Paul Rhodes *Editor*

# Beyond the Psychology Industry

## How Else Might We Heal?

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# Chapter 1
# A Drifters Handbook

**Paul Rhodes**

> You might do some good in your role as "psychologist" perhaps but treat that identity and the knowledge as a set of powerful and sometimes dangerous stories about people. Find inspiration and strength in the many other kinds of story from outside the discipline that are told about what human beings can do to reflect upon and remake themselves. (Ian Parker, 2014, p. 556)

I listened to a young clinical psychology student tell me a story recently of a placement they did in rural Australia, in an indigenous community far from our Eastern cities. This young student, trained at the top university in the country, felt ill-equipped. It was the story of a young boy, 14 years old, despairing and grieving the loss of a cousin to suicide, one of many such deaths he had experienced. He could not get up in the morning. He was harming himself. Contemplating death. One person caught in the epidemic of aboriginal suicide tied to colonization, intergenerational trauma, structural inequalities, and more. It was also the story of clinical psychology, a secular religion, with its missionaries and confessionals, focused on sin/pathology, rather than on social and emotional well-being (Dudgeon, 2017). Indigenous psychology is culturally safe, supporting the persons' strengths and their relationship with community, spirituality, and land. Contemporary therapy, on the other hand, is not safe in this context. It is a hyperrational approach to healing, built on individualism, the sole agent in a sealed room, cut off from culture and land. Thankfully this student, smart and progressive, sought the knowledge of aboriginal elders and health workers and soon learned to take her shoes off and sit in the circles.

The dominant method in clinical psychology is still cognitive and, like most models, serves as an evidence-based application of Western philosophical concepts. The original cognitive model is based on Greek and Roman stoicism (Robertson, 2018), transformed by the information processing of the 1980s into a formulation-driven metaphor for distress. Most contemporary models eventually become abbreviated in a similar fashion to support their promulgation: cognitive behavioral therapy (CBT), acceptance and commitment therapy (ACT), dialectic behavioral

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therapy (DBT). There is a new one called temperament-based therapy with supports (TBT-S). Each of these models emphasizes the intrapsychic over the interpersonal and decontextualized, with the focus on personal control or acceptance of subjective phenomenon.

I recently read an interesting paper by Waller (2009) on therapist drift, a beautiful example of Foucault's (2006) "technology of the self." Waller admonishes cognitive therapists for drifting from key principles, particularly from a focus on "doing" to "talking," lest we "behave in ways that reflect our own twisted thinking" (Waller, 2009, p. 122). This book serves as a manual for this kind of drifting.

As clinical psychologists, we are taught to keep our distance, to protect ourselves from distress and dysfunction, to objectify. This is achieved through language: the language of quantification, diagnosis, and the mental state exam. Here is an example of how we are taught to describe people in our research:

> Serial assessment of his mental state using MSES is shown in Figure 2, with a global score and sub-scale scores derived as percentages for mania and psychosis dimension scores, which were the most prominent symptom dimensions relevant to the patient. (Fernando & Carter, 2016, p. 78)

And how we might label a distressed person:

> Disruptive mood dysregulation disorder (DMDD) is a childhood condition of extreme irritability, anger, and frequent, intense temper outbursts. DMDD symptoms go beyond a being a "moody" child—children with DMDD experience severe impairment that requires clinical attention. DMDD is a fairly new diagnosis, appearing for the first time in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published in 2013. (American Psychiatric Association, 2013, p. 220)

And here is an example of what a mental state exam might read like:

> General appearance and behavior: Arnold is a 74 year-old man of average weight and height. At the time of examination, he was well groomed. On appearance, there were no signs of tremor or abnormal movements. Arnold was cooperative throughout the interview. He maintained eye contact, except when recounting his mothers' recent death. Then, he appeared depressed.

These forms of language seek to differentiate the clinician from the client, amplifying polarities. The clinician is the objective, the client is the object. The clinician is mentally healthy, the client mentally ill. We both become objects.

In our new hyper-economy, however, we are moving from objectification to "off-peopling". We are now decentering the therapeutic relationships in favor of augmentation through artificial intelligence. There are now hundreds of cybertherapy programs, including computerized cognitive behavioral therapy (cCBT), BRAVE-Online for anxiety (Spence et al., 2011), Catch It (Van Voorhees et al., 2009) for depression, and MoodGYM (Christensen and Griffiths, 2011). Gunter Anders (Muller, 2013), philosopher of technology, warns of the proliferation of machines, devoid of debate on societal repercussions. He writes of Promethean Shame, that which comes when humanity that has lost control of its technical devices, and seeks then to become objects themselves. We live in the era of horrific challenges: racism, the refugee crisis, climate change, and this is what we offer. The new frontier.

The cultural context for these developments is neoliberalism (Dudley, 2017). Psychotherapy is obviously helpful for some, but the commodification and industrialization of healing is a moral issue. This cultural dominance of clinical psychology, exercised though the labeling of individuals, the branding of treatments, and the quantification and the drive for technological efficiency all threaten the emancipatory potential of therapy. We are not easily distinguishable from our increasingly dehumanized technocratic world. We have become complicit in supporting individualism and the denial of communal life (Martinez & Garcia, 2000). I fear that as a profession, we have also become socioculturally blind. Feminism, for example, is lost on the majority of researchers and clinicians in anorexia nervosa, where body image supersedes embodiment (Malecki, Rhodes, & Ussher, 2018) and the gene code needs to be cracked (Pinheiro, Root, & Bulik, 2009). The social determinants of "mental health" such as poverty, dispossession, and employment insecurity are lost to the neurological turn (De Vos & Pluth, 2017). We focus on cultural competence, rather than critical consciousness, reinforcing racism because we fail to look at ourselves (Lee & Farrell, 2006).

So if psychology is not well, what is the treatment? Mignolo (2007) uses the term *epistemic disobedience* in the context of decoloniality. Aren't we similar to the priests of the Middle Ages, sole arbiters of man's relationship with the mind? We must wrestle back healing from the healers.

The aim of this book is to demonstrate clearly that healing is a human enterprise that must not be the sole property of the psychological industry. This is not to suggest that people should not go and see therapists, or that current models do not work for some people. It certainly is not a critique of the many caring therapists out there working hard. It is important to recognize, however, that we cannot always be trusted. Our models are simply maps rather than the territory (Korzybski, 1933). And they are colonial maps, used to annex meaning. So we must also turn to ourselves, to our interiority and to the people who we love or might, and to the many discursive resources in culture for these purposes. The healing that we require takes longer than 10 sessions.

This is a book written mostly by friends, each of whom, in their own way, is an activist-practitioner, critical academic, psychologist, and/or therapist. While we are part of one tribe, critical of mainstream psychology, there is much diversity in this group of authors. We are joined, however, in our desire to rescue healing from the psychologists.

Chapter 2 is a callback to the tradition of existentialism. Anxiety, for the existentialist, is a sign of sanity rather than pathology, a rational response to an absurd world. For Kierkegaard, anxiety was not pathology, but rather

> may be compared with dizziness. He whose eye happens to look down the yawning abyss becomes dizzy. But what is the reason for this? It is just as much in his own eye as in the abyss, for suppose he had not looked down. Hence, anxiety is the dizziness of freedom. (Kierkegaard, 1844/1980, p. 152)

The existential journey cannot be captured in manuals and scales, but rather begins at the dark wood, where Virgil calls Dante (Alighieri, 1265–1321/2013),

> It is a hard thing to speak of, how wild, harsh and impenetrable that wood was, so that thinking of it recreates the fear. It is scarcely less bitter than death: but, in order to tell of the good that I found there, I must tell of the other things I saw there. (Dante, The Divine Comedy, Inferno, Canto 1:1–60, The Dark Wood and the Hill)

Dante's journey would have been very different if he was met by a psychologist at the edge of that wood, providing psychoeducation, strategies, and weekly homework. For the existentialist, anxiety, depression, and suicidality are part of an authentic life, a search for meaning that cannot be sidelined by an exclusive focus on cognition on symptom reduction.

Ross and Rachel serve as masterful advocates for a return to an existential position in mainstream clinical psychology, particularly the recognition of the fear of death as a core transdiagnostic principle behind many "psychological disorders." They provide a rigorous scholarly argument for the failure of the field to respond effectively to human distress, largely due to the fact that we have lost touch with the philosophical origins of the discipline. They propose terror management theory as a paradigm that can help us understand cultural practices used in the face of dread and argue for a return to compassionate and community-based practices of restorative healing.

Loneliness, of course, also lies at the heart of many psychological problems, particularly depression. There are many instances in my own practice, when I have diagnosed a patient with loneliness, rather than depression, to support a process of reaching out for connection rather than an exclusive focus on introspection. Diamond et al. (2016) attachment-based family therapy supports the notion that adolescent depression can be conceptualized interpersonally, not only intrapsychically, as a symptom of breached parental relationships, being burdened by the traumas of life with no one to turn to. The association between loneliness and depression is also supported by a host of empirical reviews (Erzen & Cikrikci, 2018; Wang et al., 2018). Perversely, in the field of social neuroscience, Cacioppo and Cacioppo (2015) are attempting to open up the possibility for a designer pill to assuage the feelings of loneliness in the brain, a phenomenon they hypothesize is related to "the impaired biosynthesis of Allopregnanolone (ALLO), a brain endogenous neurosteroid" (p. 1).

Chapter 3 by Jennifer Fitzgerald serves as a wonderful primer for the critical role of attachment in establishing stability and healing in our lives. She builds on the legacy of John Bowlby, taking us on a journey from the cradle to grave, from the bonds of childhood to romantic love, from the effects of trauma on relationships to the attachment relationships that many have with God. I am grateful for her inclusion of religion in this chapter, given it is arguably an important omission for a book that aims to explore healing outside of the psychology industry. This chapter also provides an introduction to emotion-focused couples therapy, a much-needed antidote to the sometimes-mechanized individual therapies of clinical psychology.

The arts are also represented in this book. Poetry, fine arts, and drama provided means for the interrogation of self in society long before the advent of psychology. While empirical psychology searches for generalizable rules, based on observation, the arts embrace uncertainty and liminality and focus on *unconcealment* (Ireton, 2012), on processes of becoming and moments of being in the world.

> There are openings in our lives of which we know nothing. Through them the belled herds travel at will, long-legged and thirsty, covered with foreign dust. (Hirshfield, 2001)

Art also allows us direct access to the cultural nature of interiority, not simple subjectivity. Unlike the decontextualized cybernetic metaphors of clinical psychology, art can tap into the affective atmosphere of place (Anderson, 2009), revealing symbols of collective subjectivity. I first met the next author, Jhilmil Breckenridge, through a project titled We Are Barometers of the City: Collected Poems of Psychologists (Rhodes et al., 2018). In this project, we demonstrated that poetry can help us embrace "the messy entanglement of body–object–space in our personal and professional lives" (p. 15). Chapter 4 by Jhilmil is both an auto-ethnography and a primer for the use of poetic healing. She draws on the seminal research of social psychologist Pennebaker who conducted clinical trials on the therapeutic effect of expressive writing. She describes her use of poetry to heal from relational trauma and her role as founder of the mental health charity, Bhor Foundation, whose mandate is to take poetry into psychiatric institutions and prisons in India. Her writing is lyrical and moving and we are left with a series of edicts about why poetry is good for us.

The next three chapters concern themselves with community, in particular forms of practice that go beyond the confines of the therapy room. Community psychology began in the 1960s North America, when psychologists resisted conservative mainstream practice. The development of this field, from the Swampscott conference of 1965 (Meritt, Greene, Jopp, & Kelly, 1999), mirrored the influence the civil rights and feminist movements had in this period (Swift, Bond, & Serrano-Garcia, 2000). Community psychologists centered the field on social justice and the direct participation of neighborhoods, on ecological analysis and intervention, empowerment, social activism, and the recognition of cultural diversity (Nelson & Prilleltensky, 2005; Rappaport's, 1977). Clinical psychology, on the other hand, largely remained oblivious to the political realities of the time, maintaining a commitment to the scientist-practitioner model at the expense of activist practice.

Chapter 5 concerns itself with "(The ART of) Social Prescribing," a burgeoning practice in "mental health" service provision. Katherine Boydell makes a strong case for models of practice that directly target the social determinants of health rather than the reductionist targeting of symptoms. If loneliness, poverty, and lack of housing contribute to the so-called mental health problems, then these factors must be directly targeted as alternatives to a more exclusive reliance on intrapsychic therapy and psychopharmacological intervention. Rebranding the effects of poverty and marginalization as personal pathology is a perversion, and social prescribing offers a practical form of resistance. Katherine's scholarship is exemplary as she reviews the empirical evidence for this new field, including future directions.

Chapter 6 focusing on community is a coproduction by academics, researchers, and peer workers Holly Kemp, Brett Bellingham, Katherine Gill, Andrea McCloughen, Cath Roper, Niels Buus, and Jo River. This is an epic paper, the first ever written to explore the integration of open dialogue and peer work. Open dialogue is a Scandinavian practice that offers an alternative to hospitalization for those experiencing psychosis. A network is developed in the person's home, consisting of professionals, family, friends, and others who engage in a series of meetings focused on dialogue rather than action, attempting polyphony rather than medical monologue, and the toleration of uncertainty rather than psychiatric determinism (Olson, Seikkula, & Ziedonis, 2014). Peer support, on the other hand, involves the employment of people with lived experience of the mental health system, who serve as professional storytellers, counsellors, activists, and advocates within services. The authors provide a convincing argument for the potential of peer support to address some of the potential problems with open dialogue, particularly the assertion that flat hierarchies are achievable in network meetings and that polyphony can deal adequately with structural inequities in therapeutic discourse.

Chapter 7 focusing on community is led by Omar Said Yousef, a Syrian psychologist and community leader. He is supported by Abdulrahman Alhalabi, Zachary Steel, Sertan Saral, and Ruth Wells, and by the voices of many Jordanian and Syrian psychologists working in the field. They ask, what role might a psychologist play when working with those experiencing conflict and human rights abuses? How might psychologists respond to those experiencing cruelty, oppression, and displacement? Their answer is to transform psychological practice, placing justice in the front and center and supporting dignity and resilience in the face of existential suffering.

Of course, the primacy of justice is not a concept that the mainstream clinical psychology industry has embraced, focusing instead on private phenomenon. Justice, however, is a critical imperative for colonial countries, built on genocide, slavery, and marginalization of indigenous peoples. In our own Australian context, we have a shameful history of colonization, including widespread massacres, abuses in missions and reserves, and the forcible removal of children and more. It was not until 2016 that the Australian Psychological Society issued an apology to Aboriginal and Torres Strait Islander people, acknowledging our role in contributing to the erosion of culture. Meanwhile, the suicide rate amongst aboriginal young people continues to soar at five times the non-Aboriginal population (The Lancet Child & Adolescent Health, 2019).

The next two chapters concern themselves with this critical issue, one outlining a clear practical model of practice and the other a personal account. Leading Aboriginal scholars Rob Brockman and Pat Dudgeon present Chap. 8. This chapter serves as a reimagining of our field, outlining and conceptualizing a decolonized form of practice, where culture, kin, land, self-determination, and strengths are primary, providing healing in the face of intergenerational trauma and racism. These authors are not advocating for the wholesale rejection of Western evidence-based therapies, but rather their integration with Indigenous psychology under the mantle of cultural humility. Chapter 9 by Merle Conyer comes from the perspective of a Western ally developing her capacity to work with Aboriginal and Torres Strait Islander peoples. Her work is a moving auto-ethnographic account of this journey, exploring how she has grappled with Whiteness and privilege in order to transform herself into an activist-therapist. Merle's impressive capacity for personal/political language takes us on this journey in ways that both move us and hold us to account.

The last chapter is definitely what we call in cricket-loving Australia a "captain's pick," given that it focuses on running, a personal choice for healing in my own life. I recall first hearing about Merleau-Ponty's concept of embodiment (Gallagher, 2005) at a conference, where much of the program was dedicated to new materialism and qualitative research practice. New materialism (or post-humanism) is a reaction against the dissociative discourse analysis that has dominated progressive inquiry for decades, in favor of a return to flesh and bones and place, streets, and the air that we breathe. It can serve as a recast phenomenology, positioning the body in place and time and culture, and, of course, with the much more radical ideas of assemblage and rhizome (Deleuze & Guattari, 1987). Chapter 10 by Leanne Hall serves as an exposition of the concept of embodiment, applying it to the plight of injured ultramarathoners. It serves to reimagine what healing from injury might involve if a physiological paradigm was resisted, in favor of one that responded to the mindbody as being. She takes us on a journey into the world of extreme running, a response to our disconnected neoliberal culture, to understand the challenges of suffering well, while staying within the bounds of our flesh.

Of course, there are many other chapters that might have been possible, in terms of representing the multiplicity of healing practices beyond the therapy room. Each individual has a wealth of cultural resources for this purpose, resources that have been coined folk psychology by the great narrative therapist Michael White (2001)—animals, travel, nature, creative writing, sex, ecological activism; but these are stories for another day. I hope you enjoy reading this book, and that it prompts you to reflect on these resources that you hold within yourself, between your loved ones, and the cultures that you hold dear.

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# Chapter 2
# Emotional Pain and Suffering: The Search for Global Solutions

**Ross G. Menzies and Rachel E. Menzies**

## The Commonality of Impoverished Mental Health

The extent of the mental health crisis was recently highlighted by the Mental Health Taskforce for the National Health Service (NHS) in England (Mental Health Taskforce, 2016). In their 5-year forward view, they noted that approximately one in four adults in the UK experience at least one mental health disorder in any given year. Further, as in Australia, mental health is the largest single cause of disability in the UK, with a cost to the economy of over £105 billion. This is approximately the budget for the entire NHS. Further, while half of the mental health problems in England were shown to emerge in individuals by the age of 14, child services were shown to be hopelessly ill-equipped to meet the needs of the young. Children from low-income families were at highest risk of the development of mental health problems, having more than three-fold odds of a diagnosis compared to children from high-income families. The report highlighted the costs to the individual and the wider community of failing to treat psychopathology as it emerges. For example, children with conduct disorder were twice as likely to leave school without any qualifications, four times more likely to become drug dependent and 20 times more likely to serve a prison term (Mental Health Taskforce, 2016). Despite this, most troubled children get no support from public NHS mental health services. For the relatively few that are seen, the average wait for routine appointments for psychological therapy was 32 weeks in the 2016 financial year.

