

on occasion they have been dismissed as unreliable in the past. With schizophrenia being a chronic condition, any increased command over symptoms is crucial.

The book concludes with part 4, which is designed to inspire therapists to go beyond medication in order to find solutions, but never ‘*anti-medication*’ in their approach. I. Steinman, the author states that once the inner world of the schizophrenic has been elaborated and worked through, health might be possible through curative intensive psychotherapy.

I consider this book to achieve its goal of delivering a range of radical strategies to take the patient beyond only medication, to a higher form of therapy engaging their full potential and humanity. The writing is scholarly, yet accessible, and certainly well referenced, with a wide array of chapters, so I can recommend this volume to the existential practitioner. However, the subject matter might be too specific for a general title for the interested public. Although, most importantly, the book does express the radical concept, that recovery from psychosis and schizophrenia is sometimes possible.

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Psychotherapies for the Psychoses: Theoretical, Cultural and Clinical Integration

Gleeson, J.F.M., Killackey, E. and Krstev, H. (2008). London: Routledge.

There is good evidence that the brain is structurally abnormal in schizophrenia

(Lawrie, S. and Abukmeil, S.S., 1998).

Schizophrenia, its original meaning: Schiz – broken: Phrenos – soul or heart; or, ‘a chronic terror condition

(Garfield, D., and Mackler, D.).

‘*Psychotherapy for the Psychoses*’ is another important existential addition to the literature that explores a variety of different psychotherapeutic

approaches to schizophrenia, providing encouragement, and a sophisticated instruction for practitioners in their work with psychotics. The book is divided into three sections, of fifteen chapters, each with a respectable reference list, and a 14 page index. The first chapter, which serves as an introduction to the volume, written by J. Gleeson, H. Krstev and E. Killackey, is a very useful critical description of the stress vulnerability models (SVM) of psychosis. Entitled, '*Integration and the psychotherapies for schizophrenia and psychosis*', the writing laments the lack of the expansion and translation of the 1970's 'new view' of schizophrenia into both practice and research. Zubin and Spring's, (1977) new perspective on psychosis remains the most influential example of an integrated model of the aetiology of schizophrenia, with nearly 700 citations of their article is indicative of its popularity in the international research community. This enthusiasm for integrated explanations made the SVM popular, partly as a reaction to the pessimism of the Kraepelinian deterioration disease concept. The assumptions of SVMs are the interactions between genetics and personality variables, as well as life events and interpersonal conflicts, can result in acute psychotic psychopathology via the activation of latent vulnerability. The main criticism of the model is it fails to account for deterioration and other symptom domains such as negative symptoms. Although, despite this, the framework has been maintained as a basis for psychoeducation, particularly during times of social adversity, and the role of emotions in mediating psychotic symptoms. Much of the research carried out on treatment populations informs us that cannabis might have a co-relational effect on symptomology. However, this is not causal, take for instance the Rastafarians who control their use as a religious sacrament to accompany Bible study and exalt consciousness, bringing them closer to God. Fortunately, therefore, Jamaica is not plagued with mental health disorders.

Moving onto Section 1, '*Theoretical integration*'; chapter 2, '*Integrating approaches to psychotherapy in psychosis*', written by F. Margison and S. Davenport, informs us how many practitioners adapt treatments to the needs of an individual. Being too '*eclectic*' can lead to a muddled approach though, although it is rare for a model of therapy to preclude any other approach. Sometimes different therapists label the same phenomenon in different ways, two languages for the same events, it can be argued which terminology is more accurate. In fact whole delivery systems can use integration as an organizing principle. The '*need-adapted*' approach to psychosis uses social, psychological and physical treatments to create a coherent whole. Scandinavia has played a key role in developing this kind of thinking, with Finland and Melbourne mirroring these significant events. The opposite to this movement to integration could be said to be social exclusion to opportunities, advantages, and rights given to others in civil society. People with mental illness tend to be poor, socially isolated,

unemployed and at risk of victimization. Service providers in the fields of housing, arts and leisure are required to ensure meaningful social inclusion can occur. Culturally sensitive interventions integrated into a health system may reduce the impact of social exclusion.

The third chapter by B.V. Martindale is entitled, '*The rehabilitation of psychoanalysis and the family in psychosis*', and concerns the revival of the talking therapies in psychosis. It takes time to clarify whether new findings can be justified, or erroneous and dangerous. Psychiatry has been vulnerable to adopting the latest ideas, for example the idealization of just neuroleptics, and in the past leucotomy etc. Just as treatments can be overvalued, they can also be neglected and not used enough. There is a recognition following the past '*decade of the brain*', of the various different levels of explanation, and the complexity of the relationship between nature and nurture. Although, the early investigators of the family constellation in psychosis made errors, tending to describe their findings as causal, rather than contributory, and they often generalized their judgements to all cases of schizophrenia.

