sense of stigma around 'not being able to cope'. With a natural coping style of 'I would always be like, oh I'll be fine, I'll be fine, and I'm very much like that...', Jess reflected that 'it took a lot for me to kind of, be like, oh maybe I actually do need to see someone and try it out...'. Her OT remembers that 'initially Jess really wasn't keen and then after a while, a few weeks later, it got to a point where she sort of said, OK I think I need it now'.

### **How this 'different kind of conversation' might fit in with the rest of rehabilitation ...**

One of the interesting aspects of talking therapy is that it is a rare space in a rehabilitation schedule where there are fewer explicit goals as such. This is in contrast to physiotherapy or occupational therapy

or speech and language therapy where the concentration is around specific goals, e.g. 'I have to work on a muscle group, I have to stretch my arm'. Instead, talking therapy offers a space where it might be possible to hold in mind what Yalom (2008) describes as the 'four ultimate concerns – death, isolation, meaning in life and freedom', all apposite for the patient recovering from a healthcare crisis. By ensuring that these concerns are also attended to as part of the overall treatment process, there is a huge benefit to the the more necessarily agenda-driven aspects of healthcare. This 'different kind of conversation' with its curiosity and focus on process as well as content, within an engaged and safe working therapeutic alliance, can shed light on each stage of rehabilitation, with multiple intra and interpersonal levels of tension, fear, celebration and negotiation.

Jess' OT had allowed a bit more space 'a chatty kind of environment, where I'm doing a lot of work but also, a chance to chat, so we'd chat about how my home life is, how I'm getting on, what I'm progressing in'. It was in OT that Jess first felt able to share some of the anxiety and low mood symptoms that she was experiencing: 'I would get to a point where I would like have a few tears rolling down my face and then, as I got more comfortable, here, I started getting more and more open with my OT about how I was feeling, and things like that.' Other signs were feeling less motivated, more withdrawn from friends and the sense of needing to 'put a mask on' around them, and an intense sense of feeling 'different' – both visibly and inside as a result of all her experiences in the last six months.

One of the major signs that talking to a psychological professional might help was that Jess felt 'like I was...I was making a lot of progress here at the time when I first started seeing you and... on the whole, like I was making loads and loads of progress in rehab but my mind wasn't, so I felt like... like I was making good progress in my body but I was still really really upset and down about it' – making sense of that discon-

nection became an increasingly important theme with her OT and PT and led to the idea that discussing these feelings in more detail might help.

*I was like so close to being on my feet again and I think driving was a new thing I was exploring so like I think the whole stigma around it was...I was getting a lot better myself, in my body, but not in my self.'*

Jess also recalls the beginning of a post she made on social media that feels important to record here as part of reflecting on the decision process of considering talking therapy: 'Today someone asked me how I get through everything that's happened? I smiled and laughed and said that you just have to keep going, when the reality is I'm not, I put on a face for everyone, I say I'm doing really well when in actual fact I'm broken inside...The reality of being paralysed at the age of 19 isn't pretty...'

### **Could this be the right time 'to open the box ...?'**

One of the key themes we talked about when Jess first came was the idea of Jess not wanting to be a 'burden, on my family...if that's the right term for it'. We explored the process of how worry, guilt and anxiety might be being held and transferred between family members 'I would shove it all on them, then feel really relaxed but then my parents would be like, oh my god, she's really worried about this, and this and this...My sister would be like, I don't need this, like I don't need to be worrying, like as much as she was...'

Deciding to come to therapy was something that Jess talked about with her mum, especially as she was frightened that it would be a negative experience and potentially feel intrusive as it was in hospital. 'I remember just before I came to see you I was very very... nervous and I was saying to my mum, like I cried the night before to my mum, and I was like I don't know if I am going to be able to do it...'

Jess also explored some of her feelings and thoughts by posting on social media, so

a post to friends and family from the time running up to making the decision to come to therapy reflects the growing themes of fragmentation of self, vulnerability and fear of being a burden to family and friends. It reads:

*'The past few days I haven't been good at all and I haven't been stable enough to be on my own, every night I have had a breakdown and left my mum to pick up the pieces which isn't fair, but every night I can't sleep because I'm scared that if I shut my eyes and start to relax I'll go backwards and lose something I've fought so hard to get. I keep a happy smiley face on to all of my family and friends and very rarely do I drop it but on Wednesday two very important people in my life saw it drop for the first time and I was mortified that someone had seen my weakness and seen that I'm not OK and I'm not happy. It made me feel like a failure. And while I know they're there always to support me I never in a million years wanted them to hear some of the things I was saying, I didn't want them to see me give up!'*

Despite her fears about what therapy might evoke, looking back, there was a sense that six months after the initial shock of the injury, the timing might be right for Jess:

*'I remember the night before, I was really really upset and I was like I really don't know how I'm going to cope, I don't want to dip into the box of how it all happened, and things like that, and I think you have to ...to come to something like this, you have to be at the right stage.'*

At interview, we reflected on how it can be hard to get a sense of when it might feel OK for you to talk to someone in more detail:

*'In the second hospital I feel like I was still very fresh and new. It must have been about four months in, so I feel like I'd ...I don't think I'd come to terms with it properly and things like that so I think to come to something like this you have to be in the right, in the right frame of mind to do it.'*

As a psychologist at assessment working alongside the medical model, Helen recalls holding the tension of assessment form-filling, questionnaires and the more formal pieces at that first session, but recognising more than that the importance of sitting with Jess and her story so far. Jess arrived at the first session in considerable distress: tearful, not sleeping well, in pain from tension in her body, particularly around her neck, concerns over her diminishing weight and expressing 'dark thoughts' which made her anxious. From a risk assessment perspective, it was key to try and gain an understanding as to how Jess understood life now, what areas caused her the most distress and her ideas for moving forward.

This included building up a picture of Jess' life both before her condition developed, and gaining an understanding of the immediate issues at this first session: a sense of hopelessness, fear and uncertainty around diagnosis, exhaustion from recovery journey so far and loss of embodied status as a young woman at university as before. Working together to name and acknowledge some of the emotions that appeared to be enveloping Jess at this point felt very important, even at this early stage in building our therapeutic working alliance. The risk was that by doing so Jess might not have come back for a second session, but the risk for not doing so was that Helen would not be offering a safe, transparent therapeutic space.

### **The moment when it felt like talking therapy might be ok ...**

Jess explains that one of the central pieces for her in being able to talk through things with Helen was the emerging sense of trust that was established between them even from the first session. From a clinical perspective Helen made sure that she paid careful attention to aspects of the working alliance such as pace, tone of voice, cadence and the non-verbal body language and affect regulation.

Reflecting on some of the things that contributed to this sense of it being a safe place and space to work together, it was clear

that establishing trust within a relational dynamic was important from this first session: Jess commented that 'I wasn't just speaking, I was speaking to someone. I wasn't just letting all my emotions... babble out of my mouth, like, I, we were actually having a conversation...'

Elton-Wilson (1996) draws a distinction between the three main ways that a client might arrive at the start of talking therapy: in crisis, visiting (i.e. testing out the process) or ready to engage, and how important it is for the therapist to gather a sense of this at assessment. There was the sense of Jess being at a good time to connect in talking therapy, ready to engage and prepared to look at aspects of the distress she was feeling even though it felt painful and difficult to do so, as opposed to her initial experience which felt, for Jess to be too soon, and in hospital, somehow, too intrusive.

Even in the first session, Jess felt that she moved from 'being really reserved and I think it was about ten minutes towards the end I really like started blurting it out, and oh I wish I had more time, like I remember that, because I started getting more and more comfortable and maybe this could actually benefit me.'

### **How starting talking therapy began to make a difference, changing things in my rehabilitation treatment and beyond**

So reflecting on coming to talking therapy, Jess believes it has helped in several ways:

Firstly, that she has a better awareness of anxious thoughts and how she can deal with them – that she has some degree of control, a space between the thought or feeling that at first seemed overwhelming...

*'I think I just, I worry about everything and I work myself up about everything, and I still do now but I've learnt how to control it... so I think...its definitely helped...that I'm not... like...het up about everything now.'*

*'I feel because I came here and I was speaking about everything and like yeah I'd cry and*

*be upset but I feel like, then it would just be out...I was getting out all of these emotions which was then helping my body because I wasn't being so het up.'*

We discussed a bit more what 'being het up' meant for Jess:

*I was like working myself up about everything and like, and like...oh I don't know, like everything, it was becoming too much and I was getting really like...I was getting a lot of tension headaches and like holding a lot of tension in my upper body because I was getting so worked up about everything ...so.. yeah I think all the emotions were just building inside of me. And like, het up is like when you want to say stuff and you wanna get stuff out but you feel like you can't.'*

What this has meant is that Jess' physiotherapy and OT has improved also:

*I feel like, like definitely coming here has meant that my progress has got better because I'm not, ...I'm not like holding a lot of things in. I'm really open now, like...to you I will say anything, like I feel like that will help me, and it helps my recovery 'cos I'm not shutting away from it, I'm not just putting it to the back of my head.'*

And crucially, she is suffering less physical pain from the tension that she was holding in her body much of the time.

And the key point is that Jess has been able to start a conversation, a dialogue in many areas that previous felt difficult to do so, whether that is with her treatment team, friends, workplace colleagues or family:

*I really think that if I hadn't have come to talking therapy, I'd be very closed off and I wouldn't, ...I would kind of be in denial that I have mental health issues, but now I'm very open and I can speak to anyone about it, and a lot of my friends have actually come to me and have been like, I have depression, I have a lot of anxiety, like if you need, if you*

*need someone to talk to that's like, that's like, understands it, you can always speak to me, and things like that, so I think...its opened up a lot of doors.'*

*'It took me a while before I could openly speak about it but I feel like I'm in a better place for it...definitely in my head, I mean before I didn't want to wake up in the mornings, I wanted to stay in bed, and I still get like that but I know it's not because of the depression and anxiety, it's because I'm lazy..(laughs) but like it's that whole things like...to be able to come to terms with it, and I feel like I have to make a joke out of things, so to come to terms with me being in a wheelchair, I make jokes out of it, and I feel like I now have to be open about it for people to understand, so for me to be like, yeah I have these, and I'm seeking help for it, and I feel like people now look at me and are maybe she is having an off day, maybe I should just ask her if she's alright? Just to check and let her know that I'm here if you need her, so I think being open about it, has definitely helped.'*

### **Reflection and learning points**

Aside from posts on social media to family and friends, this is the first time that Jess has spoken explicitly, and publicly, about the mental health challenges she has faced at this stage in her recovery. As co-authors, we have had continual discussions throughout the process of writing, pulling apart the tensions over the different issues that could cause a dilemma in how Jess's voice might best be heard e.g. whether to waive anonymity and the impact of the existing therapeutic relationship, dynamics of difference and power.

In offering her experience to readers, Jess has decided it is important for her to claim that experience as her own, rather than the more usual route of an anonymised case study. Jess's primary reason for doing so is so that other young people facing similar challenges will be able to take something from this account. Unfortunately, it is not the case that every young person is offered the chance to access talking therapy from

a psychologist or counsellor who specialises in neurological conditions or even the adjustment process in living with a long-term health condition.

We are grateful to the experienced clinicians acknowledged below who have helped us in this collaborative process, thinking through the important points around these issues, and for a more detailed discussion around research-based practice, waiving anonymity and empowerment, we recommend the work of Anne Grinyer writing on her experience interviewing cancer patients (2001, 2002).

*From Helen's perspective as a researcher-practitioner, it has been a unique opportunity to reflect, discuss and look back over a therapeutic interaction with the patient themselves, and the treatment team – a highly unusual occurrence in her clinical work. Helen offers outpatient consultations both at the neuro-rehabilitation centre where she met Jess, and separately, in the NHS as senior counselling psychologist for a paediatric psychology service, where she is also attached to the paediatric diabetes MDT. In the NHS, Helen works with children and young people living with a wide range of physical health conditions and their families, taking general referrals from the paediatricians. Through individual sessions or group workshops, Helen uses a collaborative approach, informed by an integrative model rooted in the developmental, narrative and systemic approaches. The use of metaphor and creative ways of working, inspired by the young person, is central to Helen's way of working, e.g. the creation of diabetes Jenga game, at a workshop with eight children recently diagnosed with Type 1 diabetes.*

### **Concluding thoughts**

So, in conclusion, we would like to highlight the following around the referral process, as Jess explains in her own words:

- Trust is key, finding someone you are comfortable around allows you to be open and honest especially at the beginning of the process.

- Social media might be useful for updating friends and family – the responses were positive and gave me a bit of encouragement, but it does mean a lot of people are constantly wanting to know everything.
- Asking for help is not a defeat! It doesn't mean you are weak, a lot of the time I was just scared of talking.
- Use apps that work for you – together we searched and found a number of different calming, and anxiety based apps that were really useful.
- Talking in therapy is new and scary but once you get going it gets easier.
- Lastly, crying is inevitable, embrace it!

Jess says that she feels 'very fortunate to be offered therapy when I did as I was in a very dark place. Having a good connection with Helen helped massively, she was calming and asked questions that prompted responses that I was too scared to otherwise say.' Jess's experience backs up the evidence that it is less the therapeutic approach or modality that is paramount, but the fit of the therapeutic relationship that counts. (Norcross, 2002), a point emphasised by Cook et al. (2017) in their recent review of the various factors associated with the optimal implementation and application of evidence-based psychotherapies.

As both patients (and Helen as a psychologist working in the NHS), we feel that improving access to mental health services, empowering the patient and their families and integrating this support with our physical health services is important. This is something that will affect all of us either personally as a patient or someone that we love, at some point throughout our lifetime.

Writing this article is another part of the process of Jess having her voice heard, with the basic integrity of her story and position as an expert of knowledge, her experience of this neuro-rehabilitation process, and has given her a greater sense of empowerment around it, for her, and we hope, for others – practitioners and patients – through increasing understanding and exposition.