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Hayes and Smith (2005) argued that the extent of global psychological suffering is also revealed by the response of communities to the introduction of government-funded access to psychological services. They pointed out that progressive initiatives by governments to increase access to community mental health services have typically been followed by an inundation of individuals seeking care, usually in far greater numbers than anticipated by planning bodies. For example, the increased access to psychological services (IAPT) programme now treats a staggering 900,000 individuals in England each year. Having said this, the NHS estimates that this still only represents 15% of those with anxiety-related conditions and depression in England. The needs of the masses are simply not being met.

The introduction of Medicare-funded access to psychological services in Australia led to such a growth in expenditure that the number of available sessions in the scheme had to be reduced in several revisions across its opening decade. Since 2006, over 36 million individual treatment sessions have been provided to nearly 9 million Australians through the Better Access to Psychologists initiative. In a country with only 25 million citizens, this is an astonishing uptake of services. In response to the burgeoning costs of the Australian scheme, the number of sessions available for an individual with a Mental Health Treatment Plan from a general practitioner has been reduced from 18 per year to 10 per year. Not surprisingly, the recent submission from the Australian Psychological Society (APS) about the scheme has called for an increase to as many as 40 sessions per year for chronic, unremitting cases (APS, 2018). Clearly, the initiative is simply not meeting the mental health crisis in the Australian community.

Fairburn and Patel (2014) argued that health researchers need to ‘scale up’ their interventions if they are to have an impact on community mental health outcomes. They suggested that the traditional model of one-to-one, in-clinic intervention faces unsolvable problems of access and cost. Further, they argued that in-clinic interventions only reach those who actively seek treatment from a healthcare professional (Loucas et al., 2014). Fairburn and colleagues have championed ‘direct-to-user’ products in healthcare, such as internet-delivered ‘e-therapy’ (Fairburn & Patel, 2014). However, to date, studies of community use of such programmes are not encouraging. The most recent review of community uptake of standalone, e-therapy programmes suggests that they are typically rejected by end users. Fleming et al. (2018) reviewed all effectiveness trials of all available standalone, online programmes for anxiety and mood disorders. In a consistent finding across all programmes, non-completion and dropout were the norm. In fact, no e-therapy programme could boast more than a 20% rate of completion among users. MoodGYM and MoodGYMII, the largest online depression treatment programmes in the world, have been repeatedly shown to be complete by less than 3% of users in community-based, effectiveness trials (Fleming et al., 2018).

## Treatment Intractability: The Current Effectiveness of Psychological Treatments

The reasons for the public's rejection of automated online treatment programmes may be many, but some have speculated that standard psychological treatment procedures are less effective than the industry suggests, and that without a therapeutic relationship, rapport and interpersonal support, individuals simply abandon cognitive-behavioural procedures. Many reviews have questioned the effectiveness of supposed gold standard cognitive behavioural therapy (CBT) procedures. Westen and Morrison (2001) provided a particularly thorough review of manualised trials of empirically supported therapies (ESTs; Kendall, 1998) for panic disorder (PD), major depressive disorder (MDD) and generalised anxiety disorder (GAD). Universally, their findings were troubling.

In panic disorder, Westen and Morrison (2001) reported that 2 years after treatment, patients continue to have approximately one panic attack per week (averaged across manualised studies). This is despite the fact that most studies had excluded possible participants with moderate to severe agoraphobic avoidance, primary depression, substance abuse and suicidality. Even immediately at post-treatment, only 54% of individuals in these carefully selected samples were 'improved' as defined by the researchers at the time. Improved status typically involved only 20% symptom reduction on standard scales.

Westen and Morrison (2001) reported similarly negative outcomes in generalised anxiety disorder. Even after excluding subjects with comorbid depression, dysthymic disorder, somatic disorders, panic, obsessive-compulsive disorder (OCD) and substance abuse, 'improvement rates' across studies averaged 44% for GAD patients at immediate post-treatment. But perhaps the most negative findings in their meta-analysis were reported for depression. In intention-to-treat analyses, after screening out those with suicidal risk and substance use disorders, only 37% of patients were 'improved' at post-treatment. Of those who completed treatment, only 54% were 'improved'. Alarmingly, the author's note that at post-treatment:

> the degree of symptomatology did not constitute a return to mental health … in fact, both of these post-treatment means (i.e. Hamilton Rating Scale and BDI) are above the criteria used by researchers to indicate clinically significant depression. (p. 880–881)

After analysing 12- to 18-month follow-up data for studies on depression, the authors concluded that only 28.5% of the intent-to-treat sample remained 'improved' (i.e. were 'improved' at post-treatment and again at follow-up) (Westen & Morrison, 2001).

In summary, this thorough review revealed that manualised treatment with empirically established procedures conducted in expert research centres *did not* eliminate the psychological distress experienced by participants. On the contrary, the majority of individuals continued to experience clinically significant levels of distress. In fact, nearly 40% of participants who completed all components within these structured trials for GAD, PD and MDD reported returning to a treatment service for more support within 18 months of the completion of their original trial. Iverach, Menzies, and Menzies (2014) referred to this phenomenon as the 'revolving door' in mental health. Individuals receive treatment, improve modestly and are discharged only to return with the same disorder or a related condition. Current treatment offerings within the industry of psychology do not eliminate suffering for the majority individuals.

Results from comparative research trials tend to reveal similarly poor functional outcomes among participants, although these are often obscured by the main analyses on the primary outcomes. For example, Soares et al. (2018) compared cognitive behaviour therapy with psychodynamic therapy for major depressive disorder in a randomised controlled trial involving 247 patients. Their abstract states that:

> Clinically significant changes were found in both psychotherapy models, and CBT showed higher response rates. Regarding the Beck Depression Inventory-II [F(1,120) = 4.07, p = 0.046] and Outcome Questionnaire 45.2 [F(1.114) = 7.99, p =0.006], CBT had a better effect than SEDP. Hence, the results obtained have contributed to the literature, served to corroborate the importance and effectiveness of psychodynamic psychotherapy, as well as explored the mechanisms of change, remission, and response in the treatment of MDD, which have been ignored to a large extent. (p. 686)

While this sounds impressive, a close reading of the paper reveals particularly poor responses among participants in both groups. For example, of those who completed the treatment programmes, only 46% and 42% of participants in the CBT and psychodynamic groups, respectively, had entered the 'functional population'. This was defined as scoring below the 80th percentile on the Beck depression inventory (BDI). Staggeringly then, even at immediate post-treatment, the most likely outcome for an individual in the trial who completed all components, regardless of intervention condition, was to remain in the top 20% of the population in terms of BDI scores. Further, more than half of the participants abandoned their treatment before completion. None of these outcomes were described in the abstract.

## Why Do Psychological Treatments Fail to Produce Lasting Change?

In sum, current psychological treatment procedures are often rejected by consumers, lead to less than ideal outcomes and typically require individuals to seek further psychological services in the future. Why is this occurring? Iverach et al. (2014) provocatively argued that our gold standard treatments may not only be inadequate but may also be part of the cause for the revolving door in mental health. They suggested that common treatments for anxiety and mood disorders target the symptoms of the current presentation rather than the core transdiagnostic variables that drive mental health disorders. They suggested that existential issues underlie most of the major non-psychotic mental health problems, and that these issues are not being addressed within the industry of clinical psychology. Menzies (2018) criticised the field for abandoning its earlier links to philosophy, sociology and anthropology, arguing that insights gained about human suffering in these fields are being ignored. In particular, building on the work of anthropologist Ernest Becker and earlier stoic and existentialist philosophers, Iverach et al. (2014) argued that the critical role of death anxiety in human suffering is being routinely overlooked by clinical psychologists.

## The Dread of Death

Throughout recorded history, fears of death have been a central experience of the human condition (Furer & Walker, 2008). As a result, our species' attempts to explore and cope with our own mortality have spanned art, theatre, philosophy, music and literature. Evidence of this struggle with our own impermanence stretches as far back as Gilgamesh's 4000-year-old laments over his friend's death, and his burgeoning realisation of his own impermanence (see further, Menzies, 2018). More than 2000 years ago, the dread of death was also a popular subject among ancient Greek and Roman Stoic philosophers, who argued that we should practise accepting death, rather than being distressed at the thought of it, given that it is outside of our control. Religious and ritualistic practices have similarly featured death themes heavily across the ages. In the fifth century BC, Herodotus, considered to be the father of history, reported that at the dinner parties of wealthy Egyptians, a man would carry around the image of a corpse in a coffin, present it to each guest and say: 'Look upon this body as you drink and enjoy yourself; for you will be just like it when you are dead' (Herodotus, 1996, p. 125). Skulls have featured in various religious traditions, such as in the ritualised handling of skull-shaped bracelets in Buddhism, and in the use of human skulls as desk adornments in monastic cells in medieval Europe.

William James famously referred to our ability to contemplate mortality, a capacity arguably unique to our species, as the 'worm at the core' of our existence (James, 1985/1902, p. 119). This idea is echoed more recently in the words of Yalom (2008), who proposes that our lives are 'forever shadowed by the knowledge that we will grow, blossom, and inevitably, diminish and die' (p. 1). Thoughts of death have the power to create a sense of despair, loneliness, meaninglessness and powerlessness (Noyes, Stuart, Longley, Langbehn, & Happel, 2002; Stolorow, 1979). While all of us are likely to experience thoughts of death at some point, for some individuals, this may radically diminish their experience of joy or contentment (Yalom, 2008). Furthermore, although many people may develop effective and adaptive strategies to cope with fears of death, such as building relationships and working towards meaningful achievements, others may experience crippling dread, and engage in unhelpful, maladaptive coping strategies, such as avoidance (Menzies, 2012). As a result, death anxiety has been argued to be a transdiagnostic construct, which may underpin and exacerbate a number of different mental health conditions (Iverach et al., 2014).

For instance, death anxiety has been proposed to play a central role in illness anxiety and the somatoform disorders, with frequent medical consultations, reassurance seeking from specialists and checking oneself for signs of illness all having clear associations with death fears (Furer & Walker, 2008; Hiebert, Furer, McPhail, & Walker, 2005). Similarly, the relevance of the dread of death to panic disorder, in which patients may monitor internal symptoms, such as heart rate, or seek medical advice for fear they are having a heart attack, also appears clear (Randall, 2001; Starcevic, 2007). In obsessive-compulsive disorder (OCD), the most common subtypes (washing and checking) can both be explicitly linked to death anxiety, with patients reporting fears of contamination and contracting illnesses, and worries about household fires or electrocution, respectively (Menzies, Menzies, & Iverach, 2015). Recent empirical research has demonstrated the relationship between death thoughts and OCD behaviours, with reminders of death being shown to double the amount of time spent handwashing among compulsive washers (Menzies & Dar-Nimrod, 2017).

In addition, almost one century ago, Kingman (1928) argued that death anxiety is central to the majority of phobias, and recent evidence, revealing that reminders of death exacerbate avoidance and perceived threat among spider phobics (Strachan et al., 2007), lends some support to this claim. Significant positive correlations have been demonstrated between symptoms of separation anxiety and death anxiety (Caras, 1995), suggesting the role of death fears in this disorder. Death-related events, such as the loss of a loved one or a physical threat to the self, have been shown to typically precede the onset of agoraphobia (Foa, Steketee, & Young, 1984). Such life-threatening or traumatic events have also been argued to play a central role in post-traumatic stress disorder (PTSD; Chatard et al., 2012), and to increase death anxiety and the risk of PTSD symptoms (Cheung, Dennis, Easthope, Werrett, & Farmer, 2005). In a similar vein, there is evidence to suggest that individuals with high levels of PTSD symptoms appear less able to effectively suppress thoughts of death, relative to those with low levels of such symptoms.

Even among disorders that appear less explicitly related to death fears, such as social anxiety, thoughts of death have been shown to increase anxious behaviour. For example, among participants high in social anxiety, reminders of death lead to increased social avoidance (Strachan et al., 2007). Similarly, not only does correlational research show that death anxiety significantly predicts disordered eating, above and beyond perfectionism and self-esteem (Le Marne & Harris, 2016), but reminders of death lead women to restrict consumption of food (Goldenberg, Arndt, Hart, & Brown, 2005). Lastly, within the depressive disorders, existential concerns such as death anxiety and meaninglessness have also been argued to play an important role (Ghaemi, 2007; Simon, Arndt, Greenberg, Solomon, & Pyszczynski, 1998). This notion is supported by some experimental research, showing that mildly depressed participants respond more strongly to reminders of death, relative to participants who are not depressed (Simon et al., 1998).

One recent study (Menzies, Sharpe, & Dar-Nimrod, 2019) found that, across a transdiagnostic, treatment-seeking clinical sample, death anxiety was a strong predictor of broad markers of psychopathology, including number of lifetime diagnoses, number of medications, depression, anxiety, stress and a clinician's judgement of distress and impairment. Furthermore, across 12 disorders, including depression, social anxiety, alcohol use disorder, generalised anxiety disorder and OCD, death anxiety was significantly associated with the symptom severity of that disorder. Importantly, these relationships remained significant after accounting for neuroticism, suggesting the unique role of the dread of death.

With increasing evidence supporting the claim that death anxiety underpins numerous mental health conditions, important implications for clinical work begin to emerge. Primarily, the failure to address the dread of death may explain the revolving door in mental health services (Iverach et al., 2014). As stated earlier, it is not uncommon for a patient to present to treatment at various points across their lifespan, either after relapse or with a seemingly different disorder and pattern of symptoms. Perhaps, for instance, an individual is diagnosed with and treated for separation anxiety as a child, then returns as an adolescent with panic disorder and, lastly, as an adult presents for treatment with a disorder that appears quite different to their previous experiences, such as a phobia of heights. Indeed, some research has found that the rates of lifetime diagnoses are typically around double those of current diagnoses (Simon et al., 2007). Iverach et al. (2014) argued that the dread of death may be underpinning these separate mental illnesses, and each may be a distinct manifestation of the underling death anxiety. If this is the case, standard treatments that focus on addressing proximal threats, such as the fear of falling or worries about a heart attack, are unlikely to ensure long-term outcomes (Iverach et al., 2014). In fact, the removal of these proximal threats to life (e.g. by challenging threat expectancies through exposure and behavioural experiments) may amount to little more than the provision of reassurance. It is the present author's view that these approaches will do little, if anything, for the sufferer's broad fears of impermanence. It may be necessary to treat 'the worm at the core' if we wish to eliminate the revolving door effect.

## Future Directions

If existential anxiety is a universal human phenomenon, we should be able to learn from those individuals who are not prone to mental health problems across their life. How are they successfully responding to death-related issues? How do they manage the angst that typically arises from the knowledge of the certainty of one's death? Many authors argued that terror management theory (TMT) best accounts for the behavioural and emotional reactions displayed by most humans in response to the construct of death (Helm, Duchschere, & Greenberg, 2018; Iverach, 2018; Menzies & Menzies, 2018; Pyszczynski & Thompson, 2018). TMT proposes that broad cultural practices (e.g. seeking academic achievement, attaining professional success, contributing to social causes for the betterment of others and extending the self through children), may serve as defensive mechanisms in the face of the terror of death. Considerable experimental research supports the claim that adherence to strongly held 'cultural world views' may buffer against death fears. As Helm et al. (2018) showed us, this is partly achieved by building robust self-esteem – a sense of self that provides a virtual immortality in the face of death. In essence, TMT proposes that heightened self-esteem may enable us to deny our animal nature by elevating the self to a higher status than worms, dogs and cats. Further, close adherence to cultural worldviews may be associated with activities that give us a continuance after we die (e.g. being part of a social movement that will be ongoing, producing products that will exist when we die). Mikulincer (2018) expanded the TMT position by showing that attachment security may similarly moderate the typical responses to death priming seen in mortality salience research designs. Attachment security – a sense that the world is generally safe and that one is valuable and lovable – appears to provide a solid psychological basis for reducing death dread and is associated with a raft of psychosocial benefits (Mikulincer, 2018).

The ‘cultural worldviews’ described by TMT include religious belief. As Pyszczynski and Thompson (2018) pointed out, religion transforms death from an unsolvable problem to a controllable one by providing a pathway to literal immortality. Considerable research supports the claim that strong, inherent religious belief is associated with reduced death anxiety and increased well-being (Pyszczynski & Thompson, 2018). Of course, religious belief is not a solution that all individuals find palatable. Further, the effects of religion are not all positive. Religious belief is associated with disdain and hostility to out-groups, as well as violence towards those with different perspectives (Pyszczynski, Vail, & Motyl, 2010). Fortunately, many of the benefits of involvement in religious communities may be gained through other activities that also involve in-group identification, social networking and support. Chopik (2017) reported that increased social support is associated with reduced death anxiety across time. It is well established that social isolation is associated with a range of poor physical and mental health outcomes, and increasing social connectedness has been associated with improvements in mental and physical health in many reports (Jetten, Haslam, & Haslam, 2012). Dingle, Williams, Sharman, and Jetten (2016) recently demonstrated the benefits of choir singing and creative writing groups for the homeless and disadvantaged. Participants in this study had severe and chronic mental health conditions including schizophrenia, bipolar disorder, recurrent depression and addiction. Twelve months after joining the choir or writing groups, 44% of participants perceived their mental health to have improved and 46% reported their physical health to have improved (Dingle et al., 2016). Given the extreme disability of the sample in this research, the findings are impressive. Similarly encouraging results have been reported by Haslam, Cruwys, Haslam, Dingle, and Chang (2016) with their ‘Groups 4 Health’ programme (G4H). The programme, emerging out of social psychology, targets the development of social group relationships to treat psychological distress. Reductions on measures of depression, general anxiety, stress, social anxiety and loneliness were found at programme completion and at 6-month follow-up. Self-esteem and life satisfaction improved consistently across the trial. Notably, the treatment effects were mediated by participants’ increased identification with their G4H members. Given that identity, isolation and meaning are three of the ‘Big 5′ themes described in the existential literature, the positive effects of the G4H programme should not be surprising.

