

issues to the fore, though a more dispassionate, objective stance would have conveyed the gravitas of the author's argument just as successfully I feel.

This book succeeds in being a catalyst for scrutiny of the most fundamental questions of psychotherapeutic practice. With state intervention imminent, now more than ever practitioners are required to consider their individual practitioner status, as well as the motivations of those who represent, govern and regulate them.

Dany DuBois

Rational Emotive Behaviour Therapy In a Nutshell

Michael Neenan and Windy Dryden (2006). London: Sage

The heart has its reasons of which reason knows nothing.

Blaise Pascal (1623-1662).

The book opens with the well-known quote from Epictetus, a much earlier philosophical source than that quoted above: *'People are disturbed not by things but by the view they take of them'*.

As agreeable as this latter proposal may be (especially for those of the existential persuasion), it is the only reference to philosophical tenets in the book: in spite of this paucity of allusions, the authors and the founding practitioner Albert Ellis both insist that clients need to take on a *'philosophical'* outlook about their distress. It is unclear as to which philosophical school they are referring (one might infer the Stoics).

It is proposed that this statement demonstrates the *'...cornerstone'* of the REBT (CBT) model: one's current situation is not a product of intrapsychic conflict over unacceptable historical antecedents, but (*'largely'*) a result of one's attitude towards any given experience (one can only speculate as to what reservations are being held here).

Laudable as this statement might seem, a single epithet from a philosopher's oeuvre does not suffice as a description of the human condition.

This text fulfils its stated aim: *'...to cover all of the key elements of REBT theory and practice in as few words as possible'* (p.1). This is the very reason this reader would recommend it to anyone looking to review or clarify the model in question. The authors use one case example throughout the book to demonstrate the method, which assists in the clear and concise discussion. The language is simple and devoid of psychotherapeutic jargon.

At regular junctures, and in the final bibliography, references are recommended for those who would wish to read further on the subject of the paradigm.

By virtue of these qualities, I think the book would appeal to practitioners and lay people alike: anyone who has an interest in familiarising themselves with the basics of the various CBT approaches now in use.

The ‘*Counselling in a Nutshell*’ series seeks to ...*provide concise introductions to the key elements of theory and practice underpinning major therapeutic approaches*. The current portfolio includes psychodynamic counselling and person-centred counselling.

As to the content of the book: Albert Einstein once reportedly commented: ‘*everything should be made as simple as possible, but no simpler*’. The simplicity of the format of this book is not a problem: the simplistic view of (all) the CBT models IS very much a problem.

The CBT approach is woefully reistic: human beings are represented as somewhat mechanistic entities. If their ‘*faulty thinking*’ can be corrected, they can enjoy the benefits of a ‘*rational*’ perspective that can modify (with a lot of ‘*trying*’ and ‘*hard work*’) their emotional experience as well as their behaviour (and possibly their ‘*philosophy*’). In this perspective, there is no acknowledgement of the wonderful ambivalences or contradictions that qualify human existence as perceived by other philosophies and psychotherapy models.

Furthermore, some concerns may be raised as to the proposed definitions of what qualifies as ‘*irrational*’: there are many religious beliefs, as well as cultural norms, that might fall into this category as it is outlined here. From an existential perspective, there are many aspects with which one might take issue in the CBT paradigm.

It is fundamentally Cartesian: the ‘*mind*’, ‘*inside*’ the person, is invested with the power (and justification) for ruling the emotions and behaviour of the individual. With respect to this very fallacy, Cohn comments: ‘*In Western thinking, reason and feelings have been considered predominantly as separate functions...Heidegger views this as another dualism to be challenged: reason and feelings are both aspects of existence and cannot be separate*’” (Cohn, p.61, 2002).

There are further distinctions between existential thinking and the theory of emotions as stated by REBT. According to the Dryden and Neenan text, ‘*Rational thinking leads to a reduction in the intensity, frequency, and duration of emotional disturbance*’ (p.7). The ‘*disturbing*’ emotions are then categorised as unhealthy or inappropriate.

There is no sign of the appreciation that emotions, as well as perception, cognition, feelings and intuition are *disclosive*: they reveal to us how we find ourselves in the world. Heidegger discusses this ‘*attunement*’, as it is translated, in *Being and Time* (Heidegger, 1962). This disclosiveness, this attunement, is valuable information in recognising how we are being, how we are conducting ourselves, how we are *with* others and how others are *with* us.