The fourth chapter by A.J. Lewis, with the title, '*Neuropsychological deficit and psychodynamic defence models of schizophrenia*', informs us that psychoanalytical theory and practice is in fact not an lifeless museum piece, but a contrasting level of analysis for psychosis. The future of the mental health sciences consists of developing both pharmacological and psychotherapeutic applications of gene, brain, cognitive, affective and social studies to treat this neurological deficit. Impairment in social cognition and functioning are present even before the onset of schizophrenia, and worsen during the phases of illness. For instance, there are significant associations between schizophrenia and the subject's inability to infer a speaker's real intentions when 'dropping a hint' in indirect speech. Capgras delusion also offers a good test of the deficit theory. In this delusion a person forms a belief that their lover is an imposter who looks identical to the real partner. Practical social skills training, and mentalization, that is thinking about thinking, need to be encouraged, and cannot be achieved in an adversarial atmosphere.

Moving on to Section 2, '*Integration of psychotherapy: an international perspective*', which is made up of an introduction and four chapters. One of the complaints about the literature about interventions for schizophrenia is, that there is an imbalance due to it being written by academics working in western settings. So in chapter 5, T.K. Larsen describes Norwegian efforts to integrate biological and psychological interventions. He writes that in Norway the prevalence of homeless and untreated psychiatric patients is low. This is due to the combination of large resources and involuntary treatment, with a population of 5 million. Although, homeless people are generally a symbol of a country's lack of ability to provide proper treatment of the mentally ill, it is regarded as a basic human right to

have housing, financial support and active treatment if you are severely mentally ill. Sometimes the family environment can play an important role in protecting the vulnerable from developing schizophrenia as well. It ought to be the right of every patient in the world who has first-episode psychosis to receive treatment, just as every patient who suffers a cardiac arrest has the right to acute treatment.

In chapter 6, T.Herewini writes about the way in which Maaori concepts are joined by western concepts of treatment in New Zealand. This chapter includes fascinating insight into the complexities of respecting indigenous cultures, and encourages other countries to address the mental health needs of their indigenous peoples. The journey of healing and recovery can be challenging, and take more time to arrive at the final destination, but the most important thing is the people. The text is about the lack of information about psychotherapeutic and psychosocial treatments for schizophrenia in Aotearoa (New Zealand). The health system there is based upon the English system, but there are several Maaori models of health featuring spirituality and cultural identity. Although, often Maaori require more admission to psychiatric inpatient units and receive intramuscular medication and seclusion more than non-Maaori. Having altered experiences can be regarded as a gift for the individual to make sense of everyday experiences and reality. The chapter then describes the six Maaori models of health, illustrating the vital cultural and clinical integration.

Chapter 7, *'Development of psychotherapy in the pre-psychotic phase'*, is written by L.J.Phillips and colleagues, and it surveys the way in which three centres around the world are approaching psychological interventions for those at risk for developing psychosis. These pre-psychosis centres are based in Melbourne, Australia, Cologne, Germany and Manchester, United Kingdom. There are two ways of identifying patients at risk, using ultra high risk (UHR) criteria and the basic symptoms approach. A useful table of the four groups of UHR criteria is given, with the full range of psychotic symptomology. The basic symptoms approach is based on two distinct concepts, the Early Initial Prodromal State and the Late Initial Prodromal State. These are characterized as subjectively experienced abnormalities of cognition, perception and attention.

Chapter 8, *'Integration of psychotherapy in concept change within a culture – India'*, by I.Sanyal, tells of the challenges facing those attempting to integrate psychosocial recovery. Much of the economic development has bypassed mental health treatment, but centres like 'Turning Point' are finding ways to utilize technology to assist recovery. India is the world's most populous democracy with a population of over one billion people, with many religious and cultural differences. Globalization has had an uneven effect in India, with material success, but anxiety and depression from life's increased expectations. So, community programmes of mental

health centres help the community understand the patients in a better way and help them in their journey to successful recovery. Getting economic resources or assistance from the government is near to impossible for schizophrenics, so the creation of 'Turning Point' was crucial. Although, a person suffering from illness generally loses contact with the outside world, centres can help with confidence and end isolation. No other civilization has looked at the human mind and its functions as intensely for the last 3000 years, but still not much progress has been made there, regarding modern psychiatry.

The third and final section, *'Integrating psychotherapeutic thinking and practice into "real world" settings'*, consists of seven chapters. The first, *'An integrated treatment program for first-episode schizophrenia'*, by R.Miller, J.McCormack and S.Sevy, states that each patient is a unique person and no recovery is the same. Symptoms at first presentation vary, from socioeconomic level, intelligence, cultural and ethnic background, academic accomplishments, to the family. First episode patients may struggle with their condition, due to the stigma society places on people with severe mental illness. Perhaps, they can no longer live up to their internalized ideal selves, and may be sad, angry and hopeless, leading to depression and suicidal ideation. When patients do respond to treatment, the resolution of delusions is a gradual process. So, an empathic, non-judgemental, accepting attitude is essential until patients are stable. The treatment provides a foundation built on the triad of insight, adherence and abstinence, integrating the service to meet individual needs.