Feelings of connectedness to others may even be the mediating variable that underpins the positive emotional response associated with Buddhist meditation. While the industry of clinical psychology has been obsessed with the removal of negative affect, other fields have been interested in promoting the experience of positive emotion (Hofmann, 2018). Hofmann, Grossman, and Hinton (2011) reviewed the benefits of the loving-kindness meditation (LKM) in a range of populations. Loving-kindness is derived from Buddhism and refers to a mental state of unselfish and unconditional kindness to all beings. Loving-kindness and compassion are overlapping constructs that are related to the Buddhist notion that all living beings are connected. Together with sympathetic joy and equanimity, loving-kindness and compassion constitute the four *brahma viharas*, which are regarded as states to be cultivated through Buddhist practice (Hofmann et al., 2011). Hofmann et al. (2011) reviewed several studies showing that LKM is associated with (1) an increase in positive affect, (2) a decrease in negative affect, (3) reductions in stress-induced subjective distress and immune response, (4) increased activation of brain areas that are involved in emotional processing and empathy and (5) enhanced outcomes with depressed individuals. Similarly, the meta-analysis of Kirby, Tellegen, and Steindl (2017) reported moderate to large pre- and post-improvements on anxiety, depression and psychological distress following compassion-based interventions.

## Concluding Comments

The size of the global mental health problem has far outstripped the capacity of governments to meet the demand. Attempts to scale up treatments in automated, electronic form have generally been rejected by consumers. Further, current psychological treatments seem to offer more than they deliver. The industry of psychology has generally produced treatments that improve functioning in the short term, but are associated with relapse and the emergence of further disorders. Chronic disability from mental health problems is common in the community.

Clinical psychology has become an insular profession, unfortunately moving away from its roots in philosophy. Major theoretical models in other fields, even in subdisciplines of psychology, are rarely cited in our clinical journals. The lessons from the existentialists, stoics, Buddhists and social psychologists are generally ignored in mainstream clinical practice.

Solutions to the global mental health crisis will not be found in one-to-one, in-clinic interventions. Emerging from a complex literature are community-wide needs to promote the formation of secure attachments, participation in social activities to build identity and assuage existential isolation and loneliness, meaning-making, authentic living and, for some, religious practice. In addition, we need to recognise that mental health is severely impacted by stable housing, employment status and physical health (Mental Health Taskforce, 2016). While the profession of psychology may contribute to some of these enterprises, it is our view that many of the gains in global mental health will need to be made outside of the clinic.

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# Chapter 3
# Attachment to Irreplaceable Others

**Jennifer Fitzgerald**

Opera lovers listening to Kathleen Ferrier singing Ofeo's famous aria, *What will life be like without Eurydice*?, are moved by the tenderness, yearning and anguish of his grief. We love deeply and mourn greatly when our beloved dies or leaves us for another. John Bowlby, who patiently sat with his widowed patients as they wept and raged their way through grief, understood. He says,

> Many of the most intense emotions arise during the formation, the maintenance, the disruption and the renewal of attachment relationships. The formation of a bond is described as falling love, maintaining a bond as loving someone, and losing a partner as grieving over someone. Similarly, threat of loss arouses anxiety and actual loss gives rise to sorrow; whilst each of these situations is likely to arouse anger. The unchallenged maintenance of a bond is experienced as joy. (Bowlby, 1979, p. 130)

Seeking and maintaining contact with a few "irreplaceable others" is a primary motivating principle in our human lives, and it is an innate survival mechanism (Bowlby, 1969, as cited by Johnson & Best, 2002, p. 169). We are wired to form social connections (Cacioppo, 2018) and we regulate affect by initiating proximity to loved ones (Coan, 2010). Greenman, Wiebe, and Johnson (2017) report that

> the human brain appears to respond to separation from a loved one, especially in times of stress or perceived threat, by sending a distress call throughout the organism that leads to attachment behaviour to seek reunion and to regain felt security (Greenman et al., 2017, p. 293).

When we can regain connection in times of stress, our attachment figure can attenuate our threat responsive neural activity, as demonstrated in the lending-a-hand laboratory experiment (Coan, Schaefer, & Davidson, 2006).

Bowlby also treated children brought to the Tavistock Clinic in London for conduct difficulties such as theft, promiscuity or truancy. His interest in the stories

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of these “forty-four juvenile thieves” (Bowlby, 1944) resulted in a discovery that the majority had suffered significant separation from their primary caregivers in the course of their young lives. His continued observational research with children dislocated from their families owing to World War II, integrated with evolutionary theory, ethology and biological systems theory became the birthing ground of attachment theory. Today, because of John Bowlby, we not only have more humane practices in paediatric hospitals when our children require treatment, but we also have a vast body of research helping us to understand the nuances of attachment relationships, especially those of parents and children, romantic partnerships and attachment to God. Indeed, most of us can easily relate to Orfeo’s distress when we contemplate life without the presence of our special, few, irreplaceable others. This chapter considers the importance of secure attachment relationships for our physical, emotional and social well-being.

## Turning to Others

Attachment is all about distance regulation. Not just any distance, please note, but the distance between each one of us and our very important others. Infants are born with an ability to cry, and they later reach out their arms to be picked up and then to crawl or run towards their caregiver/s. What does a mother do when her baby cries in his cot? If she is attuned to her infant, she will move towards him, turn to him and attend to his needs. He will be fed and held, bathed and comforted, and if he is old enough to play on the floor, his mother will offer him the freedom to explore his toy box and investigate his little world. If he becomes lonely or bored or pinches his finger in an unexpectedly sharp novel object, he will cry out for her, crawling in her direction. She turns towards him again and comforts, soothes and settles, then offers him the option of looking about and playing again. Safe haven and secure base functions of attachment flexibly moving to and fro, close when needed, spacious when safe to play and explore.

The sensitivity and reliability of attachment figures’ responses are what builds a secure relationship between parents and their children, romantic partners, family members and close friends. Bowlby called this accessibility and responsiveness the building blocks of an attachment relationship:

> For not only young children, it is now clear, but human beings of all ages are found to be at their happiest and to be able to deploy their talents to best advantage when they are confident that, standing behind them, there are one or more trusted persons who will come to their aid should difficulties arise. The person trusted provides a secure base from which his (or her) companion can operate. (Bowlby, 1973, p. 359)

Bowlby thankfully challenged the notion that dependency was only appropriate in infancy and, instead, acknowledged and normalised our urge to turn towards, call to and seek out important, reliable others in times of need, “from the cradle to the grave” (Bowlby, 1979, p. 129). Susan Johnson comments that to be human is to need others, and this is no flaw or weakness (Johnson, 2013). Such an attachment perspective on human development suggests that members of families or couples "grow and differentiate *with* rather than *from* each other" (Brassard & Johnson, 2016, p. 807).

Interestingly, recent focus has turned to the problem of loneliness in our society, and Michelle Lim, Scientific Chair of the Australian Coalition to End Loneliness (2018), says:

> All human beings are vulnerable to experiencing loneliness. Unmet social needs are akin to other human needs such as thirst and hunger. In this way, while loneliness can be a distressing feeling, *it serves a function and is a signal to reach out and to rely upon others*. This reliance is critical, as it prevents us from having to depend solely on our own resources to survive, thrive or flourish. (Lim, 2018, p. 7, emphasis added)

Bowlby proposed that self-reliance is built from a child's confidence in the accessibility and support of the attachment figure (Bowlby, 1973). Costello (2013) also explains that our basic choices about who we are and can be evolve in an attachment context. He suggests that we decide with caregivers what will happen when we are lonely and afraid, whether we are best to cry out or stifle our vulnerability, and how best to get a response from others. Essentially, this means that a positive sense of felt connection with a loved one is a primary emotion regulation device (Mikulincer & Shaver, 2016).

In parent–child attachment, there is an interesting paradox, for the more a child can turn towards his parent as a source of safety and comfort, the more secure he feels. The more secure he feels, the less he clings and the more confident he is in developing his personality and venturing forth into the world of growing up. Mary Ainsworth and her colleagues in their observational research with Baltimore mothers and their infants reported that when mothers promptly picked up and comforted their crying infants, they cried *less* by the end of their first year (Ainsworth, Bell, & Stayton, 1974). Parents, grandparents, aunts and uncles and long-term nannies can all contribute to this experience of reliable responsivity, creating what Inge Bretherton (1980, p. 195) called a "small hierarchy of major caregivers". However, as Ainsworth (1967) noted, when distressed, infants and children will typically seek proximity to the principal attachment figure.

Not everyone, however, is fortunate in receiving the sensitive, responsive caregiving that early attachment researchers have identified with infants' secure attachment. Not all children grow up feeling confident they can turn towards their parents and know they will "be there" for them. Indeed, differences in experience of regulating distress with attachment figures have led to differences in responses to a very crucial question regarding whether the attachment figure can be counted on to be there when needed (Hazan & Shaver, 1994).

> On these complementary internal working models of self with attachment figures depends an individual's confidence that attachment figures, in general, will be readily available – most of the time, occasionally or almost never, and whether he will approach the world with confidence when faced with alarming situations, either by tackling them effectively or seeking support. (Bowlby, 1973, p. 203)

The models tend to be reciprocal, with children who experience inconsistent responses or worse, neglect and abuse, tending to form negative models of self along with negative models of other. (See Bretherton & Munholland, 2016, for a detailed report of Bowlby's postulates regarding internal working models.)

## Attachment and Romantic Love

Just over 30 years ago, romantic love was conceptualised as an attachment process (Hazan & Shaver, 1987), spawning an extensive body of research that helps us understand more about our adult experiences of turning to important others. In adult relationships, stage of relationship development is relevant, with physical contact and proximity somewhat more important in initial stages and provision of mutual support and care important in later stages. Further, "full-blown" attachment to a romantic partner (in contrast to parents) takes approximately 2 years to establish (Hazan & Zeifman, 1994). While sexual urges and emotional attachments are not necessarily connected, Gurit Birnbaum and Harry Reis (2018) report evidence that sex can and does promote enduring bonds between partners, with benefits for the couple as well as their dependent offspring. For example, heightened feelings of passion for one's partner and gratifying sex predicts lower relationship insecurity (Mizrahi, Hirschberger, Mikulincer, Szepsenwol, & Birnbaum, 2016).

Like the relationships of parents and children, romantic partnerships are a dyadic process, but typically involving mutual giving and receiving of responsiveness and support. In each pair bond, strengths and sensitivities in both partners will affect the experience and the effectiveness of the emotional bond. Anxious or preoccupied attachment typically develops from infancy in response to inconsistent or insensitive caregiving and is marked by hypervigilance to negative affect and heightened expressions of distress. The sense of self of these individuals is typically coloured by self-doubt and models of other by mental pictures of unavailability. These individuals tend in adulthood to react to perceived partner distance or inattention with comments like, "You put your work, your family, our children, all ahead of me. I come LAST!" Partners often hear such comments as criticism or control. Individuals with this attachment orientation are more inclined to doubt their own lovability, lack confidence in their partner's availability, react to perceived unavailability with sadness or anger and are more vigilant to threat cues (Mikulincer & Shaver, 2018).

Avoidant attachment, on the other hand, is more likely to develop in the face of rejection from caregivers and reflects rules restricting acknowledgement of distress and seeking of support. When a newly married couple in their early forties sought my assistance for their relationship distress, they reported the husband's angry criticism of his wife's grief over her recent miscarriage of a much wanted first pregnancy ("All this crying- you are just wasting your time!"). When I asked this man how his parents responded when he cried as a boy, he replied emphatically, "I was told, 'Go to your room and do *not* come out until you have stopped the nonsense!'" Understanding through an attachment framework brought a particular logic to this man's otherwise puzzling, and for his wife, distress-maintaining behaviours. He had no map to follow for tuning into his own emotions, knowing what they were telling him he needed and then acting on his own behalf to have his needs met in healthy ways (Fridja, 2007). Individuals with avoidant attachment individuals tend to be distrusting of their relationship partners' goodwill, which causes them to maintain distance, suppress emotions and strive for emotional independence (Mikulincer & Shaver, 2018). Their early experience typically results in restricted support giving in adult relationships as well (Simpson, Rholes, & Nelligan, 1992).

The Minnesota Study of Risk and Adaptation (described in detail in Sroufe, Egeland, Carlson, & Collins, 2005) has followed 180 individuals born into poverty in the mid-1970s across almost four decades. The results of this significant longitudinal study again demonstrate the impact of early attachment relationships on later functioning. Using Ainsworth's Strange Situation laboratory protocol for assessing infant attachment between 9 and 12 months of age, these infants reacted to brief separation from their mother and time with a female stranger in ways that were coded as either secure (the infants used their mother on her return as a source of comfort and base of security to regulate their affect) or insecure, with three types, namely anxious or resistant (infants were inconsolable and sometimes angry on reunion), avoidant (overt distress was suppressed but physiologically they were aroused) and disorganised (expressed odd or ambivalent behaviour towards the parent) (Ainsworth, Blehar, Waters, & Wall, 1978; Main & Solomon, 1990).

The impact of secure attachment as a resource over time was demonstrated when these children were 20 or 21 years of age and were invited with their romantic partners into the laboratory. Simpson, Collins, Salvatore, and Sung (2014) reported that when engaging in a conflict resolution task with their partners, individuals coded in infancy as insecure reported and behaviourally expressed more negative emotion when trying to resolve the conflict. On the other hand, more secure participants demonstrated better conflict recovery *and* their partners recovered more quickly also. These results were mediated by social competence at 6 years of age and quality of friendships at 16 years of age.

Two years later (when aged 23 years), if the couple were still together, they were invited back for an interview. Those who had been insecurely attached infants were more likely to still be with the same partner *if* their partner had displayed better conflict recovery 2 years previously. Emotionally well-regulated romantic partners appear to "protect" individuals with insecure attachment histories from relationship difficulties in adulthood.

A decade or so later when these participants were in their thirties, they were assessed for health status, according to self-report of health, number of health problems and cardio-metabolic functioning. Support was found for the hypothesis that individuals insecure as children would report more health problems at age 32 years. Further, neglect between 0 and 17.5 years, in contrast to physical or sexual abuse, was found to also predict all three measures of adult health outcomes (Johnson et al., 2017). This longitudinal finding is consistent with an emerging body of research that suggests attachment insecurity is associated with dysregulated physical responses to stress, risky health behaviours, susceptibility to illness and poorer disease outcomes (Pietromonaco & Beck, 2018).

## Impact of Trauma on Individual and Relationship Functioning

The positive internal working models of secure individuals appear also to confer greater capacity to adapt to aversive events than their insecure counterparts. When Fraley, Fazzari, Bonanno, and Dekel (2006) investigated the impact on people in the vicinity of the terrorist attacks on the World Trade Center in September 2001, they found more secure individuals had fewer symptoms of post-traumatic stress disorder (PTSD) and depression at 7 and 18 months after the event than their insecure counterparts. Individuals with a highly dismissing avoidant attachment style self-reported high levels of PTSD and depression at both times. These researchers drew on previous research, suggesting that secure attachment is typically associated with *support seeking* during stress. Interestingly, this may also be at the level of internal representation, as reported in laboratory-based research, in which secure individuals in a threatening laboratory task (being presented with unsolvable puzzles and being told they had failed each one) brought to mind representations of feeling cared for by significant others in their lives, which resulted in reduction in negative affect (Mikulincer & Shaver, 2004). In the real world of terrorism, in laboratory experiments, in community and clinical research, a clear conclusion is evident. Close relationships matter, and being able to turn to a responsive other in times of stress helps us to survive and flourish.

On the other hand, negative working models in survivors of developmental trauma can be infused with a sense of insecurity, which may manifest in a range of difficulties in adulthood, such as a negative sense of self, and difficulties with memory, emotional regulation, trust, closeness, empathy and perspective taking, communication and sexuality (MacIntosh & Johnson, 2008). Importantly, however, such difficulties are likely to be experienced and managed differently if the survivor can “find comfort in the arms of another” (Van der Kolk, Perry, & Herman, 1991, p. 1669).

## Attachment-Related Couples’ Therapy and Relationship Education

Turning to others and getting the response that is longed for can sometimes be hard. Seeking support in ways that draw the other close, and indeed giving sensitive support such that the recipient feels comforted or assisted, rather than ignored or intruded upon, are typically easier for individuals with secure developmental pathways and adult relationships. Insecure attachment in both partners can be associated with heightened conflict, especially at times of stress. Severe or persistent conflict is typically disturbing and erodes relationship satisfaction and security. As indicated earlier, attachment security typically has an effect on conflict situations, influencing perceptual, physiological and behavioural responses to conflict (Feeney & Fitzgerald, 2018).

However, for individuals with more difficult developmental years or adult relationships, valuable assistance is at hand. Just as therapists gain from holding an attachment framework when understanding their clients' psychological and relationship distress, so too attachment concepts can benefit individuals and couples' understanding of each other. Emotionally focused therapy for couples (EFT) (Johnson & Greenberg, 1992) aims to help couples de-escalate their patterns of conflict and alienation and restructure their attachment bond. Recent research (a first in the field of attachment research) has demonstrated reduction in attachment insecurity (avoidance and anxiety) over the course of treatment with EFT for couples (Burgess Moses et al., 2016). Emotionally focused relationship education programmes such as *Hold Me Tight: Seven Conversations For a Life Time of Love* (Johnson, 2008) and books such as *Love Sense: The Revolutionary New Science of Romantic Love* (Johnson, 2013) and *An Emotionally Focused Workbook for Couples: The Two of Us* (Kallos-Lilly & Fitzgerald, 2015) offer couples ideas and support to attune to each other, and experience new ways of talking to each other that facilitate emotional closeness. The *Hold Me Tight* programme has also been adapted for Christian couples (*Created for Connection,* Johnson & Sanderfer, 2016) and couples dealing with heart disease (*Healing Hearts Together, HHT*). A randomised controlled trial is underway in Ottawa, Canada, to test the efficacy of HHT for cardiac patients and their partners.