We would like to finish this article with a final quote from Jess' social media post around the time of first starting therapy ...

*'The point of this post is to tell myself it's ok to cry it's ok to feel like you've lost yourself and everything around you but I have to allow myself time, I can't just click my fingers and it all be normal again, it's a long road ahead and while at the moment there's more sad days than happy, it will start to pick up and I have to start finding myself again and doing things that make me really happy rather than thinking of the what ifs start think of the what can I do? And the truth is if I want it I will get it even if I have to fight tooth and nail I never nor would I ever give up on something I love! ...So next time you ask how do you do it and stay so positive? You know I'm not and even though I'll still laugh back at you and say anyone would do it if they were in my position you know that deep down I'm scared*

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*and worried for my future and everything that's being thrown at me! Finally, if you've read all of this I give you a huge round of applause because I probably would've stopped at the first paragraph.'*

**Ms Jess Walling**, Expert by Experience  
jesswalling@hotmail.co.uk

**Dr Helen Molden**, HCPC registered and Chartered Counselling Psychologist, & Integrative Psychotherapist.  
helen@psychological.me.uk

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# Part two: Collaboration between clinicians and researchers

## Editor's introduction

**N**OT ALL UK therapists are likely to know about the International Society for Psychotherapy Research. Research is a valuable resource if it focuses on the problems to which the research can be sensibly applied. As each client brings specific problems it is not surprising that generalisations from research may seem unwieldy, clinicians turn to more experienced colleagues when in difficulty, and research and application seem to belong to different universes. There are very active members of this international Society in countries throughout the world, with a UK Chapter whose current President is Dr Felicitas Roth, based at UCL. I plan to invite her to contribute to future issues of the *Review*, and to have a regular 'Research Section'.

Research can illuminate processes between therapist and client in a very direct way – for instance, research on impasses and how to manage these. I suspect that many therapists lose touch with current developments which would be valuable to them. I believe that members of this Psychotherapy Section could put our heads together and devise a way of making research findings alive for therapists and so beneficial for clients too. We will explore this in future Issues.

This section starts with a book review.

The book reports on an impeccable research study into collaboration between clinicians and researchers in the USA,

designed to show that the gap can be bridged and that clinicians find this worth-while. The study reported had the intention of triggering further collaborations, and the book review is followed by reports on some achievements of the first year after the work was completed. This further report was put together very kindly and at speed by the authors of the reviewed book, on request of the Editor, who reviews the book below.

One of the three authors, Professor Larry Beutler was twice President of the USA Chapter of the Society for Psychotherapy Research and his co-authors are very distinguished researchers with books well-known in the field of psychotherapy.

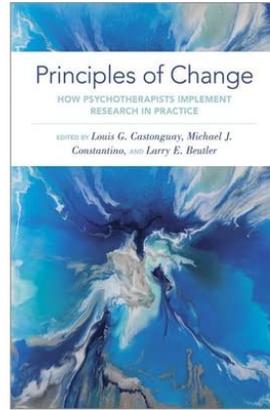
The BPS Psychotherapy Section may have an advantage in promoting the use of research by clinicians, so avoiding re-inventing the wheel. Many of our members will have first degrees in psychology, and so look to research as one part of their armoury. I invite ideas as to how we could make dissemination of research findings more systematic, perhaps through our regulatory bodies, as Professor Beutler has recently suggested, via an editorial research committee.

Jeremy D. Safran Ph.D., J. Christopher Muran Ph.D & Alexandra Shaker M.A. Research on Therapeutic Impasses and Ruptures in the Therapeutic Alliance, *Contemporary Psychoanalysis*, 50: 1-2, 211-232, Link: <http://dx.doi.org/10.1080/001075.30.2014.880318>

# Book review

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*Principles of Change: How Psychotherapists Implement Research in Practice*  
Louis Castonguay, Michael J. Constantino  
and Larry E. Beutler (Eds.)  
Oxford University Press (2019).  
Reviewed by Erica Brostoff



This is an exceptional guide to how clinicians can use findings from psychotherapy research, in a rich and challenging format, that should be in every training institute and in handy reach for practising clinicians.

Clinicians have often claimed that they feel sidelined by psychotherapy researchers, not easily able to set their own research agenda, and presented with piecemeal findings that are not easy to apply in a real-life setting. This book describes a direct two-way collaboration between researchers and clinicians, aimed at changing this potential impasse.

UK clinicians may not be aware that there is an international Society for Psychotherapy Research, with a UK chapter of well-known researchers in this field. The origin of the Society was in the USA. In this volume, three of the leading USA researchers, each with numerous studies to their credit, have set out to answer the divide between clinicians and researchers, giving clinicians their voice in an unusual challenge.

The format of the book describes clinicians' use of research findings relating to five categories of change principles: Client prognostic principles, client moderating principles that influence intervention efficacy, client process principles – behaviours that facilitate or interfere with improvement, therapy relationship principles, and therapist intervention principles. Clinicians regarded as exemplars by their peers, were asked to apply these principles to standardised case histories of six notional clients, each with a presenting profile of depression or anxiety – with or without substance abuse or personality disorder.

It is striking endeavour to demonstrate how expert clinicians can apply change principles to client needs that are very commonly encountered, with commentaries that can be returned to again and again, for thoughtful reflection. The value of this volume lies in the individual voices of the therapists from different theoretical traditions, illustrating that each clinician brings a different emphasis to the principles as they are systematically presented. The format gives each clinician their individual voice in a cascade of reflection on their own and other therapists' approach to the use of the principles, with a commentary by the researchers on the clinicians' differences and similarities.

Clinicians and researchers summarise by proposing how their experience of this project could feed into training, especially, for example, in emphasising the importance of learning how to build and maintain a therapeutic alliance with clients from the first session, which clinicians felt was crucial and not adequately taught. The ability to be flexible in applying principles was also judged likely to be the hallmark of expert clinicians, also a skill that could be learned. Clinicians and researchers were tempted by the future challenge of determining the key characteristics of the most effective therapists, the ultimate question, and whether these characteristics can be taught.

This volume is encyclopaedic in providing examples of how principles of change can be put to work by clinicians of varying allegiances. It is a step towards more direct

collaboration between researchers and clinicians, and as Beutler et al. are quoted, 'Scientists may be missing important avenues for critical areas of research. They may do a better scientific job if they were more attentive to the writing and ideas of their clinical colleagues.'

Although the authors do not specifically draw attention to this, in the final section entitled 'Harvesting the fruits of clinician-researcher collaboration and planting the seeds for new partnership', the bibliography relates to a wide range of mental health care settings, to private practice, administration and policy, supervision, college counselling, psychotherapy, consulting and clinical and counselling psychology, psychiatry and the study of clients' experience of psychotherapy.

The aims of this volume are elegantly expressed and the interactions between clinicians and researchers are deeply considered, as are clinicians' reflections on each other's work. Properly used, this masterly study could point towards a more dynamic and self-critical approach to practice by both researchers and clinicians, and a needed move away from complacency and ostrich tendencies among clinicians, researchers, training institutes and professional bodies.

The range of thought and experience shared here, perhaps deserves more generous page space, as the material is tightly presented, but against this there is the benefit of much.

# Principles of Change (Castonguay, Constantino & Beutler, 2019)

## A brief review of progress in its first year

Larry E. Beutler, Louis G. Castonguay  
& Michael Constantino

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SINCE psychotherapy's inception, many theorists have articulated different ideas about the specific strategies that promote therapeutic change. Such theories have often evolved from older theories, with various degrees of adjustments and adaptations, in the service of improving how we predict and understand patient improvement. With the perpetual pushing of ostensibly new ideas forward, there soon became a distinct theory for every treatment and a hundred different nuances for every theory. One could argue that such a 'Tower of Babel' full of theories has stunted the field's ability to mature as a science and to communicate effectively around evidence-based practices.

But what if theory proliferation could be reduced? Also, what if instead of looking to prior theoretical explications to find principles that can guide clinical practice, we were to look directly and primarily at our rich body research findings? Instead of asking 'What theory is the closest to truth?' what if we instead asked, 'What knowledge can be extracted from the amassed research to identify theory-common, or agnostic, "principles" that can serve to empirically ground our practice?' Moreover, what if we circumvented theoretical jargon for a moment and simply sought to identify patient, therapist, dyadic, and contextual factors that explain variance in patients' personally relevant treatment outcomes? Finally, what if we could then translate such findings, once they reach a critical mass of replication and trustworthiness, into a fully principle-based

approach to psychotherapy (and one that does not facilitate theoretical biases or foster an oversimplistic 'what works best' attitude)? We set out to answer these questions in our book, *Principles of Change*.

*Principles of Change* is the sequel to *Principles of Therapeutic Change that Work* (Castonguay & Beutler, 2006). In these volumes we extract from extant research theoretically cross-cutting principles of change that have indeed reached the aforementioned critical mass of replications. We then proposed that therapists' action be guided by these empirical principles in lieu of, or as enhancements to, a psychotherapist's preferred theoretical change model. Whereas the original Castonguay and Beutler volume primarily catalogued the range of empirically based change principles, the current volume had two objectives: (1) as indicated in an updated literature review, we aimed to consolidate and reduce the 61 principles obtained in the first volume, and (2) we examined the translatability (or lack thereof) of the revised list of principles as applied by experienced, front-line psychotherapists.

The success of the first objective is readily apparent. Owing to either insufficient evidence or insufficient distinction, we reduced/consolidated the total number of principles from 61 to 38. For the second and more forward-looking objective of this book, we recruited six clinicians who were widely recognised for their work with depressed and anxious patients, and who used a range of theory-based practices.

We explored with them how they would approach their work with several carefully crafted fictional patients presenting with primary symptoms of depression or anxiety, and varied secondary problems (e.g. problematic substance use). After reviewing the case, the therapist authors offered insights and helpful critique into their potential use of the empirical principles of change.

Of course, these considerations are only of substantive value if they continue to predict patients' outcomes beyond therapists relying on their theory alone. Over the past year, we each have continued to evaluate the principles and to determine their impact. Acknowledging our separate interests, our differing contexts, and the diverse places in which we work, we summarise here just a few of these relevant efforts over the past year (and since the publication of *Principles*).

### **Castonguay**

During the past year, a training study directly based on the process of training clinicians to use the principles described in *Principles* (Castonguay et al., 2019) has been conducted at the Pennsylvania State University. This study has taken place in the Department of Psychology Training Clinic, which is a Practice-Research Network created to simultaneously meet the clinical, training, and research needs of students in the Adult Clinical Doctoral Program (see Castonguay, Pincus, McAleavey, 2015, for description).

As a pilot, ongoing investigation, the goal of this study is to assess the potential helpfulness and feasibility of different modalities of training based on principles of change. Specifically, participants recruited from graduate students seeing clients at the clinic were asked to participate in four distinct phases of training, the duration of each of them being approximately three weeks. In the first phase, the participants were asked to read, as frequently as they see fit, the list of 38 empirically based principles that was published in Castonguay et al., (2019).

In the second phase, the participants were asked to read one of the six chapters in

the same book written by an expert clinician (Dr Dina Vivian) who participated in the writing of the book. The chapter assigned to students in this phase described in detail how Dr Vivian implements the 38 empirically based principles of change in her daily clinical practice. In the third phase, participants attended a three hours workshop given by Dr Vivian, during which she expanded on her implementation of principles of change.

Finally, in the fourth phase, the participants took part in weekly supervision meetings with Dr Vivian, meetings which focused on helping students to work with their respective clinical cases based on Dr Vivian's integration of the same principles of change. Before each of these phases, participants were asked to fill out a questionnaire about their expectations with regard to both the helpfulness and feasibility of the specific modality of training. Participants were also asked to fill out a questionnaire at the end of each phase regarding if and how they perceived these respective phases to be helpful and feasible. With the data collection having just been completed, both quantitative and qualitative analyses will be conducted during the next several months in order to address several questions such as: Are all phases of training necessary and/or helpful? Are some phases more helpful than others? Are some modalities of training more easily implemented than others? What could be done to increase both the feasibility and helpfulness of each of the training modality?

### **Constantino**

Dr Constantino has published both empirical and conceptual papers on topics addressed in the book. As just a few examples, he has tested, at the dyadic level, associations among patient outcome expectation (OE), patient-therapist alliance quality, and patient outcomes, demonstrating not only that OE predicts outcome (replication), but also that alliance quality is a candidate mechanism through which it does so (replication and extension). Moreover, this

research showed a partner effect, meaning that when patients had higher OE at one session, it results in greater *therapist*-rated alliance at subsequent sessions (extension to dyad-level process-outcome associations). Dr Constantino has also examined empirically the principle of therapist attunement to patient OE and its association with outcome, demonstrating that higher convergence in ratings of patient and therapist OE over time promoted greater subsequent improvement. Conceptually, Dr Constantino has published articles or chapters on evidence-based therapist responsivity to disruptive clinical process and context-responsive psychotherapy integration as applied to cognitive-behavioral therapy. Both of these reports draw heavily on principles discussed in the *Principles of Change* book.

Beutler's research group has been studying what we consider to be very critical relationships in understanding the roles of principle-based psychotherapy. Thus, historically, our research has been on the relationship between utilising a principle-based therapy and treatment efficacy. We've accumulate nearly a half dozen randomised trial research studies and a similar number of studies using alternative designs. The results have been positive in demonstrating the value-added role played following a set of principles. What has been missing in these studies is evidence of training effects. Our most recent studies have attempted to address this omission.

In a preliminary study designed to develop and pilot test a clinical supervision model for teaching the principles described in *Principles of Change* (Holt et al., 2015). Using a replicated  $N = 1$  research design, we had demonstrated that doctoral trainees in clinical psychology obtained better results among mixed outpatients when they had been systematically trained in the use of several of the principles. We followed this study with one based on comparison groups that we will describe in the following paragraphs. A third study using different (random) assignment procedures is still in process.