It might be suggested therefore, as does Rollo May (May, 1969), that there are no emotions that are inappropriate, or unhealthy. All emotions are indicative of an aspect of one's world-view, and should be regarded as an inroad to the meaning and value constructions held by the existent. This surely must be the appropriate exploration, well before one even begins to consider changing the emotional response(s).

Innumerable case studies (and personal experience) reveal that people are often ambiguous with reference to what they purport to be a desirable change in their behaviour, thought, emotions and/or experience: '*I want to and I don't*' is the frequent report. The enquiry here would probably be with respect to what IS being chosen, and experienced, and what is the possible loss in terms of values (including the value placed on self-concept) that might be incurred if things were to change. This query demands some investigation before the benefits of the intended change are exalted as the 'rational' and solely appropriate basis for the modification. In the REBT model, equivocation on the part of the client, for example, the neglect of homework assignments or a 'relapse' into previous behaviour is seen as a lack of commitment to the work on the client's part. Nowhere in this text is there a consideration of the how the efficacy of the practitioner might be evaluated, and how the incompetence of the therapist might be an impediment to the client in their pursuit of the desired modifications.

Furthermore, in the event of a lack of progress as defined by the model, the client is exhorted to work harder in their efforts at self-indoctrination: there is no query as to why the client might be drawn to former modes of behaviour, especially in light of the notion that their new '*rational*' perspectives are providing them with a more satisfactory experience. The existential perspective proposes that all behaviour is purposeful (see the various vignettes in Sartre, 1991): this concept has no currency in the REBT model. If this proposal was recognised, one would be inclined if not obliged to investigate this aspect of the world-view (as one would explore emotional engagement in the manner described previously).

There is one other essential omission in the REBT paradigm that must not escape scrutiny: the co-constructive relationship of Self and Other.

It is understandable that CBT/REBT was popularised by American practitioners: it is very much in keeping with American cultural traditions of individualism (see May et al, 1969). The individual in this milieu is expected to be self-defining and self-sufficient. This perspective is very much in antipathy with the concept of human existence as inter-subjective and contextual.

Dryden and Neenan write in the chapter on '*Regular Psychological Workouts*' (post-therapy): *..[a].. client who believes he no longer needs the approval of others and wishes to prove this to himself might seek out situations where he might be criticized...to keep at bay his approval-seeking tendencies... ("I don't want or need to be ...told I'm a nice person*

in order to justify my existence or please others to my own detriment”) (p.77).

Such unilateral self-definition is unsupportable in existential thought. Furthermore, the idea of self-sacrifice in order to serve the wants or needs of others is one that is applauded in secular and religious circles alike. In stark contrast to the idea espoused in Dryden and Neenan, Sartre states “...he who sees me causes me to be; I am as he sees me...” (Sartre, quoted in Friedman, 1991, p.189).

There are innumerable such expositions in the works of existential writers, stating quite clearly the implications for ‘*being-with*’ that are fundamental to the process of knowing oneself. It is a concept that cannot rest well with that of a REBT model.

This concept of inter-subjectivity does not, however, suggest that one can be totalised, finally or ultimately known; not by others, not even by one self.

This notion of contextualised existence would extend as well to our assumptions, perceptions, emotions and cognitions: all aspects of human being are thus implicated. As Cohn writes: ‘*The individual living in a ‘with-world’ can never be understood in isolation—s/he has to be seen in the context of her/his ‘with-being’. As the context is in constant flux, the image of a fixed’ internal’ psychic structure is a construction*’ (Cohn, 2002, p. 40).

Finally, the aims of existential psychotherapy and REBT are incompatible: the latter focuses on the alleviation of distress via a form of re-education, and the former model aims for a greater understanding and appreciation of the human predicament, which may result in an understanding of personal suffering, if not a mitigation of the same. The process of existential psychotherapy, by virtue of its premises, requires a dialogical engagement; the treatment program of REBT requires primarily an instructor. This last proposal raises the question: what is it that qualifies a process as psychotherapy, as opposed to ‘*psychological treatment*’?