Susan Johnson et al. (2013) report further findings using Coan's lending-a-hand research paradigm (mentioned earlier). Secure attachment between female participants and their male partners was found to change the female's neurophysiological threat responding using electric shock as the threat. This study using functional magnetic resonance imaging (fMRI) scans was conducted pre and post therapy for the female clients. Before treatment with EFT, these clients' brains moved into an alarm state when possible electric shock was signalled, whether they were alone in the machine, holding a stranger's hand or holding their partner's hand. After therapy, however, their brains remained calm in the face of threat *but only while holding their partners' hand.* Also, their subjective reports of pain when shocks were delivered were less than pre-treatment measures. The authors comment that these results would appear to be an example of safe haven affect regulation in operation.

## Turning to God

Psychology of religion researchers support the view that people are more likely to turn to religion in times of distress and crisis, and most particularly through prayer (Granqvist & Kilpatrick, 2016). According to theologian Kaufman (1981), God is a completely adequate attachment figure, with the Judeo-Christian scriptures replete with comforting images of God. Consider, for example, "The eternal God is your refuge and underneath are the everlasting arms" (Deut: 33.27 NIV), "God is our refuge and strength, a very present help in trouble" (Ps 46:1 NIV) and "Come to me, all you who are weary and burdened, and I will give you rest" (Matt 11:28–30 NIV). Centuries before attachment theory was formulated, such images offered the idea of a stronger, wiser other who provides proximity, safe haven and a secure base from which to navigate the world and its many difficulties, griefs and fears.

Research investigating connections between religious beliefs and psychological coping has expanded in the last couple of decades and reports a complex array of results. Positive associations between religion and mental health have been found specifically in the attenuation of grief (Brown, Nesse, House, & Utz, 2004), freedom from worry and fear and a personal sense of competence (Batson, Schoenrade, & Ventis, 1993). Further, in the context of unavailable or insufficient secure attachment figures, respondents who remembered their mothers as relatively insensitive perceived that they benefited from their secure relationship with God (Kirkpatrick & Shaver, 1992). Interesting research has examined a correspondence hypothesis (images of God correspond with internal working models of other) versus a compensation hypothesis in which images of God compensate for negative models formed in the developmental years. Evidence has been found for both hypotheses (See Granqvist & Kilpatrick, 2016, for a discussion of these interesting and complex questions).

## Conclusion

This chapter has summarised attachment theoretical research indicating that turning to and establishing emotional bonds with important others across the lifespan is a central part of both our survival code and also our capacity to flourish. This turning to others is not indiscriminate, for, indeed, Orfeo's intense grief is at the prospect of losing not just any woman, but his beloved Eurydice. A sick, lonely, injured or frightened infant or child will not be comforted by a stranger, no matter how well meaning that stranger may be, in the way that comfort will be provided by his or her mother or primary caregiver. It is in the thousands of interactions that are infused with accessibility and responsiveness that our attachment bonds are created. The deep emotional safety to turn towards just a few others when needed, and feel confident of sensitive response from them, this, is what makes them *irreplaceable*. Similarly, our willingness to be reliably available and responsive to our significant others builds the security of mutually warm and safe relationships in adulthood. Knowing that these few, special others exist, or have existed in an earlier stage of our lives leaving embedded mental representations of safety and love, protects us from much of the negative impact of life's strain and stress. When the 9/11 terrorist crisis occurred in New York, psychological recovery was greater for those who could turn to others for support, in contrast to those who were fiercely independent and unwilling to seek comfort or support.

Emotionally Focused Therapy for Couples, and its relationship education programme, *Hold Me Tight*, thus encourages couples the world over to "seek each other out in moments of stress, sadness, loss, anxiety and uncertainty because of the basic assumption in this therapeutic approach that clear, unequivocal expressions of vulnerability followed by soothing responses from a partner fosters intimacy, closeness, and general relationship satisfaction" (Greenman et al., 2017). Such interactions build emotional connections that are *felt* rather than easily measured or intellectually described, and may be what W. B. Yeats (1935/1968) had in mind in his prayer for old age, "God guard me from the thoughts men think in the mind alone. He that sings a lasting song, thinks in a marrow bone".

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# Chapter 4
# Poetry as Therapy

**Jhilmil Breckenridge**

It is possible...
It is possible at least sometimes...
It is possible especially now
To ride a horse
Inside a prison cell
And run away…
— From *The Prison Cell* by Mahmoud Darwish, (1992)

Yesterday, I attended an event at the Harris Museum, Preston, Lancashire. This museum in a small town in Northern England was hosting a reception where the mayor and other bigwigs came to open an exhibition I am involved with—for the past 9 months, I have been engaged with unearthing history from the archives on one of the largest and oldest asylums in Europe, Whittingham Asylum, and using historical titbits—photos, information from superintendent's registers, reception orders (when someone was committed, each person's personal details were logged in an admission form known as a 'reception order'), etc.—in conjunction with the lived experiences of service users, family members of those struggling with mental health distress, prisoners/service users still committed in a secure unit here in Lancashire to create fresh writing, poetry and art. The results of these workshops have been startling, politically charged and very powerful.

Using poetry and creative writing as a tool can be therapeutic as well as can be a powerful intervention to create change and affect public perceptions. Art can appeal obliquely, and as people witness the created art and writing, like they did in the exhibition last night, conversations flowed over wine that could possibly change the way people with mental distress are perceived.

In the 1990s, James W. Pennebaker started publishing results from clinical trials he had conducted, in laboratory conditions, on the connections between health markers and expressive writing (Pennebaker 1993). Although there has always been a connection between revealing your traumas and feeling better, the way Pennebaker

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conducted these trials and documented results resulted in his work being accepted as ‘therapeutic’ and ‘scientific’. He and his team invited subjects, whose health markers like blood pressure, whether they are grieving, in distress, etc., were noted individually, and then they were placed into a writing cubicle in a lab; he separated subjects into groups that wrote about general topics, like the weather, a walk, etc., and others who wrote about significant and traumatic events in their lives. The subjects repeated this for at least 15–20 minutes for five consecutive days. The results revealed that the subjects who wrote on general topics showed no significant changes in their health markers, but the subjects who wrote on distress or trauma showed significant improvements in their health markers over the next 6 months. These experiments were repeated by several scientists and they found the same results. These results were also true for people living with depression and other mental health conditions—both physical and mental health markers improved.

In my work as a poet, activist and founder of a mental health charity, I use creative writing as an important tool in helping people heal from trauma, or perhaps make more sense of living with their distress, or cope. In prison settings, classroom settings or workshop settings, I have used these sessions to varying results, mostly positive and powerful, and the participants claim ‘don’t know what it is, but I feel so much better after writing!’ I think poetry in particular helps you to make sense of grief, of trauma. Poetry opens a door to light.

For example, consider these words, created in one of my classes by a service user:

**Tea and Medication**

In seclusion, they give you
Tea and medication
In seclusion, they give you
Time
In seclusion, you can shout
The walls don’t care
In seclusion, the walls have eyes
In seclusion, they do what they like
In seclusion, you’re not really alone

For someone who is still living with the threat of facing seclusion for any misdemeanour, writing this was a breath of fresh air. This poem was created in a project I did through February and March 2018, the one being showcased last evening at the museum. We used archive history prompts about Whittingham Asylum to create new writing, poetry and songs by service users living in Guild Lodge, a National Health Service (NHS) secure mental health facility, running on the grounds of the old Asylum. For the service users and staff, who were seeing photographs of what may have happened in times gone by, realising that although a lot had changed, some for the better, many things were the same or worse, lead to some powerful words being created.

In my own work, where I head a charity in India called the Bhor Foundation, one of whose mandates is to take poetry as therapy into psychiatric institutions and prisons, this project has helped me see, yet again, how therapeutic and amazing these interventions can be. In the words of Hemlata Tripathi, a technical instructor at the

NHS facility, who was present for the series of workshops and a key part of them, ‘the service users keep asking if the workshop is definitely happening next week, this is a first that they look forward to something so much.’ The same service users kept coming back to these voluntary sessions, and said they enjoyed them so much, in one user’s words, ‘the highlight of his week!’ And although sometimes the subject of the material led to controversial words being written, the energy of the group was always contained and managed and there was cathartic, therapeutic and often political writing in response to the material we had unearthed at the Lancashire Archives.

Indeed in my own case, in 2015, I did an unusual thing—I signed up for an MA in Creative Writing. Middle-aged women, especially Indian ones, do not suddenly get up and go to England to do another degree, but on a whim, I sent off a creative piece, got admission and I was off. I was 47 years old and was trying to rebuild my life after a divorce, the kidnapping of my children, trauma, forced incarceration in a mental health institution, sexual violence and much else (Breckenridge 2017).

The irrational decision turned out to not be so irrational after all. The poetry module, when it came to me—although I went in dragging my feet, protesting that poetry was not for me—transformed me. I could suddenly breathe. Poetry turned into my gills.

Trauma is a strange beast. It is a heaviness in your limbs, it is an itching just under your skin where you cannot reach, it is the irritable bowel syndrome (IBS) in your gut, it is the hair falling out in handfuls. It is the grey dog sleeping at your feet which can suddenly wake up, lunge for your throat, gleaming white teeth bared. It is the cobwebs that flutter in every room of your house, and as you walk, they shimmy, reminding you of their presence.

Trauma loves to stay in parts of your body that therapy and medication cannot shift. And although I benefited greatly from my pony-tailed psychotherapist in New Delhi when I was going through the worst times of my marriage, I can truly say it is poetry that has set me free. I breathe differently when I am writing or even reading poetry that speaks to me. It is as if the whole world slows down and I can finally tune into what really matters.

When I began my course, I found that I related to more contemporary poets—Warsan Shire’s work resonated with some aspects of my own life, the feeling that I was not enough, not pretty enough, not woman enough. Anne Sexton’s (1981) confessional poems gave me an insight into the heart and minds of women with feelings like mine: ‘But suicides have a special language./Like carpenters they want to know which tools./They never ask why build’.

Ellen Bass and Jane Hirshfield taught me to tune into the immediacy of the moment and the thrill of being able to express it with the simplest language. This was a journey I was already on with yoga and mindfulness and meditation, which has saved me through my darkest times. And the joy of Faiz and my current attempt to learn Urdu is a quest that is transformative and is somehow taking me closer to my Muslim grandmother, now dead and gone, except that I sense her fragrance leaning into me, holding my hand as I read.

Although we cannot think of specific poems for specific illnesses, because everyone is unique, consider that in her memoir, *Black Rainbow*, Rachel Kelly describes learning and repeating lines from George Herbert's poem, *The Flower,* and the effects this simple act had on her: 'In those moments of the day when I held hands with Herbert, the depression couldn't find me. It felt as though the poet was embracing me from across the centuries, wrapping me in a cocoon of stillness and calm' (Kelly 2014).

But the other interesting thing that has happened with me thanks to poetry is that I have just become more relaxed and nothing, I repeat *nothing*, bothers me anymore! It is as if I have finally discovered the magic mantra for life, and I am grateful for every day, every breath. Stress, worry, headaches, migraines, sleeplessness, all these have just upped and left my side, whereas before they were my constant companions. And this again corroborates with the Pennebaker studies, that health markers improve from expressive writing.

In the UK, there is a lot of focus on expressive writing, as well as reading. There is an organisation called Lapidus which I am a member of; in addition to other things, their mandate includes writing with refugees, the elderly and families, to new ways of engaging with stories and poems. They aim to work with writing and words to inspire, connect and promote communication, physical and emotional health and enjoyment. Their journal debates the ways in which writing contributes to the well-being of individuals, groups and communities. The Reader, which is a charity, takes shared reading to spaces like palliative care homes and other communities to improve well-being, reduce social isolation and build resilience in diverse communities across the UK and beyond. The groups they work with include looked after children, people in recovery from substance misuse, prisoners, individuals living with dementia, parents, teachers, people with mental and physical health conditions and many more.

These organisations are not unique to the UK. Such charities and organisations are spreading up all over the world, and even in universities, there are now Medical Humanities departments looking at the intersection between literature, art and medicine, amongst other things. Universities are also increasingly conducting seminars, workshops and conferences upon the connections between expressive writing and pain, for instance the one I went to in Lancaster University. Glasgow University, earlier this year, had a conference on writing and well-being, with scholars, professionals, service users and writers coming together to talk about these not-so-mystical connections between writing and well-being.

Here are some reasons poetry is good for you!

1. Slow down

In these days of life moving so fast and a smartphone-addicted life, where our attention spans are getting shorter and shorter and we need continuous entertainment, we need to slow down. But when you read a poem, it is as if time slows down; you have to take time to understand a new thought and it forces you to engage with that present moment, without thinking of your to-do list or the latest cat video on Twitter.

2. Forces you to feel

One of the advantages of poetry over prose is that poetry can often convey a whole story in twenty lines! It may bring you the joy of reading a novel but in tiny bursts—travelling, new ideas and maybe a new way of thinking of something, or a new way of imagining something. And most poetry has a strong emotion it is conveying, so it forces you to feel and to exercise your emotional muscles.

3. Deal with difficult emotions

Research shows that poetry helps people who are grieving, recovering from a broken relationship or other difficult times in their lives. Just as Rachel Kelley mentions in her memoir, *Black Rainbow*, the simple act of reading George Herbert's poem *The Flower* helped her move away from the haze of depression, albeit temporarily.

4. Useful in conditions like dementia

We all memorised nursery songs and rhymes and certain poems can transport us right back to our childhood. Poetry is a successful intervention when used as a therapeutic tool for patients with dementia, since memories of our early life often remain and the rhymes may take you back to a space of safety and joy.

5. You are not alone!

I think when you are hurting, you feel 'why is this happening to me' and you feel very alone in your suffering. Reading poetry may help you see that others have walked this road and there is solidarity and connection in that knowledge. That somebody else felt as desperate as us, grieved as much and hurt like we do.

6. Poetry is not just for the dark times

It is such a joy to read a poem that shows us how it feels to be content, or madly in love or just present in the moment. This is one of the reasons that poetry is so popular for wedding readings and maybe on cheesy Hallmark cards!

7. Travel

Even sitting at your desk or in your armchair, a poem can help you travel to a wood, to a distant land, to imagine and see what you may never see physically. Good poetry has striking imagery and it is almost as if you are there. This can be incredibly empowering and fun—my friend, Sujatha Mathai, herself a poet, now has serious health conditions and is unable to get out much. But for her, to be able to read poetry and share with groups of like-minded people on Facebook, she finds a sense of community in this. And this can only be a good thing rather than someone wallowing in their sickness!

Lorde (2007) says, and she is right:

> Poetry is the way we help give name to the nameless so it can be thought. The farthest external horizons of our hopes and fears are cobbled by our poems, carved from the rock experiences of our daily lives.

Some ways you can use expressive writing in a therapeutic sessions are creating workshops for groups with similar experiences. I often lead sessions for a group here in the UK called Writing for Well-being and the group is made up of people society marginalises—mental health service users, addicts, disabled people, people who are not economically well off. This group uses writing, art and performance and meet once a week to write together, sometimes they perform. They find community in the meeting, and the experience of shared writing is transformative for many of them. In more individual one-on-one sessions, expressive writing can be done with set exercises as well as asking people, in a safe setting, to write about their most traumatic experiences. To have the option for therapy or a holding space while they do this, or after, needs some consideration and thought, and it is important to create these. You can also offer the option to people who do not feel competent with language to draw, to draw their trauma or create art. This will have similar effect.

Poetry, both reading and writing, continues to offer support and therapy to affected people around the world. Of course people also read it just for pleasure. In my own case, poetry helped me realise that this single breath we live in is home, that the body is home, and that while we have that, nothing else can really go wrong.

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# Chapter 5
# The Art of Social Prescription

**Katherine M. Boydell**

## Background

> Social prescribing: Has the time come for this idea?
> How creativity on prescription can improve mental and physical health
> Combat loneliness with social prescribing
> Why doctors are prescribing bingo, not pills, to keep patients happy
> Why social prescribing is the latest drug-free trend
> Two-thirds of GPs agree arts engagement helps prevent ill health

The above headlines were taken from the recent popular press (The Guardian, The Conversation, The New Daily, newsGP), a reflection that our current health and well-being is dependent on much more than what medicine and psychology can offer. Research indicates that individuals tend to underestimate the relevance of social factors such as loneliness and social isolation and other social determinants of health (Haslam et al., 2018). This is critical, given that a recent meta-analysis has shown that social isolation is associated with an astounding 29% increase in mortality (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015). Social prescribing (sometimes referred to as non-medical prescribing) is a relatively new concept that has arisen as an innovative way to move beyond the medical model and address the wider social determinants of health (Bickerdike, Booth, Wilson, Farley, & Wright, 2017; Morton, Ferguson, & Baty, 2015).

Social determinants of health, described as 'the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life' (WHO, 2018), are the cause of many health inequalities.

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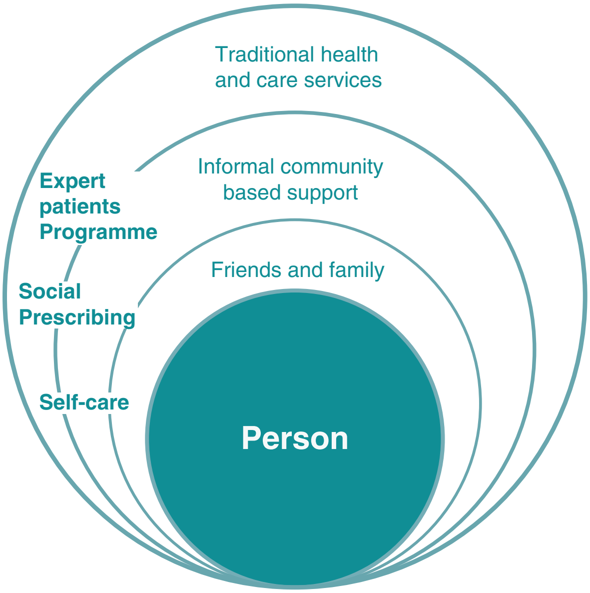
Evidence gathered over the past three decades supports the widespread effect of non-medical factors on overall physical and mental health (Daniel, Bornstein, & Kane, 2018). Internationally, there is strong evidence that individuals who are poor and less educated have more health problems and die earlier than those who are richer and more educated (WHO, 2008). Andermann (2016) notes that in order to have an impact on improving health equity and providing increased patient-centred care, a better understanding of underlying causes of poor health is required; however, they also point out that physicians and other allied healthcare professionals frequently feel helpless and frustrated when faced with the multifarious and interwoven health and social challenges of their patients. Many avoid asking about social issues, preferring to focus on medical treatment and lifestyle counselling (Andermann, 2016). It is increasingly recognised that to improve health at a population level, health equity needs to become a priority in the health sector, and methods to diminish disparities must be integrated into health programmes and services (Adler et al., 2016). Consequently, an important principle for promoting more equitable health outcomes for patients, families and communities involves training physicians, nurses and other allied health workers to adopt a social determinants of health approach (Andermann, 2016).