Chapter 10, *'The importance of the treatment alliance in bipolar disorder'*, by L.Berk, C.Macneil, D.Castle, and M.Berk, is valuable as this disorder affects 1.5 per cent of adults, with a suicide rate of 12 times higher than the general population. The writing adopts an integrative framework to highlight potential ways in which the alliance may enhance outcome in bipolar disorder. The alliance in pharmacological treatment has evolved from the authority of the doctor in 'disease management' to a more collaborative relationship recognizing the active role of the patient. Exchange of vital information between clinician and patient increases treatment adherence, and facilitates self-management. Certain clinician behaviour may be more appropriate at a particular time in therapy, making the clinician *'an authentic chameleon'*, (p.178).

Chapter 11 is, *'Fragmentation, invalidation and spirituality'*, by J.Geekie and J.Read, and it describes the quest for spiritual meaning in psychosis. Celebrating diverse perspectives and their integration will create a wider understanding of psychotic experiences. The word schizophrenia has always been used in a *'contested'* fashion, indeed there cannot be a final resolution to this debate; rather competing perspectives are the stuff of what schizophrenia is made. This plurality of meanings, each with different merits, all shed light upon schizophrenia, and improve treatment

approaches. Some psychotic experiences are even considered positive, and spiritual. When clinicians embrace the notion of ‘*essential contestedness*’, it might reduce the risk of invalidating clinical encounters.

Chapter 12, ‘*Psychosocial interventions in clinical practice guidelines for schizophrenia*’, by E.Killackey, H.Krstev and J.F.M.Gleeson, mentions the history of medicine, the science of evidence-based medicine, and the randomised controlled trial. Now the practitioner can download journal articles from multiple databases, and they are inundated with information. Clinical practice guidelines for schizophrenia are discussed, as well as the evidence of what works. Although, psychoanalytic and psychodynamic therapies aren’t always mentioned. Often, it is noted, that people want psychological and psychosocial interventions not met by medication alone. Therefore, it is important to merge these into the mainstream of treatment for people with mental illness.

Chapter 13, ‘*Families dealing with psychosis*’, by R.M.G. Norman, L. Hassall, S.Scott Mulder, B. Wentzell, and R. Manchanda, discusses the potential role of families in the treatment and rehabilitation of their own relatives, and even bringing about wider social change. Education about the nature of illness should help the family members effectively support the recovery of the person. Re-establishing personal relationships and a social network for the ill person to improve self-esteem and productive meaningful activity, should be an aim of dysfunctional families. It could be that we are witnessing the evolution of the family as a source of mutual education, support and advocacy for the needs of those with psychosis.

Chapter 14, is, ‘*Therapeutic group work for young people with first-episode psychosis*’, by G.Woodhead, and is about the in vivo practise of social and coping techniques to be found in group work. We read that participation could reduce isolation, build confidence, encourage peer support and provide psychoeducation. The value of being accepted by others, the instillation of hope, the increased sense of optimism through seeing others on their journey of recovery, is all part of such group work. Being more confident around people, learning and practising social skills, structure and routine, and developing new interests are all part of the service. Participants are encouraged to step outside their comfort zones, support one another, try new activities and have fun. It is only through further research that the value of group work programmes in clinical mental health settings can continue to grow in recognition.

Finally, chapter 15, ‘*Systemically speaking*’, by G.Couchman, looks at the interwoven threads of community, which provides comfort and protection, yet requires maintenance. Discrete family pathology concepts such as the schizophrenogenic mother, have been largely superseded by the more general stress vulnerability model. Multi-family groups provide a forum where knowledge can be constructively shared, assertively integrated and made use of.

I judge this book to achieve its target of delivering a wide ranging overview of the psychotherapeutic treatments for schizophrenia throughout the world. Again, the writing is scholarly, yet coherent, and well referenced, with an eclectic selection of chapters, so I can recommend this volume to the existential practitioner. Indeed, one day there maybe a cure for psychosis, as with the porphyria of King George III, who suffered immensely from '*his long and sorrowful illness*', (Macalpine,I. and Hunter,R., 1966). However, until medicine has solved conclusively the enigma of schizophrenia this book will remain a useful contribution.

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Publications Received For Review

The following publications have been received for possible review. People who wish to be included in the list of book reviewers for Existential Analysis for these or other publications are requested to e-mail the Book Reviews Editor Martin Adams at adamsmc@regents.ac.uk.

- Birtchnell, J. (2002). *Relating in Psychotherapy. The Application of a New Theory*. London: Brunner Routledge.
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