References

- Cohn, H.W. (2002). *Heidegger and the Roots of Existential Therapy*. London: Continuum.
- Friedman, M. (ed) (1992). *The Worlds of Existentialism*. New Jersey, London: Humanities Press Intl.
- Heidegger, M. (1993). Trans. Macquarrie, J. and Robinson, E. *Being and Time*. Oxford: Blackwell.
- May, R. (1989). *Love and Will*. NY: Dell Publishing.
- May, R. (ed) (1969). *Existential Psychology*. USA: McGraw-Hill.
- Sartre, J.P. (1993). Trans. Barnes, H. *Being and Nothingness*. London: Routledge.

Karen Weixel-Dixon

Beyond Medication: Therapeutic Engagement and the Recovery from Psychosis.

David Garfield and Daniel Mackler, (eds) (2009). London. Routledge.

Is it a deluge which induces illness, or is it a delusion, a result of illness?

(Greyson, B., 1977).

Schizophrenia is categorised in psychiatry as a *functional psychosis*, that is to say, a serious disorder with subtle changes in the mechanism of the brain. For instance, enlarged cerebral ventricles, and chemical imbalances in the function of the neurotransmitter dopamine, and related chemicals. Also, studies have also found less grey matter in the brains of schizophrenics. Clinical descriptions divide the symptoms of schizophrenia into positive and negative. Positive symptoms being hallucinations, delusions, and thought disorder, and the negative symptoms being alogia and avolition. So, psychosis is a severe mental illness in which there is a break from reality, due to cognitive impairments. Therefore, medication is vital to manage the condition successfully. However, despite these disabilities it has been said, *‘that there seems strong evidence that schizophrenics may show quite striking E.S.P. ability in everyday life’*, (Rogo, D.S., 1986). Consequently, therapeutic engagement in psychotherapy is also of great value as a coping strategy. Particularly, considering the terrible historical fate of schizophrenics generally, with the sterilization and murder of hundreds of thousands of patients with schizophrenia in Nazi Germany between 1934 and 1945 in *‘designated killing centres’*. (Torrey, E.F. and Yolken, R.H., 2010).

‘Beyond Medication’ is an important existential contribution to the current literature focused on the psychotherapy of psychosis and schizophrenia, and the hope of recovery, and reason. The book is divided into four parts, comprising of thirteen chapters, each with a respectable reference list, and the work totals 189 pages, with a five page index. The first part, *‘Engaging the Patient’*, consists of four chapters. Chapter 1, *‘Strengthening the patient’*, by Garfield, D. and Dorman, D., describes in fascinating detail the different reality that sets in when the emotional pain of living becomes unbearable. The story depicts the fate of a family moving to a wealthy suburb, and their struggle to survive. The patient, K, was the eldest of the family, who losing her self-confidence, compensates by creating a fantasy world, making her self-conscious and awkward, with her *‘dissociating’* into an anxious psychotic state. Reference is made to Louis Sass’s four stage description of psychosis. Firstly, there is *‘unreality’*, where things do not seem the same, then, secondly, there is *‘mere being’* where significance evaporates. Thirdly, there is

'fragmentation', the inability to compare the relationships of things any more. Finally, the fourth stage is 'apophany', where everything might have a meaning only the patient cannot figure out what the meaning might be.

The road out of psychosis and the role of the therapist is described with the distressing story of Ms. C., who suffering from her husband's infidelity lit herself on fire and became badly disfigured from this self-inflicted immolation. After many years of living in a halfway house following her divorce, and being worn down gradually by years on medication a new therapist was assigned to her. Over time the therapist's office became a refuge and she reported having more feelings, and it became apparent that her authentic self had never been acknowledged, or accepted, and so she concluded that she was worthless. Part of the therapeutic task is to listen to, and respond to the fragments in a genuine way, and being able to experience the moment, expanding one's perceptual apparatus. This activates the recovery process within the patient, and the flow of communication expresses vitality. So, *'the adage that affect and cognition are two sides of the same coin may be giving way to a new adage: that affect and self-esteem are two sides of the same coin'*, (Garfield,D. and Mackler,D., 2009, p.11). Patients struggling with the breaking apart of their universe require to be strengthened, and put together again.