The goal of social prescribing recognises that the health of an individual is determined primarily by a broad range of features that are social, economic and environmental and, thus, offers a holistic mode of support that is bespoke—tailored to individual need. Social prescribing involves creation of referral pathways to the 'third sector' (local non-clinical voluntary services and community groups) (Table 5.1) that enables healthcare professionals to refer patients/clients to a link worker in order to co-design a non-clinical social prescription to improve their

**Table 5.1** Social prescribing: relationship between individuals, client-focused approaches and appropriate support. https://wiki.healthylondon.org/Social_Prescribing



health and well-being (Pilkington, Loef, & Polley, 2017; South, Higgins, Woodall, & White, 2008; University of Westminster, 2016). This link worker (also called community development worker, well-being coordinator and social prescribing coordinator) holds detailed knowledge of local organisations, services and supports to ensure appropriate signposting for individuals and facilitates access. Some examples of the groups and services used by social prescribing schemes include luncheon clubs, walking and reading groups, befriending groups, literacy classes, support with housing, employment, debt and legal advice, gardening groups, cooking classes, exercise programmes and arts and creative activities.

## Models of Social Prescribing

A number of models of social prescribing have been described in the extant literature (e.g. Bertotti, Frostick, Hutt, Sohanpal, & Carnes, 2018). Whilst there is no commonly agreed upon model, these models range from low to high intensity and from limited to full patient/client engagement. The low intensity model offers information only such as a brochure in a general practitioner's (GP) office and no engagement of the patient. The next level of intensity involves direct referral with a GP or allied health professional referring a patient to community activity/programme. This typically involves a limited range of services and very limited engagement. More intense models involve signposting social prescribing, which encompasses a telephone-based prescriber, providing a single consultation and a limited range of services. The most intense model is known as referral social prescribing, where there is a link worker/social prescriber role with mixed face-to-face and telephone co-production, an in-depth coaching service and a wide range of services offered.

## Evidence for Social Prescribing

There is emerging evidence that social prescribing has the potential to result in an array of positive health and well-being outcomes, including increases in self-esteem and confidence, a sense of control and empowerment, improvements in psychological or mental well-being and positive mood linked to decreases in symptoms of anxiety and depression (Thomson, Camic, & Chatterjee, 2015). All-Party Parliamentary Group in Arts, Health and Wellbeing (2017) qualitative methods have been identified as the most common way to assess social prescribing schemes, followed by the use of scales to measure well-being (Woodall et al., 2018). Research has demonstrated improvements in quality of life and emotional well-being, mental and general well-being, and decreases in levels of depression and anxiety. For example, a study of a social prescribing project in Bristol found improvements in levels of anxiety and in feelings about general health and quality of life (Kimberlee, 2013; Kimberlee, Ward, Jones, & Powell, 2014). The Bristol study also indicated that most individuals who were part of the social prescription programme had reduced rates of GP attendance.

Chatterjee, Camic, Lockyer, and Thomson's (2017) recent systemic review of 86 articles focused on the evaluation of UK's social prescribing schemes and was published in peer-reviewed journals. They reported outcomes such as increased self-esteem and confidence, improved mental well-being and positive mood, improvements in physical health and lifestyle, increased social connectedness, reduced social isolation and loneliness, and reduced anxiety, depression and negative mood (Chatterjee et al., 2017). Carnes et al.'s (2017) mixed method approach used patient surveys with matched control groups and a qualitative interview study to evaluate the effect of a social prescribing service in inner city London. They found that, at 8-month follow-up, there were no differences between those referred to the social prescribing programme and the controls for general health, depression, anxiety and positive engagement in life. Most patients reported a positive experience with social prescribing; however, the service was not used to its full capacity. Bickerdike et al. (2017) analysed 15 evaluations and reported that all studies measured improvements in health and well-being; however, there was a lack of evidence beyond 6 months. There was only one RCT reviewed (Grant, Goodenough, Harvey, & Hine, 2000); however, it focused on 4-month follow-up only and there was some lack of clarity regarding whether it represented social prescribing.

To enable a detailed analysis, Bertotti et al. (2018) adapted the realist approach by subdividing the social prescribing pathway into stages, each with contextual factors, mechanisms and outcomes. Social prescribing coordinators were pivotal to the effective functioning of the social prescribing service and responsible for the activation and initial beneficial impact on users. A realist evaluation approach emphasises the importance of the social context and the mechanisms required to enable a social prescribing programme. As such, it is expedient to aid in our understanding of the ways in which to identify and improve health interventions and analyse in greater detail the contribution of different stakeholders. As the social prescribing coordinator is essential to social prescribing, Bertotti et al. recommend further study in order to understand their role conceptually and practically.

Using a mixed methods analysis, Woodall and his colleagues (2018) demonstrated improvements in well-being and perceived levels of health and social connectedness as well as reductions in anxiety. In many cases, the social prescribing service had enabled individuals to have a more positive and optimistic view of their life often through offering opportunities to engage in a range of hobbies and activities in the local community. The data on reductions in future access to primary care were inconclusive. Some evidence was found to show that men may have greater benefit from social prescribing than women. Some of the processes that increased the likelihood of success on the social prescribing scheme included the sustained and flexible relationship between the service user and the well-being coordinator and a strong and vibrant voluntary and community sector.

A review of 20 peer-reviewed articles on arts and health and well-being indicated that participation in a wide variety of arts interventions has health benefits, such as reduction in physical symptoms and improved mental health (Jensen & Bonde, 2018). Focusing on participant perspectives in a social prescribing, Stickley and Hui

(2012) found that, at 2 years, there was reported increased self-confidence, improved social and communication skills and increased motivation and aspiration. Bungay and Clift (2010) reviewed arts prescription practices in the UK and noted that, although the schemes varied in their approach, what they had in common was a referral process and creative activities took place in the community facilitated by artists and not art therapists. They found evidence to indicate that arts on prescription can contribute to policy objectives by building social capital and engagement with the community.

In general, social prescribing schemes appear to result in high levels of satisfaction on the part of participants and primary care professionals. In spite of this, systematic and rigorous evidence of effectiveness is fairly limited, and more sophisticated designs are needed to provide further rigour (Bickerdike et al., 2017). Many studies are small in scale and focus on process rather than outcome (Pescheny, Pappas, & Randhawa, 2018). Much evidence is based on self-reported outcomes and often lacks comparative data. However, as Woodall et al. (2018) have noted, relying on the RCT to assess social prescribing effectiveness is not only challenging but has the moral and ethical implications—primarily precluding clients from accessing voluntary and community services to improve their health.

## Challenges of Social Prescribing

Although Bertotti et al. (2018) found that social prescribing demonstrated important potential for the benefit of patients and primary care, several challenges were identified, particularly related to implementation. These challenges included ‘buy-in’ from some GPs, branding and funding for the third sector in a context where social care cuts are significantly affecting the delivery of health services. Pescheny et al. (2018) reviewed the challenges and barriers to implementation of social prescribing in eight studies, which included lack of partnership- and service-level agreements, lack of a strategic and robust approach to project management, limited financial resources to fund service providers, lack of a shared understanding among stakeholders and partners, general practice staff disengagement, staff turnover, patient engagement and lack of available and suitable service providers in the voluntary and community sector. A particular and critical factor identified was the importance of the local context and infrastructure influencing the implementation of a social prescribing scheme.

## Conclusion

Significant concerns exist regarding the sustainability of continuing to medicalise societal problems. Building social capital and community cohesion is required in order to shift the medical culture to connect more directly with the public health of a local community (Branding & House, 2009). A recent influential report on UK GPs has suggested that social prescribing is one of the ten high impact actions to encourage capacity (NHS England, 2016). Further to this, in the UK, £4.5 million scheme was introduced in August 2018 by the government to support social prescribing. Social prescribing represents a novel approach to public health, which has the potential to address the health and social needs of individuals and communities. It offers a significant opportunity to focus on biopsychosocial and environmental models of illness that move beyond traditional biomedical models, to make efficient and effective use of the voluntary and community sectors and to highlight a patient/client-centred focus. Social prescribing offers a model for integration across health and social care systems. Such a model can mitigate 'lifestyle drift'—a policy trend that partially explains the lack of progress made in reducing health inequalities—governments begin by a pledge to address the broad social determinants of health but end up prompting narrow lifestyle interventions on individual behaviours – recurrent slippage in policy statements (Williams & Fullagar, 2018).

Despite growing interest in the approach, there is a relative paucity of information in the extant evidence base about how social prescribing interventions are developed, presented and delivered (Lovell et al., 2017). For example, a comprehensive review of evidence to apprise commissioning of social prescribing from the University of York concluded that there is little solid quality evidence to recommend social prescribing programmes (University of York Centre for Reviews and Dissemination, 2015). The evidence supporting social prescribing and arts on prescription, in particular, is largely qualitative and often narrative in nature. Social prescribing is essentially a social intervention with qualitative outcomes such as increased confidence, a sense of belonging, increased social relations and strengthened identity (Stickley & Hui, 2012). Indeed, qualitative methods may be more appropriate for understanding the ways in which such a scheme works and the types of impacts it has on well-being (Chatterjee et al., 2017). The characteristics of social prescribing have been posited as best suited to qualitative research, which complements the philosophy of community-based arts interventions, and thus traditional positivistic evaluation frameworks may not always be appropriate. Jensen, Stickley, Torrissen, and Stigmar (2017) cautioned us that most efforts in research and healthcare practice are located largely within the medical model of research where randomised controlled designs are expected. Such methodological approach is challenged vis-a-vis social prescription interventions, particularly in cases where clients may be referred for a wide range of physical, social and psychological purposes (Jensen et al., 2017).

Given the influx of funds to support social prescribing, particularly in the UK, we can look forward to learning more about the potential of this scheme to move us beyond clinical options and identify and intervene in non-medical and non-clinical ways, enriching the capacity of the community to respond to the biopsychosocial and environmental aspects of our daily lives.

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# Chapter 6
# Peer Support and Open Dialogue: Possibilities for Transformation and Resistance in Mental Health Services

**Holly Kemp, Brett Bellingham, Katherine Gill, Andrea McCloughen, Cath Roper, Niels Buus, and Jo River**

> I AM grief for hire, a Poetess – not PTSDs marauded Duchess, nor the Black Dog's mistress. I used to be the clinical Countess of Distress! …
>
> I HOPE to enter your white wonderland chamber, but your syntactical activist tongue SHIPWRECKS my lips, until I'm trembling and sick.
>
> I LOVE that you said poetry is both confession and exorcism – so we should Houdini out of the syntax straight jacket by sticking it to big pharma!
>
> I am GRIEF FOR HIRE. Tell seclusion and restraint I want ceasefire.

(Alise Blayney, 2016, Poet and Peer Support Worker. Extract from 'Grief for Hire'.)

When we speak of peer support, we speak of a discipline that represents a potential revolution in how communities respond to human distress, and in care practices within contemporary mental healthcare services. Peer support workers (PSWs), unlike in other healthcare professions, openly and purposefully bring to their work knowledge and wisdom gained through lived experience of emotional distress and/

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or extreme states of mind (distress/extreme states), and/or contact with mental health services, to establish connections with others. PSWs are paid to be experts by experience. Peer support can be transformative in its rejection of individualistic, reductive and pathologising metanarratives of distress/extreme states that medicalise or psychologise human experience and subordinate lived experience perspectives. Instead, peer support advocates for solidarity, mutuality and power sharing, and exploration of multiple explanatory frameworks for distress/extreme states, including socio-political and relational aspects (Mead, 2010; Mead & Hilton, 2003). Peer support is resistant to 'thin' narratives of recovery that silence and marginalise alternative ways of living that justify restrictive and pathologising practices, and can be used as grounds for cutting support services (Beresford & Russo, 2016; Wade, 2016). Yet, all too often, the transformative power of peer support is curtailed, limited by conventional health service cultures that are resistant to change and continue to privilege biomedical responses to distress/extreme states, while drawing power from statutory mental health legislation, which safeguards risk-averse, coercive and controlling treatments and practices that violate human rights (United Nations, 2017).

Open dialogue (OD) represents an altogether different kind of revolution in mental health services. OD is a social network–based approach to mental healthcare that uses a distinct form of therapeutic conversation (Olsen, Seikkula, & Ziedonis, 2014). Originally developed in Finland, it came out of a reorganisation of psychiatric services pioneered by clinical 'psy' (psychiatric and psychological) disciplines. It radically challenged clinicians to put aside their disciplinary expertise, diagnoses and clinical judgements, to see distress/extreme states in a relational context rather than as an individual illness, to explore how people language their experience and co-create communicative relationships with people and their networks (Seikkula & Olson, 2003). The primary aim of OD is to generate dialogue with a person in distress/extreme states, as well as the important people in their social network. Practitioners strive to privilege all voices, including that of the person experiencing distress/extreme states, and dialogue is viewed as transformative for all involved. OD practitioners aim to be adaptive to the needs of a person and their social network, to make care decisions in a genuinely collaborative way and to tolerate their own uncertainties about care decisions without any attempt to rush towards resolution or provide expert advice.

Although marginalised in biomedically dominated mental health services, the implementation of OD has nonetheless transformed practice in some parts of the Finnish healthcare services and it is now implemented in mental health services worldwide, including Australia. In its initial conception, OD did not include a specific peer support role. However, PSWs and OD practitioners across the world are beginning to explore ways to work together (see Bellingham et al., 2018).

This chapter explores the histories and possibilities of peer support and OD, and the potential for transforming responses to human distress/extreme states, as well as care practices in mental health services, by the pairing of the two. It uses a co-production framework, which aims to yield new forms of knowledge through a collaborative, exploratory and reflective process of interaction between people with lived experience and researchers (Filipe, Renedo, & Marston, 2017). We, the authors, are people with an interest and/or practice in OD. We are also PSWs, mental health consumers, academics—including consumer academics—and mental health professionals who work alongside PSWs. Through an ongoing, iterative dialogue, we sought to understand what peer support and OD, in combination, may have to offer. We believe there are important possibilities held at the intersection of these two approaches, so we would like to offer you our insights and thoughts, which, in the spirit of peer support and OD, are tentative and unfinished.

## Peer Support

Mutual support between people experiencing distress/extreme states has probably occurred for as long as notions of self and madness have existed, and people marked as different have been marginalised, socially excluded and exposed to oppressive and discriminatory practices. In contemporary Western society, peer support exists on a continuum from informal, mutual relationships of connection and support, to more 'formal' relationships where someone is employed to provide peer support based on their lived experience of distress/extreme states (Bradstreet, 2006; Davidson, Chinman, Sells, & Rowe, 2006). However, to have a critical understanding of contemporary peer support, and how it came to be, it is necessary to engage with the history of the consumer/psychiatric-survivor/ex-patient (C/S/X) movement and appreciate its roots in broader fights for freedom.

The C/S/X movement first appeared in discourse in the late 1960s, at a time of radical restructuring of the US mental health system, which included deinstutionalisation—a move away from large-scale hospitalisation (asylums) to community-based mental health services—and the introduction of modern psychotropic drug treatments (Everett, 1994; Tomes, 2006). The C/S/X movement grew out of the lived experience of former 'patients', particularly their dissatisfaction with psychiatric treatments and anger at psychiatric abuse (Chamberlin, 1978). It was also informed by the radicalism of other burgeoning social movements, such as the civil rights and women's rights movements, as well as the intellectual critiques from 'anti-psychiatry' proponents and political philosophers, such as Thomas Szasz, R. D. Laing and Michel Foucault (Tomes, 2006). Despite epistemological differences—with psychiatric survivors being more radical and rejecting medical models than consumers—C/S/X were united by a desire to end coercive psychiatric practices, and to promote alternatives to harmful psychiatric treatments (Chamberlin, 1978), and they developed their own knowledge, organisational structures and methods of communication (Adame & Leitner, 2008; Everett, 1994).

During the late 1970s, the C/S/X movement gained momentum and shared knowledge, links and tactics with other social movements including civil, women's, disability, Indigenous peoples' and lesbian, gay, bisexual, intersex, queer (LGBTIQ) rights movements, which had common experiences of oppression and the quest for self-determination (Chamberlin, 1978). These movements also shared a critical perspective of society and psychiatry, born of direct experience of stigma, discrimination and oppression. It was around this time that ex-patients, Morton Birnbaum and Judi Chamberlain, coined the terms 'sanism' (Perlin, 1992) and 'mentalism' (Chamberlin, 1978), which made visible the social division between those considered normal and those considered mad, linking this to the prejudicial treatment and systematic subjugation of people with lived experience (Poole et al., 2012).

A complete history of the C/S/X movement is yet to be written, and the links between peer support and C/S/X movements are still obscure (Chamberlin, 1990). However, mental health consumers are looking back, performing an archaeology of their own history and finding that elements of peer support have always run through the C/S/X movement, and, likewise, the politics of the C/S/X movement has shaped peer support. Historically, activism was demonstrated through the peer support activities of the Alleged Lunatics' Friend Society, established in England in 1845 by ex-patients with lived experience of abuses in the private 'madhouses' (Podvoll, 1990). The group actively supported patients trapped within asylums, influencing legislative change and raising public consciousness of asylum practices that threatened civil liberties (Hervey, 1986). Perhaps the origins of more formal peer support can be traced back to France in the 1780s, when psychiatrist Jean-Baptiste Pussin employed people with lived experience as attendants in the Bicetre Asylum (Weiner, 1979). The asylum attendants formed connections with 'patients', and it was noted that they were less likely than others to be abusive to the people in their care (Weiner, 1979). This early example not only highlights how mental health systems have long recognised and valued the skills and capabilities of people with lived experience but also how psychiatric systems may incorporate peer support to maintain psychiatric practice rather than as a way of fundamentally transforming service provision.