The focus of the most recent study followed two groups of student therapists, each group being identified as working either with one of the supervisors who was trained in principle-based supervision (SAS) or one who provided supervision as usual (SAU). Those SAS supervisors focused supervision on teaching eight empirically derived principles as developed in the preliminary study described earlier. All SAU trainees were yoked by entry date to patients entering treatment in the clinic. Incoming patients were assigned on rotation schedule to either an SAS or SAU and a therapist who was supervised by that supervisor. Supervision was conducted in a group format. In SAU groups, supervision as usual focused on the advice, theory, and preferences of the supervisor. SAS trainee volunteers were assigned to a participating SAS supervisor who had been trained to follow a weekly (either 8 week or 16 week) protocol by which to teach eight principles extracted from an early draft of *Principles of Change*. Supervision included a sequence of introducing one principle per week and then practicing a method for introducing it in the coming week. Subsequent sessions followed up on the assignments.

The eight principles, themselves, followed a protocol that introduced a sequence paralleling therapy processes described in the book. Thus, one principle was aimed at adapting to patient impairment levels (a prognostic factor), three principles focused on establishing and maintaining a solid therapeutic relationship (relationship principles). Two principles emphasised moderating processes by which treatment could be tailored to the client. One of these addressed patient receptivity vs resistance (moderating principles). The other principle addressed the patient's method of coping with conflict (a moderating principle). Finally, the last principle directed the therapist to respond differentially to the patient's stage of readiness (a prognostic principle).

As expected, patients whose therapists

were trained using STS principles (SAS) showed significantly greater symptom reduction than those whose therapists were supervised in the usual manner (SAU). A large effect size ( $d = .62$ , 95% CI [.05, 1.18]) existed

between the two groups over time. Furthermore, the length of treatment (8 versus 16 weeks) did not have a significant impact on treatment outcomes.

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### **Note**

Dr Beutler fully retired from academic and clinical practice in 2018 and is no longer actively involved in developing new research programmes. The research reported above has been carried out by past students and collaborating faculty who are pursuing themes of the collaboration.

Future issues of the *Review* will contain a dedicated research section. Clinicians are invited to suggest topics on which they would like past or future research reports.

### **Conclusions from the above summaries**

This section reports on the learning from a major USA research study with outcomes pointing to the key importance of:

1. Training that teaches how to build an alliance with clients from the first session.
2. Delivering treatments flexibly, whether in therapy or in other mental health services.

This surely comes down to adjusting technique and theory to meet the needs of the client in the room, making mental space

for this developing our techniques through learning from one another, and recognising resistances in therapists as well as clients. These ideas are far from new, yet the clinicians feel they are not put into action especially at the crucial training stage. The *Review* will pursue these topics in the future Issue on Improving Therapy and Avoiding Harm.

This research shows that direct collaboration between clinicians and researchers can be a big step forward professionally. Research is not the first port of call for most clinicians, who prefer to turn to more experienced colleagues when in difficulty. But with closer contact, clinicians could give voice to their direct concerns and invite researchers to explore these issues. This could be productive in broader and more systematic understanding of difficult moments in psychotherapy, as well as in understanding ‘moments of meeting’, and the vital but potentially neglected elements in training that prepare for these events.

# Part three: Collaborative opportunities to network between readers and contributors

## Book review

*Conscience: The origins of moral intuition*

Patricia S Churchill.

New York, W. W. Norton, 2019.

Reviewed by Steve Heigham

Ostensibly this is a book about how neuroscience can help us understand moral matters that have exercised philosophers for centuries; after all the author is the founder of the emerging field of Neuro-philosophy. However, viewed from the perspective of the history of ideas, this is another tome in the growing field of cultural evolutionary studies that are increasingly explaining the present situation of mankind and the many difficulties we face in the modern era. In this case it is by explaining the many genetic and epigenetic mechanisms that have evolved to give us a sense of right and wrong, and how these have manifested in different epochs and in different cultures.

The first part of the book examines what research has shown about the origins of our hard-wired instincts to care about others, which arose in the transition from reptiles to mammals. The author then goes on to explore the rapid development of the Prefrontal Cortex as the organising superstructure that has enabled us and higher primates to coordinate impulses of perception, memory, thought and emotion in complex sequences of action that pursue our main life agendas through cooperation and competition, in the highly social world we have lived in for the past several million years.

The author examines in great detail the actions of Oxytocin, Vasopressin and other neurotransmitters to explain how these have evolved and given us such flexibility in our behaviour, developing our capacity to learn massively from the environment. This leads

on to how, through linking in to our reward system neurology, values and social norms and expectations evolved, giving us expectations of fairness and honesty, and an internalised sense of conscience. Interestingly, on this point, she shows that individual level differences in these traits shape personality, and that strength of reaction to frightening or disgusting stimuli correlate highly with political allegiances, which research shows to be also fairly highly heritable.

In the final section, the author relates much of the experimental and neuro-scientific research presented so far, to the many ways that philosophers have, over the ages, tried to conceptualise morality. Her overall conclusion is that rule bound theories of morality that try to explain moral behaviour as universal principles, though they have been invaluable in developing legal frameworks that are acceptable across whole societies, they are too narrow to explain how we actually behave. Instead, looking at the complex interplay between instincts, habits, and highly evolved problem-solving skills give a more realistic picture; in this she advises the reader to be skeptical of policies that try to enforce arbitrary, universal, ideologically based moral positions in society.

This is a good book for practicing psychologists – counselling, clinical and forensic, as it helps explain how very flexible people's extension of empathy is, and how changeable their adherence to moral behaviour patterns. It also helps us to understand why these matters can so greatly vary across cultures and eras, which is important for taking cultural and sub-cultural influences into account in our work with clients.

# Music and (narrative) psychology: A literature review

Ghislaine T.M. Regout

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*Previous research has shown that music can have a positive influence on mood, and memory, and a positive effect on learning and shaping of identity, as well as the treatment of mood disorders, and dementia, has also been found. Consequently music may be of use during therapy. This review explores these effects and discusses possible implementation of music in various forms of psychotherapy. Consequences for these findings, and possible future research, is discussed.*

**W**HETHER it is relaxing after a long day at work by listening to your favourite singer, going emotionally 'back in time' to your awkward teenage years after getting your favourite song of that time stuck in your head, or wondering how it is possible to get that tune 'stuck in your head' in the first place; even for lay people it will probably not come as a surprise that music can have a profound influence on everyday life. Previous research supports this statement, and often suggest studying the role of music in relation to psychology, has clinical relevance to psychologists working in various settings, such as schools and clinics. However, there is much debate concerning the role of music within these aforementioned professional settings To give an example: there is currently an ongoing discussion concerning the lack of proper music education within schools, or the lack of funding for art and music therapy within clinical settings. Earlier this year, *The Guardian* reported that 'A School music report revealed cuts, inequality and demoralized teachers' (*The Guardian*, April 2, 2019). According to the newspaper, music lessons were in danger of becoming accessible only to those who could afford it, and even were seen as a luxury, not a necessity. The teachers, however, point out how music lessons could not only encourage creativity, but also boost confidence, and support learning, making the lessons crucial for the curriculum (*The Guardian*, April 2,

2019). Meanwhile, another report published in 2018, pointed 'how research has shown a positive effect of music therapy on the reduction of dementia-related symptoms by delaying the early onset, but only 5% of the care homes using the therapy effectively' (*The Guardian*, January 18, 2018). Assuming it is true that music has an impact on a wide range of topics such as memory, learning, and self-esteem, it might be of interest to study how this particular form of art can have a positive influence on individuals, and how it can be used in therapy. After all, previous research has shown that memory, for example, can be impaired in various psychological illnesses, such as dementia – in which the patients struggle with severe memory loss, depression, and anxiety – patients often struggling with remembering the negative far more easily than the positive in both mood disorders. If music influences memory – and if so, how? – how could it be used when memory is impaired? (Thayer et al., 1994). If music can boost self-esteem, like the teachers in the aforementioned article claim, how can this positive effect be harnessed in therapy for those who struggle with confidence issues? One relevant field of research is music psychology, which focuses on how to describe the patterns of musical development. Some of the research discussed in this review will address subjects that fall under this category (Clarke, Dibben & Pitts, 2010). However, this review will

concentrate on a wider range of topics, such as how music is processed in the brain, and how this knowledge can be applied in practice – showing that studying music in relation to psychology can be applied in various ways.

### **Music and the brain**

Due to the technological progress made in neurological research, previous studies have shed a light on how the brain processes music, which in turn explains the influence this artform has on various cognitive functions. Previous research has shown that listening to music involves various neuronal patterns, and the different aspects of musical processing recruit almost all regions of the brain (Overy, 2009). The neurological effect of music, is unlike any other stimulus or cognitive process, therefore. Listening to music starts at the eardrum, before sounds get segregated by pitch. Then, speech and music are separated to be processed individually. The speech circuits analyse the signal to study and process individual vowels and consonants, whereas the music circuit decomposes the signal and analyses timbre, pitch, contour and rhythm. The hippocampus and temporal lobe, meanwhile, are involved to check whether there is a relevant memory that can help to process this signal. Emotion is interconnected in the process as well (Levetin, 2006). Listening to music automatically triggers memory, and memory triggers emotion. Due to the role that both play in various mental illnesses, and the therapeutic process, this article will take a closer look at these functions specifically – and how music could help to counter impairments (Levetin, 2006; Sacks, 2007).

#### *Music, Memory, and Emotion*

As discussed previously, music and speech are analysed separately in the brain, and there has been scientific debate regarding the origins of this evolutionary development. It is still unknown whether music developed first as a way of communication, which lead to speech, or music came as a consequence of the development of speech (Storr,1992). One powerful argument for those who claim

that music came first in the ‘chicken-or-the-egg’-like debate, is the fact that in music processing, evolutionarily older parts of the brain are involved. To be more precise, the amygdala, a part of the brain that plays a key role in emotion, also plays a role in music processing. Previous research has suggested that this involvement ensures that music often ‘feels’ more emotional to us than general speech (Storr, 1992), which might explain partially why one can feel an emotional bond with a specific piece of music. Furthermore, previous research also showed neuronal connections between the amygdala and the nucleus accumbus, as well as the cerebellum; if music triggers emotion, the nucleus accumbus releases dopamine in the pleasure centre of the brain, and the cerebellum triggers movement. This leads to liking a certain piece of music, and movement to its beat.

The final function that plays a large role in the enjoyment of music, is memory (Sacks, 2007). Previous research has shown that culture dictates how music “should” sound like. When one is exposed to the music of its culture multiple times, memory schemas are built by the brain for musical elements such as genre, song arrangements, and melody. In turn, these schemas are used for musical processing; after sound has entered the eardrum, the hippocampus and temporal lobe are triggered to analyse the current soundwave and match it with an earlier memory of a similar soundwave (Levetin, 2006). As a result, there is a certain expectation of how music should sound like, and when hearing a certain note, there is also an instinctive prediction of which tone will come next in a specific melody, a phenomenon called musical expectancy. However, previous research has also shown that – to an extent – there is a stronger neuronal response and dopamine release when that next note does not match with its prediction, and the musical schemas are edited as a result; the brain likes the surprise, is rewarded with a dopamine release, and is motivated to trigger this response again,

which leads to seeking out more music. Nevertheless, the pleasure received from listening to music that does not match the memory schemas, is limited; while hearing new music is rewarded by the dopamine release, and certain genres are known for drawing highly loyal fans due to having learned 'how to listen to it' - such as jazz or heavy metal - listeners do tend to prefer music of their own culture (Storr, 1992). This is most prevalent when the differences between western, eastern and Arabic music are studied; due to using different musical notations, not all notes exist within the notations, and notes that sound common to one listener, may sound off-key to another. (Western music notation is developed by the Gregorian chorales during the Middle Ages, and is heavily influenced by the Catholic church, which therefore explains why non-Christian cultures tend to work with different notations.) Besides culture, it is a matter of personal taste - depending on the memory schemas of the individuals - which music triggers the release of dopamine, and is liked.

The neuronal links between the nucleus accumbens (pleasure), the hippocampus (memory), and amygdala (emotion) have various consequences that are relevant for both psychological research, and practice. After all, songs that matches the memory schemas to a certain extent is more easily remembered, and therefore can more easily trigger an emotional response, be it positive or negative. One example is the so-called 'earworm', the phenomenon of getting a song stuck in your head. Research has shown that getting a tune stuck in your head, a commonly experienced intrusive thought, can occur when an environmental cue is encountered (Hyman et al., 2013). While it is still unclear why this phenomenon exists, it is often used to study memory as a whole. A second example is the use of music in learning, since both are strongly tied to (emotional) memory. The body of knowledge concerning learning and how humans learn in general, has grown into a field of research, called musical psychology

(Clarke, Dibbens & Pitts, 2010). Consequently, previous research has shown multiple examples in which music in combination with repeated exposure, influenced knowledge and memory. Musical expectancy, for instance, involves implicit, unconscious knowledge, as well as learning through (repeated) exposure. Previous research focusing on the music of the Aboriginal Tribes in Australia, for example, have shown that the children of the tribe become familiar with 'their' music at a young age, which shows you literally learn to listen (Hallam, Cross & Thaut, 2011). Additionally, research has shown that people who have learned how to master an instrument, have a larger portion of the brain dedicated to fine finger movement. When you learn how to play an instrument, you therefore train your brain since playing music involves complex motor skills, which are repeated often due to practice (Clarke et al., 2010). Examples like these might explain why the teachers in the introduction claim that music can be beneficial for memory and learning due to the repeated practice and exposure that music lessons offer. Moreover, previous research also showed that musical memory schema's, and implicit memory in general, is relatively spared in several types of dementia, including Alzheimers' disease (Bowell & Bamford, 2018). This leads to a strong focus on the effect of music on dementia, due to the way memory processes music. This research will briefly pay attention to this topic later on.