Moving on to chapter 2, we read of psychotherapy with three very different psychotic patients, in three very different places, from a supportive asylum, to a standard general hospital, to individual, and family therapy. With each setting the patient has an entirely different experience, as well as all the other dynamics such as the past, rapport, therapeutic alliance, wishes, fears, biases, philosophy and feelings of defeat and abandonment. Firstly, there is the 36 year old Maria, who despite being a talented linguist, has no insight that she is ill, believing she was married to a practicing psychiatrist, who conducted research in a nearby institution. Chestnut Lodge hospital milieu setting encouraged treatment in unconventional ways that enhanced Maria's initial engagement. For instance, due to movement disorder they conducted therapy on the floor, often reading Bible passages that Maria chose, and they played with words, with the therapist taking dictation. Such shared activities can give an ever fuller awareness of the patient's range of expression.

The next venue was the inpatient unit of a general hospital, which can add to the hopelessness, alienation and loneliness that are at the core of psychotic disturbances. Then finally we encounter outpatient psychotherapy in the patient's home. In this case the therapy went well, until the patient eavesdropped on a family session and became distressed and tried to fire the therapist. The patient claimed the home visits fostered isolation which kept him ill. So the treatment progressed to meeting in any number of settings, which proved to be a therapeutic solution. The chapter concludes with, *'as a nation we must realign our values, pouring less*

money into wars and more into helping the most vulnerable in our communities', (Garfield,D. and Mackler,D., 2009, p.29).

Gary Prouty, the originator of the '*Pre-Therapy Method*', writes the third chapter, on the therapy of deeply regressed and chaotic patients focusing on the ever-present existence of a nuclear 'pre-expressive self'. '*Pre-Therapy*' is presented as a possibility for an increased role for psychotherapy, stressing the positive aspects of psychoanalysis. It is this kind of therapy that makes contact with chronic schizophrenics, or those with psychotic mental retardation. The author recalls his childhood, living with his younger brother who was dually diagnosed with severe mental retardation and psychosis, and he lived in an autistic-regressed state. Prouty then explains that he believes there is a Pre-Expressive Self underlying autism, regression and psychosis, that can be contacted by contact reflections by the therapist on the client's immediate behaviour or surroundings. The five contact reflections are ,(a) situational reflections, (SR). (b) facial reflections, (FR). (c) word- for-word reflections (WWR). (d) body reflections (BR). (e) reiterative reflections (RR). They allow the therapist to establish contact with the client at the client's level of expression, to meet the client where he is. This essential contact is neither invasive nor arcane, but rather gentle, patient and trusting, for the most disturbed patients.

Following this chapter, W. Schwartz and F. Summers set out the next requisite phase in the psychotherapy of psychosis, which is the establishment of a therapeutic alliance. Seriously disturbed patients can behave in bizarre, frightening ways that require persistent and intensive attention. So, steady and emotionally intimate work should lead to greater self-understanding and positive change. It is a mature alliance used to counter the chaotic experience of symptoms. Although, if the disturbance is purely biologically driven, the problems cannot be solved by a human process. Mutual acceptance represents the opening of a third set of eyes that have a new worldview, which can inform both parties of the nature of the patient's condition. It is an atmosphere that encourages the patient's expression, development of self and understanding of symptoms.

The second part is entitled, '*The Elements of Change*', and is made of five chapters about the psychotherapeutic relationship with the therapist. So, the first chapter, by F. Summers, describes the key therapeutic ingredients used in the creation of a sense of self for an extremely disturbed paranoid patient. Such patients are painfully helpless and unable to influence others, and have difficulty with relatively routine human conflicts and tension. Lacking confidence in their own experience renders a fragile sense of self, with the result of maintaining the self through others. They are the lost, as though they have no compass for navigating the world. Therefore, a special therapeutic sensibility is required allowing for a blending of space to help tend to the patient. The therapist may find

this an excruciating, unenviable dilemma, having to accommodate the patient's exigencies. However, this is the very essence of the therapy. Soon the sense of loneliness and abandonment dissipates as the patient is able to maintain relatedness despite frustrations. An emboldened desire to pursue an individual path transforming the course of their life ensues. As the patient assumes ownership of her psyche, he gains the awareness that the relationship with all its imperfections has been useful, and the creation of a new self is brought to fruition.