More contemporary examples of peer support are 'We Are Not Alone' (WANA), formed in the 1940s by a group of ex-patients to support people transitioning from institutional care back into the community (Usar, 2014). Well-known support groups of the 1970s and 1980s include the Insane Liberation Front, Portland Oregon; the Mental Patients' Liberation Project, New York; and the Scottish Union of Mental patients, UK; which tended towards more explicit activism, expressing deep dissatisfaction with psychiatric treatment (Bluebird, 2010; Usar, 2014). Probably the most widely known example of peer support is Alcoholics Anonymous (AA), which in 1937 was the first of many fellowships within the sphere of substance use and addictions. There are also stories of individuals who mustered interest in the plight of those in asylums. For example, Elizabeth Parsons Ware Packard secured her own release from an asylum and founded the Anti-Insane Asylum Society in 1968 to work for the release of others (Chamberlin, 1990). These groups and individuals explored and developed alternative responses to human distress/extreme states, pioneering approaches that were non-medical, relational and often community-based (Chamberlin, 1990). For example, the Hearing Voices Movement positioned itself outside of the mental health framework, recognising extreme states of mind as a common, natural and meaningful variation of human experience (Hayward & May, 2007).

While some of the history of resistance, activism and peer support by people with lived experience may be lost, this salvaged history informs peer support practice, as well as the developing academic discipline of ‘Mad Studies’, which combines activism and a community development ethos with radical social and political critiques of dominant psychiatric paradigms (LeFrancois, Mezies, & Reaume, 2013).

## Change, Exploitation and Resistance

Sherry Mead (2010), who developed a model of ‘intentional’ peer support (IPS), argues that the main tasks of contemporary peer support are about creating meaning and connection through mutual, transparent and transformative dialogue. PSWs view people in distress/extreme states not as the containers of illness or disease, and themselves as containers of healing, but as equal partners in a peer relationship, exploring together the multiple explanatory frameworks for distress/extreme states, including wider socio-political factors (Adame & Leitner, 2008; Mead, Hilton, & Curtis, 2001). Owing to their lived experience, PSWs know first-hand the hierarchy and power imbalances of mental health systems, and engage in meaning-making to reclaim their voice (Mead, 2010). Peer support does not aim to ‘do to’ but aims to ‘be with’ and sit with the ‘discomfort of a difficult situation’ in non-expert, ‘not-knowing’ position, trusting that there is potential ‘learning’ in this discomfort and that sitting with risk is essential for promoting dignity (Mead, 2010, p.5; Scott, Doughty, & Kahi, 2011).

In recent years, the size of the peer support workforce has rapidly expanded (O’Hagan, 2011). Peer support is practised in a wide variety of ways and settings. It occurs one-to-one or in groups within statutory mental health services, non-governmental organisations and consumer-operated services such as Brook RED (2019) in Brisbane and consumer-operated resource centres such as Our Consumer Place (n.d) in Victoria. PSWs provide support for people in crisis (e.g. emergency departments and inpatient facilities), as well as community support with housing, education and employment, and can also support access to cultural and social activities. In addition to the discipline of peer support, lived experience roles span education, research, advocacy and activism.

Being met by a PSW as a whole human being, rather than a list of symptoms or diagnoses, can be a novel and transformative experience for service users in modern mental health services (Repper & Carter, 2011). The emerging evidence base suggests that peer support benefits service users in various ways, including increasing social networks, service engagement, well-being, employment and housing opportunities (Davidson, Bellamy, Guy, & Miller, 2013; Grey & O’Hagan, 2015), as well as reducing hospital readmissions (Sledge et al., 2011). Recent research suggests that service users who engage with PSWs have better, or at least equivalent, scores on outcome measures as those who received a conventional approach (Dark, Patton, & Newton, 2017; Davidson, Chinman, Sells, & Rowe, 2006; Repper & Carter, 2011). Peer support also provides service users with the opportunity to share a common experience and language (Repper & Carter, 2011). For example, sharing experiences of stigma and discrimination can be key to developing new insights and analyses, which may prove to be highly protective against individualised feelings of alienation and isolation.

The increased number of peer support roles in health services is linked to the increasing strength of local consumer movements, service user dissatisfaction with mental health services (Adame & Leitner, 2008) and the focus on recovery-oriented care in health reform policy and statutory mental health services (Repper & Carter, 2011). However, there is considerable critique regarding the co-opting of peer support and C/S/X notions of recovery to justify restrictive and pathologising practices (Beresford & Russo, 2016; Repper & Carter, 2011; Wade, 2016), and PSW report experiencing direct and indirect stigma from mental health clinicians. This can take place indirectly, through the use of negative language and views about service users, and directly through patronising attitudes and devaluing of peer support (Byrne, Roper, Happell, & Reid-Searl, 2016; Vandewalle et al., 2016). Clinicians, with the power and status of formal education, can perceive the deliberately informal approach of peer support to be unprofessional (Vandewalle et al., 2016). Clinicians can police ‘professional boundaries’, by positioning peer support as low status or non-essential (Asad & Chreim, 2016; Collins, Firth, & Shakespeare, 2016; Repper & Carter, 2011), and PSWs can find themselves being treated like patients rather than valued colleagues (Gill, 2018).

Stigma towards PSW has been linked to a lack of understanding among clinicians of what peer support is and what PSWs do (e.g. Kemp & Henderson, 2012; Vandewalle et al., 2016). However, the concept of stigma may serve to problematise the person with lived experience, rather than illuminate the discriminatory practices within health services (Thornicroft, Rose, Kassam, & Sartorius, 2007). Poole et al. (2012) argue that discrimination is rooted in ‘sanism’, which, like racism, can lead to outright exclusionary practices, as well as ‘multiple, small insults and indignities’ or ‘microaggressions’ (Kalinowski & Risser, 2005, p.1). Yet, less apparent in the discourse around peer support and mental health reform are broader cultural and historical influences, such as the continued dominance of psy knowledge systems that regulate notions of self and madness and shape practice in health services (Rose, 1998). As Poole et al. (2012) note, the privileging of biomedical ways of knowing guarantees the dominant position of psychiatry and supports a negative attitude towards people with lived experience. It creates a hierarchy of clinical relations among various disciplines, with PSWs being in the subordinate group. Indeed, patronising, prejudicial attitudes and bullying of PSWs are reportedly more common within biomedically oriented services (Bennetts, Pincehes, & Paluck, 2013; Byrne, 2013; Vandewalle et al., 2016), and can become a ‘normal part’ of peer support (Byrne et al., 2016). PSWs who ‘call out’ medicalising or dehumanising language are particularly likely to find themselves caught up in claims of discrimination or disciplinary action (Mancini, 2018).

Wider statutory mental health legislation also compromises the role integrity of peer support. Mental health legislation structures, sanctions and safeguards coercive and restrictive practices, including human rights violations towards people with lived experience, and health services, in fear of legal reprisal, have low tolerance for risk (Byrne et al., 2016; United Nations, 2017). As Poole et al. (2012) argue, ‘offensive and injurious practices are integrated into everyday procedures to the point where we no longer recognise them as discrimination' (p.2). PSWs risk being re-traumatised when witnessing practices they have personally experienced as harmful, such as involuntary treatments for people sanctioned by mental health legislation.

PSWs also risk becoming a new class of exploited worker in neoliberal health services, which divest themselves of care costs through withdrawal and underfunding of state supports, and increased work expectations (Carney, 2008). PSWs experience job shortages, high workloads and under-resourcing of their roles (WAPSM, 2018), poor remuneration and limited opportunity for career growth (Chapman, Blash, Mayer, & Spetz, 2018). Under-resourced, undervalued and under pressure in health services, peer support practice more easily shifts at the whims of neoliberal and managerial dictates, and can be 'colonised' by psy perspectives. Stripped of liberation politics, PSWs are often used to serve the labour force needs of biomedically oriented services, particularly when non-peer support managers determine their roles and responsibilities (Daniels et al., 2010; Rebeiro Gruhl, LaCarte, & Calixte, 2016).

The current—less than ideal—positioning of peer support is not necessarily fixed. It is historically and situationally informed and has altered, and will continue to alter, over time in different contexts. In many locations, peer support has held to its radical roots and continues to resist discrimination, sanism and clinical hierarchies, as well as coercive practices (e.g. ourconsumerplace.com.au). Peer support has promoted care practices based on emancipation and self-determination and has challenged metanarratives of distress/extreme states, continuing to expose the need for recovery from iatrogenic harm and restrictive treatments (Bellingham et al., 2018). Relations between healthcare disciplines and mental health services/organisations have also shifted over time in different settings. Some organisations actively support lived experience perspectives and diverse recovery principles (Vandewalle et al., 2016). Many clinicians report positive working relationships with PSWs (Gates & Akabas, 2007), valuing their ability to build rapport, model recovery and challenge the low expectations for service users held by healthcare professionals (Cleary, Raeburn, West, Escott, & Lopez, 2018). Some have reported that PSWs are 'a living, breathing reminder' of diverse recovery perspectives (Gates & Akabas, 2007), although the idea that gainful employment is somehow indicative of 'real' recovery aligns more closely with neoliberal values of productivity than the C/S/X movement and peer support values of self-determination (Voronka, 2017).

Perhaps more shifts are possible. The practices and knowledge embodied in peer support could serve as an invitation to clinicians working in traditional mental health roles to liberate themselves from the narrow confines of accepted and acceptable sources of professional knowledge, expertise and practice, and become allied with peer support. Together, they could actively reject reductive and pathologising narratives of distress/extreme states and open up possibilities for practice based on emancipation, self-determination and meaningful collaboration; explore multiple explanatory frameworks for distress/extreme states, including relational and sociopolitical factors; and peer support principles and safe environments for peer support practice could be actively promoted. In the next sections, we explore OD practices and how they align with peer support practice, and consider how the pairing of the two might support revolutionary transformation and resistance in health services.

## Open Dialogue

OD is an approach to care that also resists traditional ways of 'doing' mental health, and seeks to transform mental health services. However, OD has had an altogether different genesis and reception in health services to that of peer support. OD originated within psy disciplines in Western Lapland, Finland, during the 1980s, at a time when the incidence of distress/extreme states was high and disillusionment with traditional psychiatric practices was widespread (Haarakangas, Seikkula, Alakare, & Aaltonen, 2007). A rapid shift away from agrarian economies to city-based employment had led to high rates of poverty and unemployment in Western Lapland and a corresponding escalation in rates of distress/extreme states (Haarakangas et al., 2007). Following a period of deinstitutionalisation, psychiatric services struggled to meet the needs of people and families in crisis or to engage them in psychiatric treatment, which was viewed as impersonal and dehumanising (Seikkula & Olson, 2003).

Jaakko Seikkula and colleagues resisted medical and pathologising accounts of distress/extreme states, and developed OD as an alternative approach to mental healthcare. OD draws on concepts from the Milan, systemic model of family therapy, which explores interactional dynamics in families that contribute to distress/extreme states (Seikkula et al., 2006), as well as the 'need-adapted' approach of Alanen and colleagues, which emphasises rapid, flexible and case-specific interventions in mental health services (Seikkula et al., 2006; Seikkula & Olson, 2003). OD also translates into practice the dialogical principles articulated by Mikhail Bakhtin, a Russian philosopher and literary scholar, who posited that meaning and the self are not fixed, but socially constructed and continuously emergent through relational dialogue (Seikkula et al., 2006). The OD approach was extended beyond the family context to incorporate a person's private and professional social networks (Bellingham et al., 2018).

In the 1990s, seven key principles of OD were articulated. The principles represent aspirational goals aimed at integrating health system change and therapeutic techniques rather than manualised instructions for care (Bellingham et al., 2018). The key principles include the following: (1) *immediate help*: a commitment to respond timely and rapidly to the acute needs of a person in distress/extreme states, and their social network; (2) *social network perspective*: the inclusion of a person and their social network based on the underlying notion that families and social groups are generative in terms of insight and psychosocial resources; (3) *flexibility and mobility*: a creative and adaptive response to distress/extreme states that avoids rigid thinking and supports diversity of individual and social circumstances; (4) *responsibility*: the ability to respond (respond-ability) to a person in distress/extreme states. The health professional who responds assumes accountability for connecting the person experiencing distress/extreme states to a treatment team; (5) *psychological continuity*: establishing and providing continuity in the relationship between the person in distress/extreme states, their social network and the treating team to promote mutual knowing and connection; (6) *tolerance of uncertainty*: help is offered with an attitude of tentative uncertainty about what the 'help' might actually be. Resources and authority for decision-making sit with the social network, and no attempt is made to rush to agreement or provide expert advice. Treatment options and issues of risk are openly discussed; and (7) *dialogism*: generating dialogue with a person and their social network is the primary aim of OD. It involves sitting together (usually in a circle) and creating dialogue with a person in distress/extreme states and the people in their social network. OD practitioners facilitate the network meeting, ensuring that all voices are heard and responded to, exploring how people language their experience, and listening in an appreciative, non-judgemental, present-moment-focused and non-directive way. New meanings about a crisis and the experience of distress/extreme states, not previously voiced, are able to emerge (Gergen & McNamee, 2000).

## The Transformative Power of Open Dialogue

The idea of sitting in a circle and dialoguing is neither revolutionary nor unique to Finland. Indigenous peoples around the world have used dialogue circles with different protocols for conducting conversations (Bessarab & Ng'andu, 2010). In Western Australia, Nyoongah people use the term 'yarning' to describe a process of meaning-making through relational dialogue, where connection, history and knowledge are exchanged (Bessarab & Ng'andu, 2010). Yarning has also been used in therapeutic contexts to support the health and well-being of Aboriginal peoples (Burke, 2007). However, OD is revolutionary in the sense that dialogical processes become 'ordinary' in clinical practice. Like peer support practice, OD challenges the status quo in health services. Distress/extreme states are viewed as meaningful and located within family/social interpersonal dynamics rather than the individual, and medications are used judiciously if at all. There is a shift in focus from individualised, inpatient care aimed at 'stabilising' the person in crisis with psychotropic medicines, to community-based care aimed at generating dialogue with the person and their social network at the time of crisis (Seikkula, Alakare, & Aaltonen, 2001).

Having originated in psy disciplines, OD has arguably possessed greater power to shape health services than peer support, which has often been co-opted within them. OD transformed mental health services in Western Lapland, and has now moved well beyond the Finnish context to potentially transform health services in other Scandinavian countries, Germany, the UK and the USA, and, more recently, Australia (Gordon, Gidugu, Rogers, DeRonck, & Ziedonis, 2016; Rosen & Stoklosa, 2016). Research indicates that OD is a welcome alternative to conventional mental health practices (Buus et al., (2017) that reduces medication use and rates of hospitalisation, and supports service users to live in their communities and to pursue vocational and education goals (Gromer, 2012; Seikkula et al., 2001; Seikkula & Olson, 2003). OD provides a framework for organising mental health services that radically improve communication and connection between service providers, service users and their social networks (Jackson & Perry, 2015). Nonetheless, implementation studies indicate that tensions between OD principles and psy discourses in health services can lead to considerable organisational and professional resistance to OD (Brottveit, 2013; Søndergaard, 2009), and it remains peripheral to dominant psy approaches.

## Peer Support and Open Dialogue

During its introduction to contexts outside of Finland, there has been considerable variation in how OD has been adapted to fit with local needs (Buus et al., 2017; Gordon et al., 2016). In some places, such as the UK and the USA, an important adaptation to OD, which was not an aspect of its Finnish genesis, has been the inclusion of peer support (Bellingham et al., 2018; Razzaque & Stockmann, 2016; Sykes, 2015). The pairing of peer support and OD has arguably occurred due to the strength of local grass-roots consumer movements in advocating for alternative approaches to mental healthcare, as well as increasing emphasis on recovery-oriented practice in health services (Bellingham et al., 2018; Trivedi, 2010). It is also the case that core tenets of peer support resonate with key principles of OD. Peer support, and IPS in particular, is similarly a dialogical approach, whereby PSWs and service users build new understanding through mutually transformative dialogue (Adame & Leitner, 2008; Mead et al., 2001). Both OD and peer support practices are concerned with varied meanings of distress/extreme states and exploring relational factors (Mead & MacNeil, n.d.; Adame & Leitner, 2008), although peer support, conversant with C/S/X perspectives, contains a sensitised and embodied critique of socio-political power (Bellingham et al., 2018). Both approaches emphasise collaboration and democracy as well as accountable and transparent decision-making (Mead, 2010). Moreover, the OD principle of 'tolerating uncertainty' is not entirely different to peer support principles of 'not knowing' and 'dignity of risk', which support self-determination and seek to avoid risk-averse practice (Mead & Hilton, 2003; Repper & Carter, 2011; Scott et al., 2011).

Models of peer support and OD have been developed; these include peer-supported OD (POD) in the UK National Health System and IPS-need adapted OD in the US Parachute NYC program of the New York Department of Health and Mental Hygiene (Bellingham et al., 2018; Razzaque & Stockmann, 2016; Sykes, 2015). Published accounts of the peer support role in OD meetings are scarce. However, Razzaque and Stockmann (2016) report that PSWs in the POD model have acted as OD practitioners as well as support persons outside of network meetings. Potential models of peer support and OD have been explored within Australian mental health services. Bellingham et al. (2018) proposed six configurations of peer support in OD, which range from PSWs acting as support persons outside network meetings, or as members of a person's social network, to PSWs being OD practitioners alongside clinicians or other PSW. However, to date, little is known of the benefits and challenges of these six proposed peer support and OD configurations.