### **Music, emotion and identity**

Arguably the biggest role that music can play in relation to psychology, however, is tied to self-development, once again due to the triggering of emotion, pleasure, and memory. During the age in which personality is shaped, adolescence, music can have a far-reaching impact. In adolescence, the brain develops rapidly, and due to these developments, adolescents often are most open to new experience, and create fresh memories as a result. After all, adolescence is the time in which many people experience the most important life-events, such as

falling in love for the first time, discovering who they are as a person, and consider who they want to be as they grow up. These developments are not only tied to the rapid changes in the brain during this particular period, but are also commonly experienced as highly emotional, due to the development of the amygdala (Levetin, 2006). The brain connects the music heard during the creation of those emotional new memories, to the (neurological) developments themselves. Consequently, the music heard during those hectic times, is tied to the cognitive and emotional development that takes part during adolescence. This can have far reaching consequences: even years later, hearing the music loved during adolescence can trigger strong memories immediately. Moreover, since music can trigger strong emotion, the artform itself is often used as a tool when adolescents start to define themselves in terms of individual personality, and who they view as peers. Consequently, the taste of music can influence membership of a certain social clique, the selection of friends and romantic partners, hobbies and interests, the clothes bought and worn – regardless if school uniforms are mandatory or not – and how one presents him- or herself to the world (DeNora, 2000). Due to the selection of a certain social group based on musical taste, and the importance the social group places on that music as a whole, the individual listener, obtains even more positive experiences in which a specific type of music is tied to. In other words; the brain ties music that is heard during the developments during adolescence to those developments themselves, ensuring a link between musical taste, emotional experience, and identity. Due to seeking out others with a similar taste, this link is consolidated further, ensuring a strong emotional connection with a certain piece of music. Additionally, due to recognising the emotion the music tries to convey due to musical expectancy, a listener might experience an ‘interaction’ between himself and the music (Hallam et al., 2011). This interaction, which is also a fundamental part

of musical therapy, can help the listener to understand his/her own emotions better (Hesmondhalgh, 2013). Previous research states that since music can imitate/reflect, arouse, and express emotions, it helps us to self-reflect, which might be another reason why making music is such a well-loved way to spend one’s time (Hesmondhalgh, 2013). This point is supported by DeNora (2013), who has suggested as well that music can create conditions that are conducive to well-being. These conditions are created because this particular form of art ‘can communicate directly to the listener – with or without needing language, can create a sense of togetherness and is often seen as medicinal’ (DeNora, 2013). Sustained musical practice can even contribute to a better quality of life, it can afford narrative and foster the aforementioned mood regulation, and so consolidate identity.

Previous research has shown that music and the development of identity are interconnected in various ways, due to the role of memory and emotion in music-processing, so can influence the way an individual sees himself, and the world around him. Previous research has also shown that several psychological disorders, like mood disorders and dementia, often distort these factors. Previously, it has been outlined how music could be used as a tool in treatment for those disorders as well. In fact, some of those evidence-based treatments are already in use; COMET, a manualised treatment based on Cognitive Behavioural Therapy (Korrelboom, 2011) that can be used in the treatment of low self-esteem and depression, is a known example. Nevertheless, further research is needed in order to discover how music can be properly implemented in any other therapy besides music therapy.

### **Music and the daily practice**

Nevertheless, what is known is that previous research has suggested that studying the effect of music can be beneficial for therapy, since it can influence one of its key ingredients; emotion (Sacks, 2007). Since music can

conjure emotion, its effect on mood regulation has been demonstrated multiple times. To give a short overview; Erber, Therriault and Wegner (1996) found that listening to either sad or happy music can influence participants to prefer materials incongruent with their mood, in order to restore how they felt before listening to the music. In a study focusing on which methods are most effective when trying to change a bad mood (Thayer et al., 1994), listening to music was considered by the participants to be one of the most successful strategies to cheer you up, reduce tension, and get more energy. Moreover, research by Wang, Kulkarni, Dolev and Kain (2002), Nilsson (2008) and Knight and Rickard (2008) all suggested that music can lessen anxiety, for example the pre-operative anxiety patients struggle with as they mentally prepare themselves for the operation. Interestingly enough, not only the perceived anxiety decreased when the patients heard music, they also experienced less pain. Due to results like these, models (Saarikallio & Erkkila, 2007) and questionnaires (Saarikallio, 2008) have been created to explain and measure the influence of music on mood regulation. Lastly, Brotons, Chapin and Koger (1999) have suggested that music/music therapy in general can have a highly significant positive effect. Unfortunately, Brotons, Chapin and Koger (1999) have also stated that it is not always clear which factors within music therapy can have a positive effect. They did discover that the therapy as a whole has a general positive effect on dementia, and both mood disorders (depression and anxiety). However, due to the lack of clarity regarding which specific factors within music therapy help and why, more research on this subject is advised.

### ***Music as a tool in treatment***

In other cases, previous research focusing on how to understand the effects of music, and how to properly implement it in therapy, was more successful. One example is COMET-training, a manualised treatment used to treat the low self-esteem that usually

accompanies depression, based on Cognitive Behavioural Therapy (Korrelboom, 2011). The therapy is created especially for those who are aware they have an unrealistically low point of view of themselves, but struggle to gain more perspective. By using methods rooted in CBT, the client learns how to pay more attention to the positive aspects of their personality. Korrelboom (2011) points out that often, people who seek help for problems related to mood-regulation, be it depression, anxiety, eating disorders or other illnesses, also struggle with low self-esteem, and even if those aforementioned problems are treated, the low self-esteem remains. In that case, COMET, which consists of helping clients to pay more attention to the good qualities they have, might help. Furthermore, the training helps clients to challenge the negative thoughts they might have about themselves. As a result, the clients learn how to embrace the qualities they already know they have, but do not truly feel yet, and become more critical of their presumed negative qualities (Korrelboom, 2011). According to the manual, there are five steps in the programme, which contains several homework assignments. One of those crucial homework assignments, especially handpicked due to its ability to conjure emotion, so that the clients do not only know there is nothing wrong with them, but also *feel* it...is music (Korrelboom, 2011). In the assignment, the client has to select music that symbolises their positive characteristics, makes them feel empowered about themselves, and helps them remember the moments in which their negative thoughts were contradicted. During the session, the clients are taught to remind themselves of those characteristics, while listening to the selected music, which leads to a link between the music, and the positive thoughts and memories, helping them to get the perspective needed. Also, they are advised to listen to the music whenever they struggle with the aforementioned low self-esteem, and other negative thoughts. Various studies to prove its effectiveness showed that the

COMET method improved the self-esteem of the participants (Korrelboom, De Jong, Huijbrechts & Daanen, 2009; Korrelboom, Marissen & Van Assendelft, 2011). These results not only underline the effect music can have on mood regulation, or the role music can play in defining one's own view of him or herself, it also showed that music can be implemented successfully as a tool used in therapy, due to its effect on memory, learning, and mood regulation.

Naturally, the clients who might benefit from the COMET training discussed above, struggle with how they view themselves and their place in the world, but this training is not the only form of therapy with a focus on how the self and identity are defined. Another example of a therapy that has the way someone views himself or herself and his/her life story as its focal point, is narrative therapy (Vassilieva, 2016). Narrative therapy is a psychotherapeutic approach based on the theory that people construct stories about themselves in order to give meaning to life. Psychological problems are seen as the consequences of constructing problematic narratives, and the purpose of therapy is to help the client narrate their life stories in a healthier way. Previous research by Lopes, Concalves, Machado, Sinai, Bento and Salgado (2014) suggested Narrative Therapy as an alternative option for CBT in the treatment of moderate depression. The results showed that both CBT and Narrative Therapy were effective, but Narrative Therapy seemed to be more effective for those who dropped out of CBT-treatment. If NT focuses on how a client narrates his or her own life story and forms his or her own identity, and music also plays a role in defining that same identity, using music as a tool in Narrative Psychology, might not be a far-fetched theory. However, future research is needed to study this hypothesis. Previous research sounds promising; a study by DeDiego (2013) for example suggested that using song lyrics in counselling might be effective, mentioning the long history of using prerecorded music in therapy in order

to connect with the client on a deeper level. In fact, even Nathalie Rogers, daughter of Carl, suggested using art in order to help clients discuss difficult emotions (1993). Later on, Gladding et al. (2008) studied how song lyrics selected by the client could be used in therapy. In research focusing on grief, the study showed that editing or rewriting pre-existing lyrics to fit their own situation better, provoked an even stronger emotional response, which then would help expression of grief. Also, the researchers suggested using song lyrics as coping skills by constructing a helpful playlist in order to motivate clients and discussing the emotional effect of those songs in the therapy session. Meanwhile, Sawyer and Williams (2011) conducted a pilot study in order to research the effect of digital storytelling (using multimedia when telling a story) and music lyrics on self-reflection, within a secondary school context. The 30 adolescent participants had to create a story on positive coping strategies, and socially appropriate behavior. The participants specifically chose songs that conveyed the tone and emotion in their stories, and the results showed that mixing narrative and music seemed a powerful way for the teens to express themselves. These results suggest that using music as a tool in Narrative Therapy can have a positive effect on mood disorders like depression, helping the client express him or herself. However, future research is needed to study this hypothesis further, and to ensure an evidence-based method is created, and properly implemented. Further evidence that seems to suggest that using music as a tool in order to narrate a life story, is the Soundtrack To My Life (STML)-method used in dementia treatment. In order to study the effectiveness of the treatment Subramaniam and Woods (2016) asked six participants to create their life story, using Windows Moviemaker. The story was divided into six segments; childhood, teenage life, career, mid-life, retirement, and current time, and materials included the narration of their story, as well as the original book used, favorite songs,

photographs, and background music. The results showed that the project helped to trigger memories in participants who struggled with Alzheimers' disease. Moreover, it also improved their mood. Based on these results, The Utely Foundation has recommended further research and implementation of therapy using music – as well as music therapy – in dementia care settings (Bowell & Bamford, 2018).

## Discussion

Previous research has suggested that music can have a positive influence on mental wellbeing, and therefore using it as a tool within a therapeutic setting, could be beneficial (Sacks, 2007). The aim of the current study was to further research why music has a positive influence, and how it could be properly implemented within therapy. Previous research has shown that the amygdala, hippocampus, and nucleus accumbus, among others, are actively involved in the neurological processing of music, ensuring that music can have an effect on emotion, memory, and the experience of pleasure (Levetin, 2006). Consequently, music is used in order to consolidate one's own identity, and that as part of a specific cultural group (Storr, 1992), as well as playing a role in memory training/learning. Due to these effects, it has been suggested that music could be a helpful tool for therapists when treating various disorders such as mood disorders – in which emotion, and partially memory is impaired, and dementia – in which memory,

and partially emotion, are impaired. In fact, there are therapeutic methods already in use that use music in a constructive way, such as COMET, a CBT-based training focused on improving low self-esteem that often accompanies depression, as well as other disorders. Possible implementation of music in other forms of therapy, such as Narrative (Psycho)Therapy, is discussed. However, future research is needed in order to gain more knowledge of the effectiveness of music within a therapeutic setting, and to ensure professional implementation. In the studies mentioned, participant groups were often small, and there was not always a control group. As a result, statistically stronger research is recommended. This recommendation is in line with the report of The Utely Foundation (2018), which also pointed out that lack of funding in various settings, such as care homes and the NHS, is another hurdle relevant to this topic. Meanwhile, similar problems are mentioned when discussing positive effects of music (lessons) within therapy catering to children and young adults in a school setting. Hopefully, the current study, as well as others, shows that music in relation to therapy deserves to be studied in greater depth.

## Ghislaine T.M. Regout

The author invites readers to form a collaborative network on the use of music in psychotherapy.

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A commentary on the history of science and simplistic concepts which contribute to the treatment of clients' 'problems', rather than the clients' 'life experience'

## Mind-forged manacles<sup>1</sup> 2: Science and practice

Sheelagh Strawbridge

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*Ideas in this article are a development of those in Strawbridge (2016).*

**I**N MY previous article (Strawbridge, 2019) I explored some aspects of ideological control that we can be caught up in as practitioners. That article considered how we can be implicated in depoliticising psychological distress by working with models that foreground the individual and which can divert attention from its socio-political contexts. I referred to Adlam's approach to 'eating distress', conceptualising it in the context of social practices, as one example of a way of challenging the category of a 'disorder'. (Adlam, 2018) I want here to continue this exploration of ideological control by focusing on the particularly narrow model of scientific knowledge and evidence-based practice that dominates the provision of therapeutic services through the policy of 'managed care'. As there is already a good deal of criticism of this policy, I want to focus here on questions concerning the nature of science and its relation to practice. I am conscious of trying to link a range of ideas within a complex matrix, but I hope my attempt to sketch a broad picture can contribute to ongoing debates and conflicts by placing our own struggles in a wider context of current socio-political issues.

When I first studied psychology there was a strong emphasis on its status as a science. With 'A' levels in biological sciences and having trained as a science teacher I enrolled on my degree in psychology in 1966. I had a strong, if naïve, belief in the power of science and an attraction to psychology influenced by my reading of Skinner, as a science capable of improving human society through behavioural engineering. This was reinforced in the very first lecture in which psychology was described as the 'science of behaviour' and Freud dismissed in a sentence as unscientific. Subjective experience was not yet considered amenable to scientific study by mainstream psychology which was very much 'rats and stats'. Despite some disillusionment and a developing interest in the history and philosophy of science, ethics and political activism, I stayed the course and graduated in 1969 with a BSc. Others graduated with BAs, a distinction determined by 'A' levels rather than the university course, though, as the promotion of psychology's scientific credentials affected its funding, it was important for it to be linked with a Faculty of Science.