Chapter 6, by J. Kipp, contrasts the individual work with milieu treatment, which is useful as there is a high percentage of patients with psychosis are treated in such settings. Psychodynamic programs are not in common use, however, the therapeutic community was originally used to treat people with mental illness. Such communities were used for prisoners of war, brutalized, and suffering from post-traumatic stress disorder. There are eight features of the therapeutic community, being: patients can help one another, flattened hierarchy, the community meeting, the provision of learning experiences, openness of communication, the culture of analysis, the staff support group, and change at one level affecting the whole. This model is an attempt to map the sophisticated concepts of individual treatment to the milieu settings used for large numbers of the mentally ill in the United States.

B.Koehler authors chapter 7, navigating the storms of psychosis, with a '*therapeutic symbiosis*', and avoiding the overwhelming terror of elimination, that can plague the mentally ill. In such psychodynamic therapy therapeutic partners are more on a level, due to psychobiological, sociocultural, and relational processes that can contribute to psychotic symptoms. The inter-subjective duality established with the patient is in effect '*antipsychotic*'. As the patient mutates and moves towards individuation the therapist's professional identity will be confirmed in keeping with the therapeutic frame. In helping the patient achieve intrapsychic coherence, the schizophrenic's structural needs will be fortified.

The next chapter, by P.L.Gibbs, looks at work with psychotically depressed patients, providing a language for the unarticulated experiences of the patient, and the emergence of the '*true*' self. Conditions considered to be caused by biological or genetic factors may improve after psychological and social interventions, according to the author. The bizarreness of the psychotic's experience of the world, with the fantasies, hallucinations and delusions, could sometimes be interpreted, thus avoiding the separation of the patient from the human community. For too long, reports of hallucinations and delusions have caused analysts to refuse treatment to patients. Interpersonal communication is always possible.

The final chapter, of part two, is written by D.Mackler, reviewing psychotherapeutic work in hostile places, with externally imposed

limitations. He speaks of managing a difficult supervisor, who treated him as a dissident, a cavalier, or even worse, as irrelevant. Mackler complains of not having the opportunity to share alternate literature on recovery, and being considered an arrogant risk to his patients. He uses the quote, '*everyone is much more simply human than otherwise*', (Sullivan,H.S., 1953 in Garfield,D. and Mackler,D., 2009.p.131). The author was conscientious in keeping a very healthy personal lifestyle to avoid the environmental pressure, and proving a balanced life manifests self-esteem, and self-respect. In time, as his patients did well he describes an exciting process as the psychiatrists perfected the patients' medication, despite their massive caseloads. On occasion they assumed that the positive changes was a result of an initial misdiagnosis, the experience was described as enlightening.

The third, and penultimate part, is entitled, '*Listening to the patient: stories of what really works*', and comprises of three chapters. The first chapter, written by C.Penney, is a personal account of her own recovery from schizophrenia, through the therapeutic engagement with her therapist. She describes her symptoms of an influx of uninvited murderous voices, that effectively snuffed out all emotion. Following her hospitalization she describes becoming like a walking zombie, in a kind of limbo-land with no passion, or life, with a prevailing sense of doom. The author describes her slow return to health after many sessions. Excitement and fear coexisted as she became more motivated. Not all of her inner experience was reduced to mere pathology, she states, '*Everyone has a dream no matter what their diagnosis*', (p.154). Her doctor believed in her wholeness and capacity to heal even when no one else did.

Chapter 11, a short chapter written by the author J.Greenberg, telling of her treatment and recovery from schizophrenia. She describes taking industrial doses of sleeping drugs in hospital to help prevent the screaming nightmares, and guarantee a good night's sleep. The writer mentions that there are people who call out the healthier parts of sick people, and who seem to be able to show them the potential of an open world. These people had an accepting open-mindedness, and a willingness to start at the beginning with the patients. She concludes, that mental illness, the social clumsiness, or the creative individualism, can be debilitating, and so should be tackled with every strength that the patient and therapist can bring together.

Chapter 12, the final one in part three, is by R.Foltz, and it concerns the patient's subjective experience of being medicated. Side effects, such as the concept of '*deactivation*', are mentioned, which refers to disinterest, blunting, lack of spontaneity, reduced emotional reactivity, apathy and stupor. Neuroleptic dysphoria is another side effect, due to the dopamine blockade of the medication, resulting in being tired, listless, and lacking ambition. Although schizophrenics can experience these cognitive deficits,