say we stand here on the edge of a mystery? We cannot know how God might exist both outside and inside space and time. Accepting cognitive dualism creates space at the edge of reason for not knowing and Scruton is content to live with this uncertainty.

He believes we must live in awareness of our mortality and acceptance of death as our completion and that herein lies our salvation, not in the notion of a physical afterlife but seeing ourselves as part of the eternal order. He suggests a mystical afterlife where 'God is the all-knowing subject who welcomes us as we pass…beyond the veil of nature [and return] to the place whence we emerged…[which unites us] with the soul of the world' (p 198).

Scruton writes in a discursive, conversational style, reflecting on his own earlier writings as well as that of a wide range of other thinkers and sacred texts, during a process of personal discernment through which he arrives at a realisation of his own preference for a theological elaboration. We're invited to follow the byways of his quest and to reflect on the complex recursive web of his sometimes elusive ideas in pursuit of the transcendent dimension, the sense of the sacred, that endows the world with a soul. Although at times challenging, it is a highly erudite, thoughtful and rewarding read.

## Notes

[1] Masaccio, *The Expulsion from Paradise*, Florence, Santa Maria del Carmine.

**Diana Pringle**

## Doctoring the Mind

Richard Bentall. (2009) London: Penguin

This compelling and closely argued book sets out to provide a rational critique of psychiatry, on the basis that it is unscientific and unsuccessful. The book provides both a passionate plea for a more humane approach to mental suffering and a careful critique of the science underpinning a biological interpretation of mental distress. Complicated concepts are described in easy to understand terms, making it suitable for anyone with an interest in what is commonly described as mental illness. The book makes for particularly important reading for existential psychotherapists. Although the notion that human behaviour is meaningful and relational forms an essential part of existential thinking, we may be inclined to overlook this in cases of psychosis, viewing this within a medical rather than therapeutic paradigm. This book is a powerful reminder to focus on the person rather than the brain suffering mental distress.

The first chapter of book demonstrates the while there have been dramatic improvements in physical health over the last century there is no evidence that psychiatric treatments have led to improvements in the mental health of the nation. In fact the prognosis is better for schizophrenia in developing countries than in developed countries.

The following three chapters provide a detailed description of how the medicalisation of mental suffering has evolved, an approach which views patients as bearers of symptoms, as opposed to people with histories. The chapters outline Kraepelin's development of psychiatric diagnoses and the revival of his thought by the neo- Kraepelians. These chapters also provide horrifying accounts of psychiatric treatments prior to the discovery of chlorpromazine, treatments delivered by men in white coats who wished to be seen as real doctors delivering physical therapies. They discuss the discovery of chlorpromazine and the development of the chemical imbalance theory of mental illness, including the dopamine theory of schizophrenia and the serotonin theory of depression.

The book goes on to challenge some of the central assumptions of modern psychiatry: the notion that there are discreet mental illnesses with a clear underlying pathology and the notion that mental illnesses are genetically transmitted brain diseases. There appears to be a continuum of psychological health from people with normal functioning to people with psychosis, and people with psychosis often have symptoms associated with both schizophrenia and bipolar disorder. Bentall wryly concludes:

> *My own view is that most psychiatric diagnoses are about as scientifically meaningful as star signs, a diagnostic system which is similarly employed to describe people and predict what will happen to them, and which enjoys a wide following despite compelling evidence that it is useless.*
>
> (p 110)

His thoughts on the belief in a genetic underpinning to mental illness are similarly damning. The search for genetic explanations for these so-called diseases and treatments associated with this (altering patients' brains and now medication) have blinded doctors to patients psychological and social needs, causing a great deal of harm to patients. Whilst there is some evidence of a genetic component to psychosis (recent studies showing a 22.4% concordance rate for monozygotic twins) many studies, particular early ones, used a number of tricks to overinflate their findings. Furthermore, attempts to isolate genes for schizophrenia and bipolar disorder have been unsuccessful. By contrast the evidence linking sudden childhood trauma including violence and sexual assaults to psychosis is compelling. To what extent are families then responsible for their child's psychosis? In a sensitive

discussion, Bentall points to firm evidence that critical and over protective relatives can exacerbate, rather than cause symptoms, with an attitude of 'laid back indifference' associated with the best outcome. Nevertheless, he also discusses one study demonstrating a link between critical and over protective parents and development of psychosis. This study also finds that children of parents who also spoke in a way which was fragmented, vague and contradictory are especially likely to ~~be~~ develop psychosis. This is very much in line with Laingian thinking. He also points to studies linking insecure attachment and psychosis.

Evidence of the differences between the brain structure and brain chemistry of psychotic and non-psychotic is also decisively challenged. Whilst studies have demonstrated a difference in brain anatomy between schizophrenic patients and others, no account has been taken in these studies either of the effect of medication on the brain or of the effect of trauma, known to alter its shape. In terms of brain chemistry, studies into the dopamine theory of psychosis have come to inconsistent conclusions.