This potted personal history seems rele-

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<sup>1</sup> In his poem 'London' William Blake coins the term 'mind-forged manacles' to indicate how the dominant ideology of a society shores up its power structure by obscuring the awareness of oppression.

vant because, despite all that has happened in our discipline since the sixties, we are struggling again with the same issues in relation to the nature and establishment of scientific credentials. This is reinforced by some tendencies within psychology and, in the field of psychotherapy, NICE's narrow version of evidence-based practice. All the work to establish a human science perspective on the exploration of subjective experience by qualitative methods and the legitimization of psychotherapy and counselling as genuine psychological practices is being pushed aside in favour of a technical-rational definition of 'scientific' research deemed to set the 'gold-standard'. As I was, in the sixties, practitioners are required to oversimplify the richly complex ways in which we encounter, experience, understand and interact with ourselves, others and the wider social and natural worlds we inhabit.

Within this reductive frame, socio-political issues are redefined as individual 'mental health' problems to be addressed by a formulaic approach dominated by a simplistic application of CBT and social protest is discounted or even criminalised. Cognitive behavioural engineering is very much alive, not only as championed by Layard, but in increasingly sophisticated and disturbing forms (see e.g. Davies, 2015). All of this helps to construct and legitimise the 'mind-forged manacles' of the individualizing neo-liberal ideology dominating the West.

As noted above, managed care in general, and in particular, the IAPT model, has been widely critiqued, Dalal's (2019 a & b) analyses being amongst the most detailed and telling. Therefore, I want to ask a more general question about how we understand the nature of science itself and its relation to practice. Science is complex. It is not value-free but value-full, observations are shaped by theories and it is a social activity. It implies an ethical stance in relation to evidence and truth, but it is also culturally situated. It can perform an ideological function and is prone to political influence. At

its most dangerous 'science' can be elevated into the model of rationality itself, bestowing legitimacy over and above all other domains of knowledge including politics, the arts and ethics – which was for a time viewed purely as emotional expression not amenable to rational argument (see e.g. Ayer, 1934). As Midgely (1992) argues, science can function as 'a myth of salvation' when seen as the key to solving all our problems. It seems important to question this image of science that is widely taken for granted.

The notion of science emerged historically, in the seventeenth century, and challenged the prevailing religious world-view. The universe was imagined as a giant clockwork mechanism, at first seen as put in motion by God, though in more secular times divine intervention is no longer invoked. This guiding mechanistic metaphor favoured a technical-rational approach to understanding the natural and social worlds. The power of science and technology would drive social progress, improving human life by combating disease, famine and other social ills. It is not difficult to see why claiming scientific status became important for psychology as it emerged as a distinct discipline.

Central to this vision of science was the aim to understand the complex phenomena of reality in terms of their most fundamental elements and unifying principles across the sciences were sought. 'Higher level' explanations, such as those of biology, were considered to be ultimately reducible to 'lower level' explanations, with the laws of physics seen as the most fundamental, and the search was for the basic components of matter by empirical methods. Some of the most successful scientific ideas of the nineteenth and twentieth centuries were inspired by this powerful idea. For example, it underpinned the spectacular developments in molecular biology arising from the discovery of the structure of DNA (Watson, [1953] 2012) and Crick declared the ultimate aim was the explanation of all biology 'in terms of the level below it, and so on right down

to the atomic level' leading to 'a great influx of physicists and chemists into biology'. ([1966] 2004: 14) More recently Dawkins has described us as survival machines for DNA molecules, ([1976] 2006: 21–22) and has evoked the clockwork image of the universe through his metaphor of a 'blind watchmaker' ([1986] 2006). Mapping the human genome has been one of the triumphs of this approach. The achievements inspired by this mechanistic image of the universe and the reductionist drive to discover its fundamental building blocks and unify the sciences are not to be underestimated.

This conception of science has, nevertheless, generated intractable problems and raises persisting questions about the limits of our knowledge. For example: There are unresolved tensions between determinism and moral responsibility, dependent on free-will, as well as between consciousness and material reality (Velmans, 2009). The realisation that experience is inseparable from techniques and instruments of observation (including telescopes, MRI scanners and the Large Hadron Collider) and is ordered and made intelligible through conceptual maps, challenges naïve notions of objectivity. The image of a stable clockwork mechanism requires modification in the light of theories of evolution and thermodynamics. Notions of matter, space and time are rendered problematic by theories of electromagnetic fields, relativity, subatomic particles and quantum mechanics.

Moreover, this view of science involves isolating specific problems to analyse and solve, which is also problematic. Whilst breaking down complexity for the purpose of analysis can be effective, whether it be the anatomy of a plant, human liver function, the mutations of a virus, the structure of the atom or a person's psychological distress, it can result in unforeseen and unintended consequences for interconnected natural and social systems. For example, the widespread use of plastics has caused enormous problems as has the large-scale use of fertilisers in agriculture and the overuse of anti-

biotics. Losing sight of the systems within which a problem is embedded is blinkered and can be disastrous on many levels. In psychology the behavioural and the later cognitive-behavioural models fit the mechanistic vision well, as do some neuropsychological approaches to understanding consciousness. In our own areas of professional practice it has led to individualising socio-political issues into a virtual epidemic of personal 'mental health' problems and the imposition of formulaic systems of managed care.

As well as questioning reductionism, studies in the philosophy, history and sociology of science have also undermined the notion of a unifying 'scientific method'. Science can no longer be conceived as unitary and socially detached but as characterised by diversity and embedded in communities of scientists guided by shared conceptual maps. These may remain stable for long periods but can undergo significant shifts. Chalmers (1999) usefully introduces differing conceptions of science, continuing controversies and key thinkers including Popper, Kuhn, Lakatos, Feyerabend and Foucault. We can no longer think in terms of an all-encompassing 'modern' world-view with rationality defined within a hierarchically ordered but unified science. It now seems appropriate to think more modestly, in plural terms, of the sciences, alongside other disciplines including the humanities, as charting important domains of knowledge and inquiry. Sciences, such as molecular biology, chemistry, ecology, quantum mechanics and climatology, map particular domains of inquiry with sometimes radically different guiding metaphors and metaphysical assumptions. Their research methods, theories and explanations are generated and maintained within the discourses of their respective scientific communities. This is recognised by the 'Human Mind Project', School of Advanced Studies, University of London, launched (2013) and resonates with Serres' (1995) contention that no domain is sole arbiter of reason. He sees it as

the job of philosophy to negotiate channels of communication between the sciences and humanities. (and see Brown, 2002).

Despite all the questions the technical-rational vision of science still exerts ideological power. Some historians of ideas have linked it to the Promethean myth of a masculine hero, who, in his quest for freedom, progress and mastery over the natural world has, 'constantly striven to differentiate himself from and control the matrix out of which he emerged' (e.g. Tarnas, 2010: 441). Feminist critiques have noted that the language of the technical-rational vision of science is infused with sexual imagery. Nature has been imagined as female with knowledge created in a process of interrogation in which she is unveiled, penetrated and forced to reveal her most intimate secrets. (Merchant, 1983; Harding, 1986). Moreover, it has been argued that we ignore the latter part of the Promethean myth at our peril. (Neville, 2012: 32). This tells us that our liberation from the gods or nature is illusory. In focusing on resolving specific problems, but failing to comprehend the complex interactions of whole systems, our technical solutions often cause new problems. McGilchrist (2009) has associated this reductionist tendency with the increasing dominance of left-brain mentality in Western culture. Whilst resisting an oversimplification of divided brain theories, he argues and presents a wealth of evidence for the increasing bias in Western culture towards the abstract, analytic and instrumental thinking characteristic of the left hemisphere over the more contextual, humane, imaginative and holistic perspective of the right hemisphere (and see Rowson & McGilchrist, 2013)

Such concerns are not new. Though it persists as a dominant vision the mechanistic world view with its motivation of power and control has been contested from the start. As early as the eighteenth century some scientists questioned the mechanical model of nature. Amongst them Humboldt proved a key figure who became the most famous and influential scientist of his time. He trav-

elled widely collecting specimens, making detailed observations, finding connections everywhere and arguing that no single fact could be considered in isolation. He viewed the natural and human worlds as fundamentally relational, linking together plants, animals, climate, geography, agriculture, politics and economy. Seeing the environmental devastation of colonial plantations and deforestation, he became the first scientist to write about human-induced climate change that could have serious consequences for future generations. Humboldt described nature as a 'web of life', stressing the interrelationships vital to the balance of the complex system. Together with Schelling and Goethe he adopted an organic rather than a mechanistic metaphor. A mechanism, such as a clock, can be dismantled and reassembled, whereas an organism, such as an animal, cannot. In an organic system it is the whole that shapes the parts and in this he perceived a vulnerability to unbalancing interventions (Wulf, 2016). However, this holistic interdisciplinary perspective became eclipsed by the competing tendency to separate fields of study into distinct disciplines, often driven by the desire to control nature and harness natural resources in the interest of progress.

There were, nevertheless, still those who perceived the danger in this desire. In Shelley's novel *Frankenstein*, published in 1818 four years after volume one of Humboldt's *Personal Narrative*, her scientist creates a monster he cannot control. Mellor (1989) cites this as highlighting the dangers of scientific hubris. Jung also warned:

*'our progressiveness, though it may result in a great many delightful wish-fulfillments, piles up an equally gigantic Promethean debt which has to be paid off from time to time in the form of hideous catastrophes'.* (1980: para. 276)

Current fears and attempts to address the likely devastation of pandemics, the decreasing effectiveness of antibiotics, and the climate crisis, suggest such a debt. In

the light of these challenges, the organic, holistic and systemic worldviews of some natural scientists are becoming more widely accepted. Indeed, the Promethean myth is countered by Lovelock's alternative myth of Gaia, prefigured by Humboldt, which sees the Earth as a self-regulating system unbalanced by the depredations of humanity. (Lovelock, 2006). This is capturing imaginations beyond the confines of ecology and climatology and entering political debates advocating sustainability over exploitation. (see also Capra & Luisi, 2014 and Foster, 2000)

The nature of 'science' is and always has been contested. However, much of science is esoteric and what many scientists actually do is incomprehensible to most of us. Therefore, seduced by the technological wonders it generates, it becomes easy to mythologise science into the sole source of our salvation. We can see this happening in a more limited way in psychotherapy in the grandiose claims made for managed care which seeks to implement a simplistic notion of evidence-based practice to solve complex issues. For example, 'depression' and 'anxiety' are decontextualised as 'disorders' with prescribed 'treatments'. This grandiosity is underpinned by the notion that it constitutes a scientific approach based on solid evidence and this is maintained in the face of extensive criticism. It is not my intention to deny the contribution to practice of well-designed scientific research but to dispute the reduction of practice to the technological application of a single model of science. Schon (e.g. 1983) has made an important contribution to the understanding of practice in a number of fields that shows how limited a view this is. I want to look more closely at science, or the sciences themselves, as forms of practice.

Subsuming practice to science is linked to a tendency to associate knowledge with what can be made explicit. Ryle (1949), however, made an important distinction, significant for practice, between 'knowing that' and 'knowing how'. The latter acknowledges that skilful action reveals that we can know more than we can tell. Polanyi (1967) termed this

'the tacit dimension' and explored many everyday examples, such as recognising faces and the moods they express, using tools and riding a bike. From a different perspective Kahneman (2011) has added to our understanding of the tacit dimension distinguishing fast intuitive from slow deliberative thinking and showing the significance of the former in making judgements and decisions. Polanyi, was particularly interested in the role of the tacit dimension in scientific discovery. He argued that creative acts are driven by strong personal commitments, guesses and hunches. Drawing on Merleau-Ponty's work (e.g. 1945 and 1981), also Gestalt psychology, he argued that discovery is akin to perception; going from an awareness of many particulars to grasping their joint meaning in a coherent whole. It involves skilled, imaginative integration rather than formal reasoning, and he stressed the value of dialogue within an open community in fostering creativity. Polanyi's work prefigured that of Kuhn (1962) in pointing to the importance of scientific communities and Schon draws on it in his discussions on reflective practice.

Also following Polanyi, Collins (1985, 2013) has led research into the part played by the tacit dimension in science. For example, scientists found it impossible to replicate building a laser from research papers or detailed written instructions. Only those who were shown how to do it by others who already had the experience, were successful. Collins argues that this kind of research suggests two models of learning. One he terms 'algorithmical' which rests on formal instructions, as in a computer programme. The other he terms 'enculturational' which he likens to learning a new language or culture. Enculturational learning requires personal interaction and guidance, showing rather than telling, involving watching, visualising and copying bodily movements. In psychology, this relational construction of our shared worlds is perhaps most strongly emphasised in Gestalt theory and practice. So 'knowing how' involves knowing more

than we can tell in language, and scientists learn as much from experience and interaction with colleagues as from formal papers.

Learning from experience within a community of practitioners is crucial for acquiring the competence demanded in complex practice situations of all kinds, including those of science. This suggests the value of the kind of apprenticeship required in learning any skilled craft. Sennett (2009) has explored the tacit dimension in craftsmanship across a wide variety of practices including pottery, musicianship, and medicine. He stresses the intimate connection between head and hand, 'the dialogue between concrete practices and thinking' (2009: 9) as well as the importance of guidance by experienced teachers. This emphasis on the embodied nature of skill acquisition, challenges the Cartesian conceptual split between body and mind that has bedevilled British education. Academic 'knowing that', is the highly valued province of universities. It is regularly separated from 'knowing how' with arts and crafts in particular being relatively undervalued and often learnt in specialised schools or apprenticeships. Learning the craft of those professional practices, including psychology, counselling and psychotherapy, that have found their way into universities, is largely delegated to placements outside the institutions and often inadequately integrated.