## Possibilities for Transformation and Resistance in Services

This brings us to our question, what transformations might the pairing of peer support practices and OD achieve in contemporary health services? Previously documented benefits of this union include psychosocial benefits for service users that may lead to improved health outcomes (Bellingham et al., 2018); promoting democracy and disrupting clinical hierarchies in health services (http://apopendialogue.org); humanising health services and fostering greater understanding of peer support/lived experience perspectives (Stockmann et al., 2017); and expanding role opportunities for PSWs (Bellingham et al., 2018).

The notion of a combined peer support and OD model promoting democracy and challenging clinical hierarchies is appealing. OD attends to dialogue from multiple perspectives and attempts to privilege all voices, which would necessarily include the voices of service users and PSWs. OD also asks practitioners, including psychiatrists, to relinquish the 'expert' position and practice from a place of 'not knowing' (Anderson, 1990). PSWs are well acquainted with this position. Indeed, providing peer support has been described as the ability to be 'expert at not being expert', which 'takes a lot of expertise' (Repper & Carter, 2011). PSW could potentially support clinicians to give up the authoritarian role, lean into the discomfort of uncertainty, tolerate risk (Scott et al., 2011) and facilitate spaces to discuss treatment openly and democratically.

However, sitting with uncertainty is not a trivial thing, and OD is not a panacea for medico-legal frameworks that sanction discriminatory, coercive and restrictive practices. Yet, both peer support practice and OD do support transparent and collaborative decision-making that can resist and potentially mitigate some of the impacts of legislative agendas. PSW can also bring a lived experience perspective of the trauma of restrictive practices into the space of collaborative decision-making of OD, and may increase team capacity to bear uncertainty (Haarakangas et al., 2007) and withstand coercive practices that can be traumatising for service users, PSWs and others.

Peer support and OD could potentially lead to more humane health services. OD asks clinicians to reflect on their own lived experience and to bring more of themselves into their practice (Olsen et al., 2014; Stockmann et al., 2017). Clinicians, previously trained in objective and impersonal ways of practicing, may have much 'unlearning' to do in terms of deep-seated assumptions about themselves, professional practice and service users (Putman, 2015; Shotter, 2015), and PSWs may play a key role in supporting the clinicians' unlearning process. PSWs do not share the discipline-specific training and systemic culturalisation of clinicians and are well versed in the intentional use of lived experience, as well as having a more critical and nuanced understanding of recovery that can inform care practices. PSWs may also open up space in OD for clinicians to sit with difficult feelings, and to improve their understanding of service users' negative encounters with sanism and discrimination in health services.

The coming together of peer support and OD may not necessarily be straightforward in practice. For example, PSWs are likely to bring highly sensitised and embodied analyses to their work, offering nuanced critiques of power that may be resisted by other OD practitioners (Bellingham et al., 2018). PSWs also hold a less privileged position in services and may continue to find themselves as victims of ingrained discriminatory practices that are overlooked by other OD practitioners. On the other hand, working within a peer support–OD framework, with a shared language and democratic practices, may embed cultural change within organisations and, if not transform awareness, at least support resistance to sanist, or other discriminatory ideas. In such a context, PSWs may be able to enact a central tenet of the C/S/X movement adopted from the disability movement 'nothing about us without us' and provide a space for critical understandings from the C/S/X movement to be voiced, via principles of transparency and dialogue enacted in a network meeting.

Similarities in the origins of OD and peer support, with each resisting traditional and pathologising approaches to care, may assist peer support to retain its radical roots in C/S/X perspectives. OD specifically aims to respond to human distress/extreme states rather than to serve psychiatry, and actively pursues and supports multiple perspectives rather than promoting psy ways of knowing. As such, OD is well positioned to champion and assist peer support practice to retain its connection with core tenets, and resist being colonised by psy perspectives. This is perhaps crucial in the shift from a tradition of peers informally supporting each other to a more formalised provision of peer support in mental health services, and the professional standards, accreditation and associations that come with the professionalisation of a discipline.

Other transformational possibilities of combining peer support and OD may include broader engagement with a person's social network. In the context of OD, PSWs can have dual roles as network members or practitioners (Bellingham et al., 2018). In a network role, PSWs can provide social support for a person with reduced social connections, and support service users to expand their social network. However, Bellingham et al. (2018) argue that sitting in the practitioner role may represent a move away from the peer support principle of mutuality to a less symmetrical relationship of 'giver and receiver of care' (Repper & Carter, 2011). On the other hand, PSWs frequently work in parallel with clinicians in competing or conflicting discourses, and OD may offer PSWs new opportunities to work more collaboratively with clinicians, and expand their roles in health services (Bellingham et al., 2018).

It is early days for peer support and OD, and it is hard to consider them in concert when a lack of understanding about both approaches exists. Healthcare cultures comprise discipline-specific traditions and hierarchies, with systems and ideologies that situate particular clinical practices and therapeutic work within specific disciplinary domains. Tensions around the province of psychotherapeutic work can exist, and psy clinicians are powerfully positioned in a space where the peer support role and lived experience perspectives are not yet fully understood and accepted. Nonetheless, OD practice requires interdisciplinary collaboration and the possibility of working in teams without emphasising prescribed roles, to value ever-changing knowledge and understandings, and to ensure all voices are heard and respected (Brown, Kurtti, Haaraniemi, Löhönen, & Vahtola, 2015). OD, then, could have a positive role to play in advancing peer support as a distinct and adjunct discipline in the mental health landscape. Yet, teaming up with OD will not solve many of the issues faced by the peer support workforce identified in this chapter, such as its under-resourcing.

Arguably, OD has much to learn from peer support, C/S/X movements and Mad Studies scholars. These groups have pointed to the intersections between social structures and distress/extreme states, contending that particular groups of people suffer more, not because they are predisposed to suffer, but because the socio-political system creates and sustains poverty, racism, sexism, displacement, domestic violence, colonisation, detention, homophobia, transphobia, etc. (Beresford & Russo, 2016; Wade, 2016). In other words, humans are relational beings in socio-political contexts, and social systems are ‘crazy making’ for those worse off and subjugated, marginalised, violated, incarcerated and impoverished. Also crazy making is the lack of recognition for the unequal distribution of distress/extreme states, and the reframing of these states as individual, or even family/social network issues (Wade, 2016). OD may need exposure to this knowledge, to avoid being complicit in putting responsibility for care back to family and community, or in the increasing rationalisation of services and under-resourcing of peer support.

## Co-producing a Critically Informed Model of Peer Support and Open Dialogue

To facilitate the power of peer support and OD to co-transform and co-resist conventional practice in health services, we propose that a more critically informed model/s of peer support–OD is now required. Such a model would move beyond simply pairing the two approaches and deliberately consider a framework that attends to the strengths of both peer support and OD.

Disciplinary power in OD warrants greater critique. It is not sufficient that OD practitioners purport to privilege all voices, as this may not necessarily influence the flattening of clinical hierarchies. There needs to be an explicit critique of disciplinary hierarchies, and exploration of how some clinical voices are more advantaged than others, receiving greater social recognition and remuneration. Disciplinary power affects relationships both within and outside network meetings, and can be linked to the devaluing and under-resourcing of the peer support role. If OD practitioners, including PSWs, are to be equal in the network meeting and other organisational structures, solidarity between disciplinary groups is required, and there must be action to redress power imbalances through resource sharing, and active support for equal pay and meaningful career progression. Additionally, to preserve the distinct qualities of each discipline and to avoid these being lost, or co-opted by dominant clinical professions, there needs to be meaningful dialogue about the values, practices and responsibilities of each discipline, including the unique insights of peer support (Byrne, Roennfeldt, & O'Shea, 2017).

Furthermore, it is not enough that OD lays claim to being a social movement simply because it provides an alternative to conventional psychiatric treatment (Buus et al., 2017). Just as we cannot work with a person's mind in isolation from body and context, equally we cannot regard social networks as being separate from the same systems of power that negatively impact on persons in distress/extreme states, while potentially blinding others to their own privilege. We need to understand how power operates in network meetings, so that OD includes transparent recognition of socio-political causes of distress/extreme states, in real time, to avoid augmenting those states. Critical peer support–OD model/s could be informed by peer support and the C/S/X knowledge, as well as knowledge from civil rights, women's, disabilities, indigenous and LGBTIQ movements. This would provide explicit critiques of privilege and power, including sanism discrimination, and understanding of the intersections between social structures and distress/extreme states.

A critically informed peer support–OD model would also explicitly address the diverse and alternative narratives of recovery, avoiding clinician-centred definitions that support sanist ideas of normalcy, and 'chokehold' psy practices and legislatively sanctioned deprivation of human rights (Wade, 2016). Finally, we need to look for ways to promote wider socio-political change rather than expecting a person to manage their distress/extreme states solely through models of care and psychotherapeutic techniques. As Samuels (2001, p.21) argues, 'the world is making people unwell; it follows that, for people to feel better, the world's situation needs to change'.

We end by proposing two practical methods that could enable continued critical reflection with an explicit focus on power differentials. Both methods privilege the embodied knowledge arising from peer support, C/S/X perspectives and Mad Studies scholarship. The first is co-production, which aims to build new forms of knowledge through a collaborative, exploratory and reflective process between people with lived experience and researchers (Filipe et al., 2017). Co-production deliberately seeks to redistribute power amongst partners, giving those with less power in the partnership more space to contribute and more influence than they would have in usual circumstances (Roper, Grey, & Cadogan, 2018). Importantly, in the context of developing co-produced models of critical peer support–OD, harnessing C/S/X perspectives and Mad Studies scholarship may ensure critical reflection on important issues that may otherwise be overlooked. For example, at a structural level, co-produced methods could ensure that overt and tacit stigma and discrimination, and the effects on the peer support workforce and service users were not overlooked, and that service impacts such as restrictive practices would not be discounted. Additionally, co-production at the practice level would consider what can be learnt from the embodied knowledge of PSWs arising from lived experiences of distress/extreme states, and/or mental health services.

The second method for redressing power differentials within a critical peer support–OD model could be the development of a supervision discipline by PSWs. Supervision led by PSWs is essential to retain the unique values, identity and practice of peer support, and to resist being colonised by psy perspectives, and neoliberal work cultures. Supervision led by PSWs has many potential positive functions. For example, PSWs could facilitate co-produced reflective practice spaces where PSW/clinician teams can deeply engage together in deliberations about, for example, power, intersectionality and ethics through the lens of peer support principles, C/S/X perspectives and Mad Studies scholarship. Such groups would also be modelling the co-produced methods they espouse.

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# Chapter 7
# Community Interventions in Conflict Settings

**Omar Said Yousef, Abdulrahman Alhalabi, Zachary Steel, Sertan Saral, and Ruth Wells**

> Oppression manipulates facts in people's minds, leading people to believe that whoever seeks truth is sinful, that whoever abandons his rights is obedient, that the one who cries out [against oppression] is mischievous, that the perceptive and intelligent are godless, and that the useless one is upright. It transforms genuine advice into intrusiveness, caring for others into enmity, magnanimity into transgression, enthusiasm/zeal into foolishness, mercy into illness, just as it considers hypocrisy to be a policy, manipulation to be civility, and pettiness/villainy to be kindness. – Abd al-Rahman al-Kawakibi, Syrian Intellectual (1855–1902), *The Nature of Despotism* (al-Kawakibi, 2013)

## Psychosocial Programmes in the Context of Injustice

International consensus on priorities for addressing the psychosocial consequences of conflict and displacement has highlighted the need to attend to the provision of basic needs, community and family supports, as well as providing skilled professional support (IASC, 2007). An increased focus on community consultation in the field has aimed to promote programmes that address the identified needs of community members (Semrau et al., 2012) and attend to cultural adaptation of therapeutic

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approaches (Bolton & Tang, 2004; Murray et al., 2014). A wealth of literature has demonstrated the deleterious effect of the physical, social and emotional costs of conflict on well-being, including heightened risk of post-traumatic stress disorder (PTSD), depression and distress (Steel et al., 2009). While an array of individual therapies has demonstrated efficacy in improving symptoms, identification of individual level distress may not assist in identification of the best way for communities to recover from the psychosocial burdens and costs of conflict. Our review of psychosocial needs among Syrian refugees in Jordan (Wells, Steel, Abo-Hilal, Hassan, & Lawsin, 2016) highlighted many prominent causes of distress (lack of basic needs, rights and employment; disrupted roles; social isolation; family violence), which cannot be effectively addressed by a focus on individual symptom impairment. We would like to present a framework for practice from a Syrian psychologist (OSY) whose deep engagement with displaced Syrian communities in Jordan, Turkey and Syria has led to an important insight. Psychological symptoms are a manifestation of suffering. The root of this suffering is injustice. Psychosocial programmes must respond to this social phenomenon of injustice.

Many psychological treatment models for people who have experienced potentially traumatic events are focused on helping individuals modify emotional (Foa & Kozak, 1986) and cognitive processing (Ehlers & Clark, 2000; Resick & Schnicke, 1992) and are based on evidence of disruption to brain functioning (Shin et al., 2004). While this work has contributed to our ability to support many people with post-traumatic stress disorder, human responses to war and displacement cannot be viewed as individual patterns of thinking, feeling and behaving independent of their political and social context. Otherwise, any work carried out in the service of affected refugees and displaced people will be ineffective, and, at best, its impact will be temporary and unsustainable. Mental health symptoms, in addition to somatic signs of a psychological origin (classified in hospitals and clinics as 'medically unexplained symptoms'), are the form in which human suffering—the root of the problem—manifests. The root of suffering among people displaced by conflict is indeed the oppression of human beings and of communities which demand freedom and dignity. This is exacerbated by a lack of social justice where justice may be a key component of well-being (Barber et al., 2014). Metaphorically speaking, in the events of conflict and war, when programmes and psychosocial interventions are adopted that neglect the root of suffering, it is like a patch on a worn-out gown. It is a cosmetic solution to a deep-seated problem.

In light of a renewed focus on ecological approaches to global mental health (Hoshmand, 2007; Kohrt et al., 2010; Miller & Rasmussen, 2017; Silove, 2013; Tol, Jordans, Reis, & de Jong, 2008; Wells et al., 2018), we would like to highlight the importance of attending to sociocultural and political contexts in the provision of clinical care, and the designing of appropriate systems to administer care. We argue that interventions which attend only to individual symptoms risk providing treatment approaches without considering the root of the problem. The injustice occurring to members of societies in conflict through their ongoing displacement, discrimination, lack of access to justice mechanisms, the unfolding of violence, war in their country of origin and oppression is the root of suffering, causing mental health symptoms. That is, these symptoms, and the complaints expressed by these individuals, are manifestations of their deeper pain.

## The Crisis in Syria

To understand the current situation in Syria, we must consider the history of the past 100 years. After the fall of the Ottoman Empire, Syria passed to French occupation (1920–1946), followed by a period of intense coups until the rule of Hafez Al-Assad (1970), and then his son Bashar Al-Assad (2000). The tyranny practised by Assad led to an authoritarian structure of society, which supported his ongoing influence through the media, education system and economic policy, and penetrated through various sectors of society (social strata, work environments, religion, family) (Van Dam, 2011). In 2011, people in Syria protested corruption and injustice as part of the broader Arab Spring movement in the Middle East and North Africa. In Dara'a, a group of children were tortured and murdered by the government for painting slogans on a wall (Yazbek, 2012). Many protested the murder of these children and the government's violent response against these protests escalated tensions to armed conflict (Yassin-Kassab & Al-Shami, 2016). Decades of systematic and cumulative propaganda engineered to erode civic life (Wedeen, 2015), combined with international military intervention, led to full-scale war. The people of Syria called out for global justice, but the world refused to hear. The role of international groups so far has been akin to letting a fire burn until it has run its course, only to then add fuel to sustain it rather than douse it with water. It is estimated that over 500,000 people have lost their lives (SOHR, 2018), over 5 million refugees have left the country and 6 million people have been internally displaced (UNHCR, 2018). Atrocities such as the use of chemical weapons (Organisation for the Prohibition of Chemical Weapons (OPCW), 2018), barrel bombs (Heisler, Baker, & McKay, 2015) and deliberate targeting of health facilities (Elamein et al., 2017) and the widespread use of torture and extrajudicial killings continue unabated and have expanded to state and non-state actors within the conflict.

## Our Aims in Writing This Chapter

We are psychosocial activists who believe we must work to ensure that the psychosocial impacts of these injustices are not obscured by the psychologised discourses of the Global North. Rather we must continue to engage with the complexities that arise from human conflict and human rights abuses.

The central argument of this chapter arises from the praxis of the first author, Omar Said Yousef, who graduated from the Department of Psychological Counseling Faculty of Education, Damascus University, Syria. He has worked in the mental health field throughout this crisis to promote well-being and help those affected (individuals and groups) to use their strengths and resilience towards recovery. He is a community leader who has trained countless fellow Syrians to use psychosocial skills to support their own communities. His reasons for writing are as follows:

> Human behavior is centered on looking for safety in the society in which we live. This feeling gives us comfort, the ability to think calmly and effectively, to interact with others with confidence and find the reassurance which strengthens our sense of belonging. Safety is the feeling that results from situations founded on human rights in a loving, supportive, and compassionate environment. The society that is ruled by a dictatorial regime suppresses liberties and destroys any action which does not favor the regime. People in such a society are afraid, most of the time, to exercise their freedom. The practice of political violence is reflected in all fields of life. When dictators rule, justice does not exist due to the absence of an independent judiciary. All State institutions must be under the control of dictatorship, which makes aggression the dominant expression among members of society. Those who do not exercise aggression will not succeed. This situation contributes to making anger and hatred prominent feelings. Behind these cruel feelings, the feeling of love is absent, as well as forgiveness. You can imagine how society and its members will be in this situation.
>
> This is the society in which I live.

The remaining authors have contributed their expertise to support and amplify Omar's voice. AA is a Syrian intellectual and activist living in Turkey. ZS is an Australian psychologist and researcher who specialises in the impacts of trauma, global mental health and cultural psychiatry. SS is an Australian gender and cultural studies researcher who specialises in the discursive force of military service and its entanglement with democratic institutions to produce and reproduce nationhood. RW is an Australian psychologist who seeks to work together with members of the Syrian refugee community to understand how psychological therapies can be adapted to be useful to Syrians who are living in displacement. This chapter also draws on data collected by RW in interviews with Syrian and Jordanian psychologists working with Syrian refugees in Jordan between 2013 and 2016. Twenty-eight key informants were interviewed regarding how members of the Syrian refugee community understood and explained mental health concerns and how they accessed services. The study was approved by the Sydney University Human Research Ethics Committee (Project No. HREC 2013/803 & HREC 2015/148). Thematic analysis with key techniques from grounded theory (Charmaz, 2014; Strauss & Corbin, 1998) was conducted. (See Wells et al., 2018 for detailed description of the methods and their limitations).