In place of this biological approach, Bentall provides an alternative theory, suggesting that very low self-esteem, a tendency to jump to conclusions and difficulties imagining what others are thinking and feeling all play a role in paranoid delusions. This style of thinking is likely to develop with early insecure attachments and victimisation, experiences which create a sensitivity to further adverse experiences through a sensitisation of the dopamine system. This reverses the traditional model of causation of mental illness. Rather than an overactive dopamine system causing ~~of~~ mental illness, this overactive dopamine system is a consequence of life experiences. The notion of existence preceeding essence very much comes to mind here. Interested readers may want to read Bentall's earlier book , *Madness Explained* which provides a much more detailed account of his psychological explanations for psychosis.

Bentall goes on to to question the benefits of treatments for both psychosis and depression. In terms of SSRIs, he demonstrates that a majority of the trials submitted to the FDA showed negative results and most had serious methodological flaws, including patients being given sedatives alongside the anti-depressants, and clinically insignificant differences compared with placebos. Bentall acknowledges that anti-psychotics, by contrast, are evidently effective for many. However, both first and second generation anti-psychotics have very serious and potentially dangerous side effects. Whilst the pharmaceutical industry has been at great pains to demonstrate the advantages of second generation drugs, the most widely published trial used to support this, once again, has serious methodological flaws. A medical profession which swears to do no harm needs to restrict its prescription of these drugs to people who will benefit from them, but this does not

appear to be the case. About 1/4 to 1/3 of patients don't and won't respond to any anti-psychotics. Despite this, these patients are given different drugs and higher dosages.

Furthermore, the effectiveness of early and persistent use of medication in the case of psychosis is open to challenge. Whilst longer delays between the onset of symptoms and start of treatment have been associated with increased probability of long-term disability, we need to take into account the difference between patients who seek early treatment verses those who delay it. Patients with a sudden onset of symptoms have a better prognosis than those whose symptoms develop gradually, and it is the former group of patients who are likely to find themselves receiving medication quickly. Arguably it is the patient group, rather than the treatment, which accounts for the different prognosis. Yet the strongly held belief in early intervention is now being used as a basis for an argument that people at danger of becoming psychotic should be treated before they have symptoms. Given the serious side effect of anti-psychotics, this is a very worrying development.

Much of the research into effectiveness of anti-psychotics themselves is problematic. Most research has been carried out on people who have had a number of episodes of psychosis and who have been been medicated, sometimes withdrawing them from medication to place them on a placebo. Given the powerful effects of anti-psychotics on brain chemistry, it is strongly arguable that it is this, as much as the underlying psychosis, which accounts for the research findings. The six studies that have followed up patients suffering their first psychotic episode for at least a year found no evidence that patients who were medicated did any better than those who were not. Although based on a small number of studies, this appears to be an extremely significant finding, fundamentally calling into question the seemingly unquestioned assumption that psychosis requires medical treatment.

In the final chapters, Bental considers what the meaning of all this might be both for the practice of psychiatry and for psychological/therapeutic alternatives. These sections, with their emphasis on autonomy and the centrality of the therapeutic relationship, hold particular interest for the existential practioner. Bental is not an existential therapist but his approach to therapy is very much in line with a phenomenological approach:

> *The task for the clinician faced with the patient who lacks 'insight' is not to dispute his patients' explanation for his symptoms, but to understand these explanations, to explore their origins and to respect them as genuine attempts to account for experiences that are puzzling and frightening.*
>
> (p 280)

In terms of therapy Bentall concludes that good therapeutic relationships

may be the single most important ingredient in psychiatric care. As he points out, it is an indication of how far psychiatry has taken us from ordinary empathy and common sense that we have forgotten that suffering is usually caused by unsatisfactory relationships with others. It is also an indication of the degree to which existential therapists have departed from existential principles that we accept a biological underpinning to severe cases of human suffering.

In the final chapter Bentall highlights the dangers of coercive treatment, arguing that this coercion should only be exercised when doctors know what is in the patient's best interests. The history of psychiatry strongly suggests that this has not been the case. The purported lack of insight used to justify this coercion can also be questioned, given the questionable nature of psychiatric diagnoses and the dubious efficacy of medication. In the place of coercive psychiatry, Bentall argues for a recovery orientated, autonomy-enhancing approach, in which drugs are prescribed according to their emotional and cognitive effects, with an acknowledgement of the limitations in our understanding of this, an awareness of their side effects and a willingness to discontinue them if need be.

I have found this book an inspiring read, making me consider what existential thinking in particular has to offer psychotic patients. It would be good to continue the work of R.D. Laing and Jo Berke amongst others with intensive therapeutic impact founded on existential principles. I don't believe that therapy needs to leave cases of serious suffering to the medical profession. Arguably it is here where our input is most needed.

**Marcia Gamsu**

## R.D.Laing – 50 years since *The Divided Self*

Theodor Itten and Courtney Young (eds). (2012). Herefordshire: PCCS Books

> *'If I could turn you on, if I could drive you from your wretched mind, if I could tell you, I would let you know'*
>
> (Laing, R.D., 1967: p 234)

This is a well-presented book, over 331 pages, with 4 pages of photographs, not including a useful 15 page reference list, a 3 page bibliography and a 13 page index. Laing's legacy is a charmingly mixed bequest, and this rich and varied selection could, perhaps, make your therapeutic work allied, and re-stimulated by the thought of R.D.Laing. So, the brief biography, and quotation pages, situated in the final pages of the book make vital reading. The main text of the book is divided into four sections, 'Conversations';