Recognising 'know how' also shows how limited is the view of cognition central to cognitive-behavioural psychology and practice in linking it too closely with thinking. Systems theory, however, suggests a way beyond the mind-body split, conceiving mind and consciousness as processes not entities. Bateson (1973) was one of the first to view mental processes, such as learning, memory and decision making, as systems phenomena characteristic of all living organisms, consequent upon certain level of complexity, but not dependent on brains and highly developed nervous systems. Maturana and Varela have independently proposed a similar theory of cognition as the organising activity

of living systems at all levels of life. (e.g. Varela et al., 1993). Strongly influenced by Merleau-Ponty's emphasis on embodiment and the primacy of perception, they see cognition as increasing in complexity along with the evolution of sensory organs. This extends the notion of cognition beyond conscious awareness, recognising the physicality of a whole organism's learning from interactions with its environment; a brain being one specific, highly-evolved, structure through which the process operates. Consciousness is conceived as a particular kind of cognitive process that emerges when a sufficient level of complexity is reached. These ideas situate cognition in an evolutionary context and have opened up new avenues of research in cognitive science. They resonate with Damasio's (2000) notions of 'core' and 'extended' consciousness and suggest a neuroscientific foundation for understanding embodied learning and unconscious processes. They also seem somewhat akin to Rogers' conception of organismic knowing and valuing, which Neville (2012) links with theories of deep ecology, whilst Rogers himself (1995) makes reference to complexity theory and the process philosophy of Whitehead ([1927-8] 1985).

Recognising the tacit dimension then points to the significance of both embodied learning and direct contact between people. It helps to understand the difficulty in being explicit about the crucial interpersonal connection between client and practitioner in psychotherapy, which implies the possibility of knowing (and communicating) more than we can tell, and of entering the world of another and relating in ways not amenable to causal explanations or explicit interpretations. Rogers' humanistic perspective has been central in drawing attention to the importance of the therapeutic relationship, 'being-with' rather than 'doing-to', and Buber's distinction between 'I-It' and 'I-Thou'. Stern (2004) too, from a psychoanalytic perspective has explored the profound impact of 'moments of meeting' as

distinguished from ‘moments of interpretation’, whilst Gestalt approaches stress the co-constructed nature of client-therapist perceptions.

Our capacity for knowing from the inside as well as the outside is, as recognised in the human science tradition, a feature of our common humanity. We are the same kind of beings as our clients and research subjects and this is at least as important in our work as the understanding that scientific research can provide. Comparing the heroic fictional detective Sherlock Holmes and the self-effacing, but equally successful Father Brown, illustrates this well. Holmes is a man of action, amateur scientist and logician. He is an acute observer who sees from the outside, focusing on factual evidence and employing remarkable powers of deduction. In contrast, Brown puts himself imaginatively into the minds of criminals and in discovering them through his empathy, grounded in their shared humanity, discovers his own capacity for sin. In disclosing Father Brown’s secret Chesterton (1981: 461–67) tells us something about his art as a writer, excavating his own experience to enter the lives of his characters. Similarly in writing about being an actor, Callow says:

*‘To interpret human life requires unending observation, profound sympathy, wide reading, the ability to open yourself to strange and unexplored areas of your personality and to penetrate deep into the lives of others’* (Callow, 2004: 230).

Neuroscience may now be contributing to our understanding of the tacit dimension and our capacity for deep empathic connection in close relationships; the direct understanding that most of us have experienced

but which has proved difficult to explicate. (e.g. Cozolino, 2006)

I am only too aware of ranging widely over what I see as interconnecting issues and I realise that many threads could be teased out and pursued in more depth. However, in painting in broad brush strokes it has been my intention to try to gain a more holistic perspective for myself as a psychologist, a psychotherapist, a citizen of a troubled society and an inhabitant of an endangered planet. It seems important to me to return to fundamental questions in facing current challenges posed by the ‘mind-forged manacles’ of a narrowly defined, ideologically driven notion of science and practice, together with a limited view of cognition. For psychotherapists, these concepts are particularly restrictive to those who work in medicalised settings delivering managed care. It is sad to recognise that our parent discipline of psychology, contributes to these difficulties in so far as it fails to resist the domination of this single technical-rational model of science and practice. It seems imperative that as well as examining our own individualising therapeutic models, as previously discussed (Strawbridge, 2019), we ask these broader questions about the nature of science and practice. I believe that drawing on a range of perspectives may help us resist current constraints, situate our struggles in a wider socio-political context and find ways of contributing to understanding and addressing both the professional and the enormous global issues confronting us.

**Sheelagh Strawbridge**

Chartered Psychologist, Retired Counselling Psychologist/Psychotherapist  
sheelagh@strawbridge.karoo.co.uk

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# The past and future of psychiatry and its drugs

Joanna Moncrieff

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*From the Editor: This following article pointing towards non-drug treatments in psychiatry and describing a Norwegian intervention recently put into law, is reminiscent of an initiative by the Quaker movement, such as the York Retreat and other creativity-based rehabilitation approaches: so that the preferred treatment might over time come round in a circle to client-based, rather than drug-based treatments and healing environments.*

I AM DELIGHTED to be able to contribute to this issue on my work. It has provided a useful stimulus to think about what my ideas about drug treatment mean for the future of psychiatry, and more broadly for the care of people classified as having ‘mental health problems’.

## The implications of theories of drug action

My theory of drug action is obvious and undeniable on the one hand, but on the other it is profoundly challenging to mainstream psychiatry and its assumptions about the nature of mental disorder and how it should be treated. It is not possible to deny that psychiatric drugs cause mental and physical alterations to normal functioning, nor that these are likely to interact with the behaviour, expressions and feelings we refer to as mental disorders. This is what I have called the ‘drug-centred’ model of drug action, and if we accept that it is even credible, it challenges the currently accepted ‘disease-centred’ model that suggests that drugs work by modifying some underlying biological mechanism that is involved in producing the symptoms of the disorder (Moncrieff, 2008, Moncrieff & Cohen, 2005).

Some of the drugs prescribed in psychiatry have stronger effects than others. Most people who take a dose of haloperidol can feel the alterations it produces pretty quickly, but those produced by an SSRI, for example,

are much more subtle. An interesting property of mind-altering substances is that people are not always able to appreciate or communicate the changes they experience while they are under the influence of the drug. In David Healy’s fascinating study of the effects of droperidol in volunteers, for example, people were only able to describe the complex emotional and cognitive alterations they had experienced after the effects of the drug had worn off (Healy & Farquhar, 1998).

The characteristic ways in which drugs like neuroleptics change normal thinking, emotion and behaviour were welcomed by the psychiatrists who first prescribed them, who recognised that it was these very alterations that were responsible for the beneficial effects the drugs seemed to produce in people who were acutely psychotic or disturbed for other reasons. As French psychiatrist, Pierre Deniker, remarked, drugs that diminish people’s responsiveness to their environment in general can cause people who are in a psychotic state to lose interest in their delusional preoccupations (Deniker, 1960).

This drug-centred model of drug action was soon abandoned, however, not because of empirical evidence supporting the disease-centred model, but because it came to be profoundly challenging to psychiatrists’ views of themselves and their practice. Psychiatrists have always been deeply inse-

cure about their medical status. As general medicine started to discover effective and disease-specific treatments during the 20<sup>th</sup> century, it became increasingly important for psychiatrists to present themselves as having sophisticated treatments that targeted underlying biological mechanisms (Moncrieff, 2008). The idea that drugs target an underlying biological defect is one of the strongest justifications for claiming that mental disorders emanate from the brain or the body, just like other illnesses. Concrete evidence of a causal association between biological variations and symptoms of mental conditions is lacking, or at best inconclusive.

Challenging the idea that the drugs target an underlying disease or symptom-mechanism makes it difficult to maintain the notion that mental disorders are akin to medical conditions and to assimilate the practice of psychiatry to that of medicine.

Although the drug-centred model of drug action challenges the notion that mental disorders are medical conditions, it does not deny the utility of pharmaceutical interventions and hence of forms of medical knowledge. The drug-centred model suggests that the alterations some drugs produce may be useful in suppressing the manifestations of mental distress in some situations. This approach demands a better knowledge of psychopharmacology, as understood in a drug-centred framework, than most psychiatrists currently have. It demands that professionals have a comprehensive understanding of the phenomenology of drug-induced alterations and how these might interact with different forms of mental and emotional disturbance, as well as detailed knowledge of the results of effectiveness research and of all the possible complications that drug treatment can entail.

### **Mental disorder as a variety of social problems**

We have been so indoctrinated into the idea that mental disorders are problems that are located in individuals, just like other

medical conditions, it is sometimes difficult, even for the most critical of thinkers, to step outside this paradigm. Yet, mental disorders are not identified within an individual like diseases of the body. Mental disorders are problems of social groups or units. We too often think just of the individual's emotional state, whether they are depressed or anxious, for example, and not of what social expectations or obligations they are failing to fulfil that makes their emotional state problematic to them and to others. Similarly, when someone is diagnosed with schizophrenia, we focus upon their unusual beliefs, rather than looking at how these impact on their ability to get along in the world.

Historical scholarship, however, reveals how mental health problems are problems of communities. Modern psychiatric care and the legislative framework that surrounds it, emerged out of the mechanisms devised by local communities for maintaining social order and providing care for dependents. Before formal legal systems were introduced, early societies such as Anglo Saxon England, had informal ways of maintaining the safety and order of the community, dispensing justice and caring for those who were sick and incapacitated (Dershowitz, 1974). In England and Europe religious institutions played a role in providing care and sustenance for those who could not provide for themselves. With the dissolution of the monasteries under Henry VIII, a new state-sponsored system of social welfare was introduced in England called the Poor Laws. These laws, which were updated periodically over succeeding centuries, placed an obligation on local communities to care for their poor and needy and to help safeguard the safety of the community as a whole. Family members could apply to the Poor Law officials of their local area for food and clothes if the harvest failed, or if some other catastrophe meant they were unable to sustain themselves, including situations in which one of the family breadwinners became incapacitated due to a mental disorder. If the family were unable to look after the

individual concerned, the Poor Law officials could make arrangements for other local people to provide care. If the safety of the community was threatened, the officials would also ensure the individual was placed somewhere safe and secure, sometimes, if no local solution could be found, involving transfer to the nearest prison (Rushton, 1988). Wealthier people made their own arrangements, since they could not call on the resources of the state.

For the next few centuries, the Poor Laws provided the framework within which people without their own assets were cared for if they could not provide for themselves. Although most people remained in their own homes, and received aid or welfare known as 'outdoor relief', institutions such as Poor Houses and Workhouses, grew up to house those poor people who did not have homes, or who could not be supported within the family home. Michel Foucault and historians, such as Andrew Scull, have documented how the mental asylums and the practice of psychiatry emerged out of these institutions, providing supposedly specialist care for those who were too incapable or disruptive to be managed within the meanly-funded and brutally managed Victorian Workhouses (Foucault, 1965; Scull, 1993). The asylums continued the dual functions of the Poor Law system by providing care for those who could not provide for themselves, and safety for the community from individuals who were behaving in a threatening or disruptive manner, and were too mentally disturbed to be amenable to the dictates of the criminal law.

### **Modern mental health care**

When we look at the history of psychiatric care in this way, we can see that the modern system fulfils the same social functions. Behind the façade of treating an individual's medical pathology, what the system provides is care for those who are not able to look after themselves, and containment and policing of those who present a threat to the peace or safety of the community, but whose

behaviour cannot be addressed within the confines of the criminal law due to a lack of rationality or capacity.

Just as in pre-Victorian days, much of this system now operates outside the concrete institutions that exist to contain the most severely disturbed. The state spends considerable resources supporting people who are not able to provide for themselves in the form of sickness and disability payments for depression, anxiety and other 'common mental disorders'. The fact that these have increased, more rapidly than payments for other medical conditions, despite a huge increase in the availability of treatments, suggests not only that the treatments are ineffective, but that they miss the point (Viola & Moncrieff, 2016). What the system is providing is money and care for those who are unable to provide for themselves either temporarily or permanently.

Similarly, the idea that people diagnosed with schizophrenia or 'bipolar disorder' have a disease, provides the justification to lock them up against their will and forcibly change their behaviour with drugs, as if this process were as uncontroversial as treating pneumonia or lung cancer. Some individuals will later be thankful that measures were taken to contain their behaviour when they were 'not in their right mind'. Others never see the world quite as others see it, and for these people treatment means forcible modification of their behaviour in the interests of maintaining social peace, often on a life-long basis.

The current system, built as it is upon the 'myth of mental illness,' that is the unsubstantiated claim that mental disorder is just like any other medical condition, serves the useful function of keeping potentially controversial issues out of the public arena. Just as the rate payers of old complained that hordes of 'undeserving' poor took advantage of the benefits provided by the Poor Laws, people nowadays might begrudge their hard-earned taxes being paid to those who appear to be physically capable of earning a living. The state, too, occasionally becomes

alarmed at the extent of welfare costs, and makes tentative efforts to rein in disability spending from time to time, but it cannot afford to dispose of the system altogether. Sickness and disability benefits in the western world are overwhelmingly paid to those in manual social classes for whom decently paid, reliable work has disappeared over the last few decades. They are the price that western capitalism pays for the outsourcing of unskilled jobs and heavy industry to the developing world where labour is cheaper. This process has left devastated communities in its wake, rife with the demoralisation and insecurity that is labelled as depression and anxiety, so that individuals can be emotionally subdued using chemical suppressants, and any challenge to the system as a whole is stifled before it is even born.

### **The future: An alternative understanding of mental disturbance**

The future of psychiatry is thus intimately entwined with the future of society as a whole. As long as society needs a myth to keep the peace and manage disorder and discontent, then a system that fosters the idea that mental illness is a brain disease and that treatment is a sophisticated medical process will continue to flourish. People may benefit from the financial support the current system offers in the absence of opportunities for more fulfilling ways of living, but they may be harmed too by the implication that they are biologically flawed, chronically impaired, that their problems are beyond their control and that toxic chemicals represent a simple and benign solution.

Accepting that mental disorder is not a disease, but simply how some people are or come to be, did not used to be a particularly radical idea. Adolf Meyer, the leading American psychiatrist of the mid 20<sup>th</sup> century suggested that what we refer to as mental illness could be thought of as ways in which some people respond to the world around them and the challenges it can pose (Meyer, 1948). Some ways of reacting to the world may be, or appear by conventional stand-

ards to be, self-defeating, but they can still be genuine and meaningful. Meyer reflected the influence of psychoanalysis, but thinkers and practitioners from many other traditions have also described mental disorder as a meaningful response to life's challenges, or simply as 'ways of being human' (Jenner et al., 1993) that are not fundamentally different from ordinary, more familiar forms of behaviour. If we understand mental disorder in this way, how should we, as a society, respond? How are we to help people whose behaviour causes themselves distress, and how should society react to people whose behaviour causes harm or inconvenience to other people? What role, if any, should psychiatrists have in an alternative system?

### **Helping people to change**

First, if we understand mental distress as a reaction to life circumstances, then the first question we must ask is what is it about our current society that drives so many people to feel anxious or unhappy or that they cannot manage the demands that are made of them? Mental disorder can often be usefully seen as a 'signal to change', an indication that something is wrong, either with the nature of society as a whole, or with an individual's current way of life. Insecure employment, inequality of wealth, lack of meaningful opportunities for communal engagement all take a toll on people's emotional wellbeing. People in more advantaged situations may still be under immense pressure to perform and compete, to work long hours and to sacrifice time they could spend in more personally fulfilling activities. The solution to much current mental distress is not the tweaking of individual brain chemistry or cognitive inclinations, but political pressure to create a society that provides accessible opportunities for everyone to lead secure and rewarding lives.

Sometimes, however, an individual's reactions and behaviour seem to be part of the problem. There are many ways that people can be helped to change. Traditionally people turned to family, friends, colleagues or

religious leaders for guidance about how to conduct themselves and how to address obstacles and challenges in life. More recently, people have looked to professionals including therapists and councillors. Mind-altering drugs are another enduringly popular technique for changing one's mental state and behaviour. For millennia people have used drugs like alcohol and opium to dull grief, worry and sadness. Yet, it is far from obvious that drugs are useful in this sort of situation when consumed on a long-term basis.

Many of us have had a drink once or twice when we have had a shock or are trying to deal with a crisis in our lives, and we may well have found that the intoxication it produced brought temporary relief from our worries. Few people would think that long-term drinking is a sensible solution to any emotional or personal problem, however. Indeed, we only have to look at people who have problems with addiction to drugs like alcohol or heroin to see how using drugs to combat personal difficulties can become a problem in itself. Being under the influence of a substance that numbs emotions and dulls pain and anxiety makes people less likely to learn other techniques for managing emotions and getting by in the world, and prevents people from addressing underlying problems. Under the influence of something that diminishes one's sensitivity and reactions, people may be able to cope more easily with boredom and frustration and tolerate difficult, unrewarding or even abusive relationships.

There is no doubt from dozens of advertisements from the 1950s and 60s that drugs like the benzodiazepines were widely prescribed to mute people's discontent, in that period very often the discontent of women. An advertisement of that period for Serax (oxazepam) has the headline 'You can't set her free, but you can help her feel less anxious', showing a young woman shut in by prison-like bars with brooms and brushes as companions; by implication a young woman being frustrated and anxious – limited by the household duties.

But modern antidepressants like Prozac are presented in a completely different way. They are presented as a disease-targeting treatment, something that works by rectifying an underlying chemical imbalance, not by putting people into a mild state of drug-induced stupor. This way of promoting antidepressants has concealed their mind-altering properties. Although most SSRIs have only weak psychoactive effects, they do seem to induce a subtle state of emotional detachment or numbing (Goldsmith & Moncrieff, 2011). People speak of finding it difficult to cry, for example, and not being able to feel particularly sad or happy. Therefore it seems that, although less blatant than their predecessors, modern antidepressants may also help people accommodate to adverse circumstances that they might not otherwise tolerate. Although data from randomised controlled trials does not convincingly demonstrate that antidepressants are any better than placebo (Moncrieff, 2018), these effects may theoretically provide some short-term relief. However, this sort of suppression of feelings and reactions seems unlikely to help people to deal with life challenges effectively in the long run, and may help to perpetuate situations which are making people unhappy in the first place.

Today, psychiatrists meet many people who are struggling with difficult circumstances such as divorce, unemployment, debt or the feeling of lacking meaning and direction in life. Psychiatrists, like other professionals, can help people to weigh up the pros and cons of using different strategies to address their particular difficulties, including considering the use of mind-altering drugs. First, however, they must disabuse people of the idea that they have a brain disorder that requires a drug to put it right. Then they can start a conversation about what the individual's problems actually are and how these can be most effectively solved or managed. They can discuss honestly with people the possibility of using mind-altering substances to alter and suppress emotional reactions, acknowledging the limited evidence that this

strategy is helpful, the risks that it entails and sharing our accumulating knowledge of other people's experiences.

### **Forcing people to change**

What about those people whose behaviour is more severely disturbed, or disturbing to others? Sedative drugs of any sort are likely to quieten down agitated or aggressive behaviour and, in my experience, antipsychotic drugs can help diminish people's preoccupation and emotional investment in psychotic experiences. Sometimes this enables people to engage in other activities again, to look outward in a way they were unable to while psychotic. We should be mindful, however, that the way this effect is achieved is at the cost of dampening down people's interest and motivation as a whole, and that, quite apart from the serious physical complications of long-term antipsychotic treatment, this is a high price to pay for relative normality. As antipsychotic user, Peter Wescott wrote in the *British Medical Journal*, 'in losing my periods of madness I have had to pay with my soul' (Wescott, 1979).

We need to acknowledge that treating people with mental disorder is behaviour modification, not medical treatment. We are giving people drugs to change their state of mind and the behaviour that it is manifested in, not to cure an underlying disease or biological abnormality. If this is done against the individual's wishes, this is an exceptional situation that requires strong safeguards and ongoing scrutiny to ensure that it is properly justified.

We need to be quite sure, therefore, that forced treatment is completely necessary and that no alternatives are possible. Yet we know that some people can recover from psychosis naturally, without drugs and have a good long-term prognosis (Bola & Mosher, 2003; Wunderink et al., 2013). Non-intrusive social support and activities to maintain some engagement with the world would seem to be helpful in this situation, although we need more research in this area (Cooper et al., 2019). We need to have facilities,

therefore, that enable people to be treated without antipsychotics, if this is what they want, and to wean off antipsychotics safely after recovery where these have been used.

This is not a Utopian dream – in 2015 Norway passed a law that mandated the introduction of such facilities (Whitaker, 2017). In Tromsø, in northern Norway, a six-bedded unit has been set up for people who wish to avoid using antipsychotic drugs altogether, or who wish to reduce them in a gradual and supported way. The unit provides therapeutic activities including art therapy, music therapy and outdoor exercise to support people during their stay. People can come back more than once, if they want to take their medication reduction in stages. The directors of the unit also have the ambition to extend the service to provide community support following discharge, in recognition that surviving without medication, or getting off medication, may be a process that takes place over several years. Although such services may be expensive in the short-term, the costs of maintaining people who are permanently impaired by the effects of antipsychotics are likely to offset this in the long-run, even if it is only a small proportion of people who can be helped to avoid long-term drug treatment.

Where people remain acutely psychotic for long periods, then I think antipsychotic treatment should be tried, sometimes even if this is against the individual's wishes. This decision should not be a medical decision, however. Over-riding someone's wishes in this way should be a legal decision, where evidence of the benefits and harms for the individual, their family and society is all weighed in the balance. It must also be subject to ongoing legal scrutiny.

The use of potentially harmful drugs requires personnel that have some medical and pharmacological expertise, so psychiatrists can play a role in this scenario. Again, however, what is important is an acknowledgement of the actual nature of the activity; that 'treatment' in this case involves forcible modification of behaviour, often princi-

pally in the interests of other people rather than the individual, which is ultimately a socially-driven activity and not a medical one.

Whether such changes in our approach to mental disorder will come about depends on whether society is willing to confront the complexity of addressing the huge variety of social difficulties that we currently bundle under the label of ‘mental disorder’ in

a more transparent way, or whether it prefers to keep sweeping it under the medical table. In the meantime, critical psychiatrists can only continue the difficult task of trying to have an honest dialogue with patients within a framework of understanding that has been constructed to disguise the truth.

**Joanna Moncrieff**

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# Exploring integrating mindfulness Chinese Calligraphy Enhanced Therapy (CCET) as a complementary psychotherapy to bridge underrepresented Chinese clients in the UK

Juan Du

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**A**CCORDING to the National Institute for Mental Health in England (2003), Chinese clients tend not to request support from available psychological services and have been described as an ‘invisible population’ (Weich et al., 2004). However, this does not mean that Chinese people in the UK do not experience mental health struggles or need psychological therapy support (Bebbington et al., 2007).

There are obvious obstacles for Chinese clients to access psychological therapy, including therapists offering services that do not meet the clients’ social, cultural and linguistic needs (Dowrick et al., 2009; McLean et al., 2003); clients’ language barriers and a lack of awareness of mental health services within the minority community (Nagayama, 2001); perceived discrimination from professionals (Suresh & Bhui, 2006). Therefore, the need for psychological therapies to be culturally appropriate and responsive to Chinese clients has been recognised (Zane et al., 2004).

Chinese Calligraphy Handwriting (CCH) as a mindfulness-based brush meditation intervention has been practised for thousands of years in China, CCH traditionally uses a natural ink stone with water added to generate ink, which is then applied on rice paper in strokes, using a soft-tipped brush, in the form of the structure of Chinese characters (Kao, 2000). To Chinese people, calligraphy practice is not just a national art and cultural-historical heritage (Qian & Fang,

2007), it is, in fact, a well-known and familiar way of achieving relaxation and harmony of the body and the mind, which are also essential for physical and psychological functioning (Davey, 1999).

Chinese Calligraphy Enhanced Therapy (CCET) is a complementary therapy designed as a culturally sensitive and non-threatening approach to bridging Chinese clients’ access to psychological therapy. The four sessions of CCET is an innovative integrative approach which also draws on cognitive theory, mindfulness theory and psychoanalytic theory. The design is inspired by my clinical work with Chinese clients in the UK and is also based on personal experience of psychotherapy practice and my role as a mindfulness teacher for community services.

The research project method and data analysis are in progress, but it will be using a qualitative theory-building case study method, it will not directly aim to address the effectiveness of the CCET approach itself, but instead will hope to build an explanation for western psychotherapy field of how the approach works.

I hope this study will provide benefit for culturally sensitive psychological therapy access for the Chinese Community in the UK, improve the awareness of a cultural-sensitive psychological approach in the psychotherapy community and promote race equality in mental healthcare services in the UK.

**Juan Du** is a bilingual Mandarin and English speaking psychotherapist, Mindfulness teacher, currently studying a doctorate in Counselling Psychology and Psychotherapy at Metanoia Institute. This research is part

of her doctorate thesis. For further enquiries about this study please contact:

Email: [juan.du@metanoia.ac.uk](mailto:juan.du@metanoia.ac.uk)

Website: <https://juanduthery.co.uk>

Twitter: @ChineseMentalHealth

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The application of technology to rare human conditions

## What it means to see the neurons 'rush into the Brain'

Letizia De Mori

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*Future topics. The author of the following vignette will be invited to develop her short article in the Issue on Special contexts for psychotherapy in 2021–2022, with reference to emotional as well as cognitive and motive experience of these clients.*

**A**S A Neuropsychologist Researcher I study how the brain works mostly in the field of rare genetic syndromes.

In practice, my work involves studying neurons active in different areas of the brain using the comparison of analyses between cognitive assessment data results (neuropsychologist tests) and the neuroimaging data (through the fMRI – functioning Magnetic Resonance Imaging).

The most important part of my job is first to look at the functioning of the brain, especially of children with rare genetic conditions, to investigate their strengths and weaknesses. I study how the brain is functioning and see neurons literally coming to life with different tasks that the client is completing. I then devise cognitive rehabilitation programmes to improve functioning.

This is very rewarding work. Everybody can wish to improve their quality of life, their limits, their edge: themselves! I see the children as our future, they are a step of us in the future, our projection in the future. Even

with rare genetic syndromes, the brain is plastic as as in typical development, and such children deserve a chance as with anybody else, to improve further.

To communicate to parents good as well as bad results it is the most difficult part of my job. In these moments the professional as a neuropsychologist, enters people's lives and then stay there for life. Finally the families have answers to their many questions, doubts, and fears. At the the same time it is amazing to see how often an initial dread becomes the will to transform a limit into an opportunity, for the family and their child.

To watch the 'neurons rush into the Brain' is also to have the honor to be part of a common aim: to build the future, for us all, and for these clients and their families in particular.

**Dr Letizia De Mori**  
Neuropsychologist Researcher  
BPS – Chartered Member

# Student mentoring reports

*Mentoring opportunities are regarded as key stages in the development of future psychologists, by the Psychotherapy Section and by the BPS as a whole.*

## An A-level student's learning from a psychology conference: My experience in attending my first psychology conference

Ting Ting Lin

**M**Y NAME is Ting Ting Lin and I'm an A-level student, one of the subjects being psychology which is really great considering I had no idea what it was about beforehand. After passing my first year in A-levels my interest in psychology developed and now I can proudly announce that I know a nice handful of facts to impress my family during visits.

But in order to continue my studies at a degree-level, I also knew that I'd have to have more experience outside of lessons in order to really make my personal statement stand out so I attended my first conference; the topic being, 'Inclusion and Exclusion of therapeutic relationships'. The speakers on the day each gave a presentation surrounding the idea of how to better understand psychotherapy and the barriers that exclude marginalised groups.

Although there were some terms that I didn't quite understand having only studied psychology at a surface level, I found the details of each presentation interesting in their own right. I commend the speakers for going into such depth and detail about a subject that I had thought to be a niche; the speakers covered areas from politics to complaints to issues within therapy itself.

One of the speakers that caught my attention was Dick Blackwell's presentation

called 'Liberation Psychology, the Social unconscious...'. Blackwell himself is an accomplished writer in the field and in this particular case, he looked upon the subject from a political perspective whilst also taking into account the matters of social constructs and how society can consciously or unconsciously exclude others.

Additionally, another speaker that I rather enjoyed listening to was the presentation by Ms Isabel Clark called 'Comprehend, Cope and Connect...'. Ms Clark is a consultant clinical psychologist who spoke about trauma and things of the like. Her enthusiasm for the topic was childlike and charming, making her very fun to listen too. In her presentation she covered things such as different ways to approach clients, taking into account their culture, boundaries and upbringing.

I also spoke with one of the students and her poster which encouraged Chinese calligraphy as a form of therapy. Since I am Chinese as well, I was (not being biased!) drawn to this topic and I was able to learn more about the vast difference between western and eastern culture and how both deal with mental health issues, namely depression. We spoke about how it could be possible to overcome some of the stigma surrounding depression in the east and that

calligraphy could serve as a great therapeutic tool in doing so.

Towards the end of the day, as if to prove the point of the entire conference, we gathered in a large circle and those who spoke encouraged those who didn't to voice their opinions, thoughts and feelings, which was, rather ironically, their way of taking the first steps into inclusiveness. There was a debate and I found my head turning from speaker to speaker as they all raised valid points that I hadn't even thought about before; it was the end discussion that gave me a true insight as to how life and professions function and work for the entire field of psychology.

Overall, the day was incredibly interesting, especially for my first conference. Naturally, I wasn't too sure what I should expect and worried that the content would be far too advanced for me to understand. Instead, I was pleasantly surprised by most of the speakers and found myself agreeing or disagreeing (internally, of course) on the points that they made; which, for the most part at least, meant that I was properly engaged. Despite the content not being entirely relevant to the topics I'm learning at A-level, I still felt its effect on me and my opinion towards psychology as a whole.

## Student mentoring reports

# An A-level student's experience of an intensive BPS Mentoring Placement: What makes a psychologist? – A beginner's voice

Wiktoria Dziurawicz, with contributions from Ho Law

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*This article aims to describe what makes a good psychologist from the perspective of a student at the beginning of her professional journey. It also describes the role and practices of psychologists based on her experience of participating in a mentoring programme in Cambridgeshire, England, UK.*

*Keywords: education, evaluation, mentoring, psychology, training, work experience.*

**I** AM A young ambitious student studying psychology at A-level at Hampton College, Peterborough, Cambridgeshire, with high hopes and big dreams to become a psychologist of the future. For my college work placement week in 2019, I wanted to gain experience of working with psychologists. I know owing to various reasons such as client confidentiality in the practice, it is very difficult to gain such working experience.

I was delighted to learn that there was a student mentoring programme\* supported by the British Psychological Society in the region. The programme took place in Allia Future Business Centre – a modern building in Cambridgeshire, designed with community and collaboration in mind with a strapline, 'For people, planet and place'. The Centre is a home for several organisations, professionals, social entrepreneurs and individuals with an aim to make positive change and address the most pressing global and local challenges by developing innovative and effective solutions that can transform peoples' lives. As part of the application process, I was asked to think about the role of psychologists and write an essay about 'What makes a psychologist?'

The role of a psychologist is to study and understand human behaviour as well

as applying vital knowledge to help other individuals who may be struggling with mental difficulties such as depression. To me, psychologists are the future for our generation because of the huge demand of expertise that is required who can help these people, understand their difficulties and improve wellbeing. Psychologists also do fascinating research to discover new knowledge about human mind and behaviour which could lead to a change of approach in many areas of application – from psychoanalysis, behavioural therapy to cognitive behavioural therapy, all psychologists contribute by helping people, as well as creating research and theories which can have a major impact on today's society.

Applications of psychology include improved employee productivity as a result of work from occupational psychologists; student happiness in school from positive psychologists; crime prevention and reduction and improving policing from the contribution of forensic psychologists. All these fields require a psychologist.

However, what makes a *good* psychologist? I would say a good psychologist is a psychologist who is able to help, contribute to today's society *and* be the future of psychology. First, they should be able to

listen and relate to a wide range of people (that is the key and most important skill of a psychologist). Editor: readers please note! This applies to all areas of psychology as listening skills will allow them to build a rapport with their clients – in both research and practice. For without trust, the collaboration of participants is curtailed, leading to inaccurate conclusions in research or unsuccessful outcomes in treatment.

Second, psychologists must have good communication skills to communicate with clients and other professionals, to articulate their thoughts, rationale and action plans effectively and disseminate their knowledge and research findings to diverse stakeholders.

Third, analytic/problem-solving skills – a good psychologist should be able to draw inferences and examine the information they gather and use that information to help create solutions for change of behaviour or draw valid conclusions in the research that they are conducting. Often, progress is slow (certain longitudinal studies may take years) therefore it is very important for a good psychologist to have patience when it comes to their work. Very often, individuals and families seek the help of a psychologist because they are experiencing difficulties and they are not able to solve the problems themselves. Psychologists therefore must have problem-solving skills and be solution focused which may take creativity and ingenuity to help their clients.

I felt that I was lucky to be offered a place after the initial draft essay and two interviews. I was told that the intensive interviewing process was already part of the mentoring process with objectives to enable students to experience what it would be like in applying for a professional psychologist job in the real world, in a safe and learning environment as feedback was provided afterward.

During the mentoring week, I had the privilege to work alongside a chartered and registered psychologist Professor Ho Law, a well-established psychologist with more than thirty years' experience.

Each day of the week was packed with activities; some of the highlights were:

Day 1, after the health and safety briefing in the morning, I learnt how to conduct a SWOT analysis to establish areas of weakness and strengths as well as opportunities and threats for myself and the organisation.

I was instructed to prepare a questionnaire for a semi structured interview with Dr Hau a forensic scientist to take place the next day. The objective was to appreciate the multi-disciplinary work where and how the police, forensic psychologists and scientists work together for crime investigation within the criminal justice systems.

Day 2, involved a discussion with Professor Law of the in-depth interview with Dr Hau I gained knowledge about the differences between a forensic psychologist and forensic scientist and how they worked together to assist CJS to achieve its objectives.

Day 3. We had another multidisciplinary meeting with local community leaders, social entrepreneurs and other stakeholders including Jackie Chibamu, director of African Business Network, Katrina D'souza, iDream Academy, Ghislaine Regout, a psychologist in the Netherlands and Mark Argent, a psychoanalyst at Cambridge. Both Ghislaine and Mark were also musicians. The meeting was conducted both face to face at the Centre with some of the stakeholders joining the discussion over an internet platform. The aim of the project was combining music and narrative approach in an art project for community groups and organizations such as schools and hospitals who would gain the health benefits from the power of music and story telling integrated in a structural way.

Day 4. We had an awayday to Cambridge. Professor Law was showing me around places, spaces and various Colleges of the University, explaining their histories and significance in the scientific discoveries. I visited Cambridge many times, mostly to

do shopping with my friends. I had never been into the University. Professor Law was trying to inspire young people to raise their aspiration for the excellence which he said the so-called 'Cambridgeness' represented. Despite this encouragement, I did not plan to study at Cambridge University. I applied to study BSc Psychology at Nottingham Trent University instead because I found that the content of the course was more suitable to my interest. To me, it does not matter about status and privilege if I am happy and satisfied with what I do; that is the most important thing. In the afternoon we had another meeting with Mark Argent at the University Centre Grads Café on the topic of psychotherapy and spirituality. I was enlightened by Argent about the importance of not labelling clients. According to Argent, 'Not labelling' is crucial to enable the wellbeing and treatment of clients. I think a good psychologist should know about the stigma which comes behind a label. This could lead to set backs with further anxiety and stress to the clients.

Day 5. Friday was the final day of the work placement. I had to document my learning of the week (including revising and writing up this essay) and give a presentation about the whole weeks' experience in a PowerPoint at the Centre which I found very challenging. I was happy to comply as I know communication is an important part of what makes a good psychologist. It was important to rehearse and practise in a safe environment, said Professor Law, so that one could improve from constructive feedback before the 'real thing'.

In Professor Law's company I have understood that psychology is very advanced and consists of many different branches of specialism for example clinical, counselling, forensic, health, occupational and sport & exercise psychology. The important job of being a psychologist is irreplaceable today as groups of experts from different fields can come together and work on projects which can benefit and help people of all ages and

from different backgrounds. An example of this was the Art and Music Project, bringing many stakeholders from Cambridge, Peterborough and the Netherlands together to create a big community project which will benefit young and older people. This project shows the importance of collaboration – psychologists coming together, combining all their skills to help boost people's confidence, health and wellbeing.

Good psychologists do not only create research, but also practise what they know. They work in diverse settings with people who struggle with mental health, CJS and multiple stakeholders to create a safer and healthier community. They do this by bringing in their knowledge, skills and wisdom. Overall a good psychologist should have these skills – analytical, building rapport, communication and patience. After the week of work experience with a psychologist at work, I should add on the list, leadership, ability to work independently and in an interdisciplinary setting. I believe that psychologists are the future for our generation as they are not simply studying human behaviour and the theory of mind, but also applying the vital knowledge to help people of all ages, diverse organizations and build a safer and healthier community.

#### **\*Note**

The mentoring programme runs each summer to provide shadowing and work experience to students or trainees in psychology who want to learn about various specialist areas in practice. It was initially set up as part of the BPS East of England Branch (see separate article) in its foundation year with the aim to engage volunteers to raise awareness of the application of psychology which was implemented locally by Ho Law (the founding Chair of the Branch) and continuously runs with support of various BPS member networks and local Colleges. The 2019 programme was supported by the Psychotherapy Section and Hampton College at Peterborough. For further information, please contact drholaw@gmail.com

# The application of technology to rare human conditions

## What it means to see the neurons 'rush into the Brain'

Letizia De Mori

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with rare genetic syndromes, the brain is plastic as as in typical development, and such children deserve a chance as with anybody else, to improve further.

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**Dr Letizia De Mori**  
Neuropsychologist Researcher  
BPS – Chartered Member

# Contact details and further information

The Hearing Voices Network [www.hearingvoices.org](http://www.hearingvoices.org) Also covers 'visions'.

Experts by experience (general) Choice Support website  
<https://www.choicesupport.org.uk/about-us/blog/experts-by-experience>

Experts by experience (BPS Division of Clinical Psychology)  
[https://www.bps.org.uk/sites/www.bps.org.uk/files/Member Networks/Faculties/Intellectual Disabilities/Easy read Experts by Experience Strategy 2018 2019 draft.pdf](https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Faculties/Intellectual%20Disabilities/Easy%20read%20Experts%20by%20Experience%20Strategy%202018%202019%20draft.pdf)

## Authors of articles in this issue

[psychotherapyreview@bps.org.uk](mailto:psychotherapyreview@bps.org.uk) (Erica Brostoff, Editor)  
[drphilcox1@bps.org.uk](mailto:drphilcox1@bps.org.uk) (Dr Philip Cox, Chair)  
[matthewpugh@nhs.net](mailto:matthewpugh@nhs.net) (Matthew Pugh)  
[john.adlam1@btinternet.com](mailto:john.adlam1@btinternet.com) (John Adlam)  
[joy.goodall.leonard@gmail.com](mailto:joy.goodall.leonard@gmail.com) (Joy Goodall-Leonard)  
[helen@psychological.me.uk](mailto:helen@psychological.me.uk) (Helen Molden)  
[jesswalling@hotmail.co.uk](mailto:jesswalling@hotmail.co.uk) (Jess Walling)  
[lbeutler@paloalto.edu](mailto:lbeutler@paloalto.edu) (Beutler, Castonguay and Constantino)  
[steve.heigham@gmail.com](mailto:steve.heigham@gmail.com) (Steve Heigham)  
[g.regout@hotmail.nl](mailto:g.regout@hotmail.nl) (Ghislaine Regout)  
[sheelagh@strawbridge.karoo.co.uk](mailto:sheelagh@strawbridge.karoo.co.uk) (Sheelagh Strawbridge)  
[j.moncrieff@ucl.ac.uk](mailto:j.moncrieff@ucl.ac.uk) (Joanna Moncrieff)  
[juan.du@metanoia.ac.uk](mailto:juan.du@metanoia.ac.uk) (Juan Du)  
[demori.letizia@gmail.com](mailto:demori.letizia@gmail.com) (Letizia de Mori)  
[tingy009@gmail.com](mailto:tingy009@gmail.com)  
[drholaw@gmail.com](mailto:drholaw@gmail.com) (Wiktoria Dziurawicz)

## Articles and books of interest

Solms, M. (2021). *The Hidden Spring: A journey to the source of consciousness*. Profile Books. Affective neuroscience. This offers a comprehensive new approach to affect as the determining factor in human development and pathology, marrying neurophysiological and psychoanalytical research and concepts. Will be reviewed in next Issue of *Psychotherapy Section Review*.

## Collaboration and internal voices

Ribeiro, E. et al. (2013). How collaboration in therapy becomes therapeutic: The therapeutic collaboration coding system. *Psychology and Psychotherapy*, 86, 3, 294–314.

A number of useful articles if you google 'collaboration' and/or 'voices' in therapy.



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