## Getting to the Root of the Problem

For people exposed to conflict and displacement, the root of suffering is injustice: to lose loved ones; to lose the support structures of home, work, education and family; to lose the ability to make life plans and follow through with them; to lose access to rights and resources; to lose your social status; and to be moved around by violence and conflict. These are all injustices contributing to suffering. Some will be more resilient to these challenges and some will already carry mental health concerns that these injustices compound. If we seek to intervene to alleviate suffering without a sufficient understanding of the full range of causal factors, we will fail in our efforts to assist individuals and communities to recover from the effects of war and displacement. We must look at how these factors interact. Syrian psychologists we interviewed in Jordan described the impact of the crisis as a spring of suffering, pouring forth pressures, which render their efforts to reduce client distress ineffective.

> Actually this has a similarity, it's like when you go to the spring of the water, so this is the main source of the water... If you solve the problem in the filter it's not for the whole problem, it's a part of the problem. But if you go to the spring itself, the source, so this is like mental health. – Male Syrian Psychologist

As a result of this, some Syrian psychosocial activists we interviewed had to give up their work due to burnout:

> Because at the beginning, we stand until it's finished. We all said, maybe one month, maybe two months, maybe 1 year, maybe more… And sometimes when a patient comes to us, we start to work with him… after 4 or 5 sessions, he will be better and go back to his life. Then he comes to us in relapse because his home is bombed in Syria or his sister killed or his neighbour. Because the crisis is continuous, it doesn't stop. For this reason, you can't make a good job in treatment if the crisis is continuous. For this reason, I work for 6 months in the clinic and then I stopped because I will burn out. – Female Syrian Psychologist

This leads us to ask, what is the purpose of psychosocial intervention in the context of human rights violations? Imagine there is a group of people standing on a mountain who are pushing others off a cliff. There would be little use in rushing to help people when they have already fallen to the ground; we would need to prevent people from being pushed from the top. We do not know exactly how psychosocial intervention in human rights violations can help us to respond to this problem, but it makes sense that understanding, acknowledging and responding to the social processes involved in this injustice is a necessary component of any answer.

## Food for the Soul

The current crisis in Syria emerges from decades of authoritarian government. The inability of the individual or the community to secure existential protections and basic needs deepens suffering. This inability is not merely about survival, it is the striving of the individual and community to achieve dignity, goals, personal role and the meaning of presence in life. Hunger is more than a lack of food in the body:

> I don't need bread, I need food for my soul. – Male Syrian Psychologist

Derrick Silove developed the ADAPT mode (Silove, 2013) to provide a framework for psychosocial intervention in post-conflict settings, which can be more responsive to this need. He proposed five adaptive systems, of which one is the safety system, which may be directly undermined by conflict and displacement and encapsulates a range of the concepts considered in a threat-based model of PTSD. In addition, he makes the case that there are additional adaptive systems that are affected by displacement. These include the following:

- Personal bonds and affiliations, which may be lost through separation, death or destruction of human trust, resulting from interpersonal violence and abuse
- Justice which is impacted by experience of human rights violations, transgression of moral systems and betrayal
- Roles and identities which may be challenged by loss of access to work or one's place in the family or social system
- Existential meaning which may be shattered or shaken by the above experiences and valued religious or philosophical understandings may be questioned

This focus on a range of adaptive systems may help to broaden the focus of individual therapy formulations to include socio-political factors that impact on how suffering is experienced. For example, anger may be a justified emotional response to the ongoing human rights abuses and disregard for human dignity associated with the conflict in Syria, a matter identified in other post-traumatic settings (Gray, Nash, & Litz, 2017). A focus on the intra-psychic experience of anger may not identify the causal mechanisms related to the manifestations of uncontrollable anger, limiting the efficacy of therapeutic work and invalidating the true origins of debilitating anger. An individual therapy approach, which employs theories of anger attacks as failed emotion regulation (Gardner & Moore, 2008) or as simply a result of stable individual traits (Fulwiler, King, & Zhang, 2012) without considering the social conditions which lead to anger, fails to acknowledge the impact of injustice. An alternative response may be to direct this energy into symbolic or material ways to seek justice. For example, testimony therapy (Cienfuegos & Monelli, 1983) emerged from social justice movements in response to rights violations by dictatorial regimes in Latin America in the 1970–1980s. Individuals provided detailed accounts of their experience of rights violations, such as torture. Their de-identified stories were used as evidence to demonstrate human rights violations to the international community. The detailed recounting of traumatic events and their connection to socio-political issues is now an important component of narrative exposure therapy (Neuner et al., 2008; Onyut et al., 2005). Drawing attention to these ecological factors need not detract from employing established therapeutic techniques, such as cognitive behavioural therapy (CBT), where they are appropriate. Rather, foregrounding these issues may help to ensure that individual therapy techniques are not employed in ways that could pathologise or injure people by failing to consider their social context.

## Human Rights Violations Are Different to Disasters

Thinking about injuries resulting from conflict between humans is very different from the injuries resulting from natural disasters. In situations of conflict, deliberate human rights violations can have mental health consequences, which reach beyond those captured in the category of PTSD. Deliberate harm, as in the case of torture, is specifically designed to demoralise, fragment and destroy interpersonal connections, at the level of the individual and society. It is a highly effective form of social control, as the enduring harm it causes serves as a warning to others (Gorman, 2001). Traumatic reactions are the result of a complicated array of interpretations of the meaning of a potentially traumatic event and the individual's role in it (Ajdukovic et al., 2013). These interpretations are shaped by culture and individual coping patterns as people find a way to cope with what has happened (Gorman, 2001). In addition, the nature of interpersonal violence in conflict can lead to a sense of injustice, leading to anger (Brooks, Silove, Steel, Steel, & Rees, 2011; Quosh, Eloul, & Ajlani, 2013), and moral injury (Litz et al., 2009; Shay, 2012) leading to guilt and shame. In order to survive in violent contexts, people may be forced to act in ways which contradict their values. What is understandable behaviour in such a context may be difficult to integrate into a coherent identity as life goes on.

Hilbrink, Berle and Steel (2016) have sought to broaden clinical conceptions of PTSD to take into account alternative pathways to PTSD symptomatology other than through threat responses. They argue that experiences of horror, shock, injustice, guilt and shame can give rise to shock, disgust, disempowerment and anger. In such cases, it is one's moral system which is mortally threatened. This can seriously undermine the ability to function in the future. Moral injury may occur from moral pollution (e.g. witnessing horrific scenes), moral betrayal (when trusted social systems fail to protect) and moral compromise (when extreme situations force one to act in ways that contravene one's own moral code). The Syrian conflict is unparalleled in recent times in the scale and brutality of war crimes and thus the potential for moral injury. Long-term sieges of areas, such as Eastern Ghouta, have seen ongoing bombardment of civilians. One day, in February 2018, saw over 200 bombardments and 110 mostly civilian casualties, along with denied access to food, healthcare and humanitarian supplies (Jabbour et al., 2018). The deliberate bombardment of health facilities in Northern Syria (Elamein et al., 2017) and the arrest, torture and murder of medical staff (Heisler et al., 2015) are other stark examples of atrocities, which can seriously challenge one's existential view of the world. It is impossible to know what one may do to survive in such a situation.

The Arabic word *fitra* alludes to a natural human instinct, which includes a sense of equity, dignity, freedom and curiosity. These qualities resist oppression yet they are undermined by the rigid structures of the regime, which reach all levels of society. As the Internet increased the unrestricted flow of information into Syria, people began to question more openly the unspoken rules of despotism, helping *fitra* to flourish, especially for younger people. As people broke unspoken rules imposed by the regime, they experienced harsh and unexpected blowback from the government and other (sometimes trusted) authority figures. This created an environment for moral injury, as people began to wonder whether the system in which they live has the potential to create justice. That is, injustice does not only exist in the official structures of the regime, rather they are encoded in social systems and re-enacted every day.

This is what distinguishes repressive governments in dealing with citizens: freedom of opinion and expression is forbidden, freedom of thought is punished. Such a climate produces an invalidating environment, leading to shame because of victimisation (Brooker, Albert, Young, & Steel, 2017). Human relationships are damaged. How will a society develop when feelings of grief, oppression, hatred and revenge prevail over the souls that form that society? Dictatorial regimes create these conditions through violence and the threat of violence, preventing people from claiming their rights, expressing their opinion or defending the vulnerable.

No dictatorship can sustain itself without instilling terror among citizens, without spreading informants among those who campaign for a system of government based on freedom, dignity and human rights. One of the tactics of the Assad regime has been to infiltrate activist networks by taking advantage of the intimacy and trust necessary to work together, building romantic relationships based on false pretences to extract information and then publicly expose these relationships as ‘illicit’. It is cruel, merciless and immoral to destroy the heart of the people by exploiting their needs for intimacy, forcing them to live in fear of love and romantic relationships. Even the most private corners have become part of the political battleground.

## The Political Situation Carries Personal Meaning

Whether or not people support the uprising, the collective decision to gather and oppose decades of systematic silencing of meaningful civil discourse (Cooke, 2007) has impacted the cultural, social, familial and individual lives of every Syrian. The very structure of the Syrian autocratic regime is one which is designed to generate sectarian division and prevent collective action (Van Dam, 2011). This carries forward the deliberately sectarian policies of the French colonisers, following the fall of the Ottoman Empire (Provence, 2005; Van Dam, 2011). In an ancient civilisation, one of the leading centres of Arab thought and culture (Shannon, 2006), the long arm of the Syrian regime reaches into the homes and personal lives of Syrians, shaping discourse and influencing what can and cannot be said among trusted loved ones (Wedeen, 2015). The impacts of colonisation are still felt through their enactment in institutions and everyday discourse (Said, 1978). The work of Black feminists in the United States offers us an articulation of the kind of systems of oppression that Syrians face as ‘manifold’, ‘interlocking’ and ‘simultaneous’, and a deepened understanding of the political as lived experience (Combahee River Collective, 1983) where everyday actions can carry huge weight.

Consider life under ongoing threat of arrest and torture, for yourself and your loved ones. Consider the reality that no matter the level of love and trust, no one can be expected to withhold information under torture. Consider what inner thoughts and desires you would consider sharing with those you wish to protect, and the traditional saying, *Even if you have blood in your mouth, swallow it,* begins to make sense. As Jesuit priest from El Salvador Martin-Baro identified, it is under such conditions of totalitarianism that social capital and trust between citizens and groups within a civic space are eroded and destroyed (Martín-Baró, 1994). His ideas echo those of Al-Kawakibi, Syrian dissident and intellectual under the Ottoman Empire, who argued that despotism transforms society so that mercy towards others is seen as an illness. Both colonisation and totalitarianism operate in the social, political and cultural spheres to shape us at an individual level, such that our thoughts, emotions and actions are occupied with the concerns of those who stand to benefit from such oppressive systems (Lorde, 2007: 113), to the deleterious effect on our family and peer relationships, and any groups and coalitions we might try to form in response. Arthur Kleinman argued that embodied suffering is constructed through both transpersonal (social) and subjective experience. A biomedical focus on subjective meaning-making out of unmentionable horrors belies the social and embodied nature of those horrors—and the fact that certain kinds of bodies are designated to endure them (Kleinman, 1997). Any attempt to address social suffering flowing from such a situation must seek to understand what it means to Syrians that people stood up and protested. It is thus imperative that psychosocial programmes recognise and address the socio-political context, to ensure that they address the lived experience of Syrian community members and that international service providers can guard against the recapitulation of colonial power dynamics by unquestioningly importing foreign therapeutic models.

Psychologists we interviewed in Jordan working with Syrian refugees spoke about the significance of political protest in questioning oppression and the impact this has had on established social systems. Elsewhere, we have described an ecological model of adaptation to displacement among displaced populations (Wells et al., 2018). Taking Syrian refugees in Jordan as a specific case, we discuss how an ecological approach involves examining how individual and collective behaviours perform adaptive functions within the new displacement environment. We use this framework to examine how a change in environment has modified the adaptive function of social practices at the levels of the individual, family/peers, social and cultural layers. We explore how the Syrian concept of *karama* (dignity) is moderated by gender and other identity markers. Importantly, psychologists described how the uprising provided an example of questioning authority and how this process may be echoed within families as women take up opportunities to challenge gender roles.

> She now is strong, OK? I like that. The woman can talk. Can put her things in the right way. No one can now impact on women's thinking. For example, a lady told me, 'I want individual counselling sessions'. I said 'Please, I want permission from your husband because you are a lady and I am a young man, ok, we are in a society where we are not allowed to be in the same room'. She laughed. 'You speak about that?' [laughs]. She raised her mobile, called her husband and put the speaker on. 'Hi, Hi, me and Mr [name] are doing individual counselling. Don't ask me why, don't ask me. After one hour I will come, thank you.' I asked her. 'Before the crisis, you could speak like this?' She said 'No! Why now? Because me and my husband and all Syrian refugees, we have the same problems. We are equal now. He's out of work, but I work hand crafts. OK? I take care of our sons. He can't take care of our sons because he's male. So, I am better than him'.
>
> – Male Syrian Psychologist

> So now [men] think that 'My dignity becomes better because now I'm able to talk about whatever I want, to do whatever I want. But also, I lost dignity because now my role becomes less'…It's really funny that when someone applies some rigid rules, like the political issues for the system in Syria, they don't allow men to do specific things. The men also do not allow their wives to do specific things. Also, women themselves will not allow each other to talk freely about things themselves. So, this is displacement of the authority… So if you want to see what is changed, now they have the ability to say no to authority… Women and children, they have the ability to do what was taboo.
>
> – Female Jordanian Psychologist

Another way to think about this 'displacement of the authority' is to draw on ongoing feminist concerns over whose accounts and what knowledge count as legitimate or authoritative according to various and often overlapping identity markers and histories (Haraway, 1988; Harding, 2004; Moreton-Robinson, 2013). Feminist concerns over what knowledge *counts*, combined with feminist work that deepens our understanding of how the political is entangled with lived experience, provide us with more tools than is currently available in the field of clinical psychology to think through and conceptualise the socio-political context of Syrian community members. Feminist standpoint theory, for instance, emphasises the authority and legitimacy of everyday knowledge practices, allowing us to see the partiality of practices that assume universality and as a result dismiss socio-political context or relegate it to the margins (Moreton-Robinson, 2013: 332). The linkages between these disciplines can help us to centre the accounts and cultural concepts (such as *karama*) of the marginalised.

## An Ecological Approach to Mental Health Programmes in Conflict Settings

An ecological perspective recognises the interdependence of individual and environmental factors (Kelly, 1966) by defining mental health concerns as a product of 'a lack of fit' between an individual's adaptive resources and the environment they are in (Miller & Rasco, 2004). Adaptation is a dynamic, reciprocal process, which changes over time. This includes responses to environmental challenges before, during and after displacement (Drozdek, 2015; Ryan, Dooley, & Benson, 2008). This approach can help to focus clinicians on the importance of understanding explanatory models of distress and how these relate to the circumstances of displacement. An ecological approach can give us pause when approaching therapy with people who have lived through human rights violations. Though there is a long tradition of cultural psychiatry that calls on therapists to discover and respond to the possible cultural meanings of behaviours (Hinton, Rivera, Hofmann, Barlow, & Otto, 2012; Kirmayer, 2006; Kleinman, 2008), an ecological approach explicitly asks us to take this a step further and look at the relationship between the individual and the world around them, bringing power relations into focus.

Humans are social beings whose basic needs are met within the framework created by the reciprocal relations in society and the availability of resources. Therefore, their psychological needs are met within the context of meaningful relations. The fact that the suffering of refugees and displaced people has complex psychosocial roots is not an excuse for the absence of holistic methodological approaches. This makes it necessary to establish community service centres based on this holistic concept to provide a service to support displaced people in building or restoring their ability to preserve their dignity and the dignity of their loved ones until the environment in which they belong is established on a system of justice. Attention should be paid here to advocacy campaigns that help people claim their rights and express their suffering. Psychosocial support interventions and psychological programmes should aim to help the suffering people to build resilience in their new environment. This will involve focusing on the kinds of relationships they can build, as well as helping them to build skills to live with a dangerous reality towards taking up new opportunities and living with *karama* (dignity). While psychologists can focus on helping people to deal with internal pain (including specialised services for trauma sequelae), there should be a focus on empathy and compassion and seeking culturally congruent ways to mourn loss. In order to achieve sustainable, effective programmes, there is a need to avoid the language of 'big numbers' of beneficiaries and, instead, adopt quality standards and ensure that local workers are provided with appropriate training and supervision. This means staying away from fast food, fly-in-fly-out training and adopting continuous training to enhance staff skills and support professional development according to arising needs. This can also help to promote staff care for staff who often live with the same realities as the people they seek to help.

## Conclusion

In conflict and post-conflict settings, injustice lies at the centre of suffering, especially following decades of authoritarian government. In such contexts, the sources of social suffering are manifold and ongoing. Human rights violations are different than disasters because of the way that deliberate violence can challenge people's moral systems. In response, we must work to support dignity and resilience. This means focusing on relationships, identity, moral understandings and meaning, as well as symptoms. As psychologists and allies, we cannot provide a lasting solution to injustice. While we recognise both the potential futility of rushing to help people once they have already fallen from the mountain, we are not sure how to rush to the top and prevent them from falling. However, as clinicians, researchers, thinkers and members of our own communities, we can ensure that injustice is not compounded by ignoring, silencing or explaining away its existence. We can recognise human dignity by acknowledging where injustice has occurred and supporting communities to find adaptive ways to respond. We can also do this by examining how our own practices may contribute to the social processes which support injustice.

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# Chapter 8
# Indigenous Clinical Psychology in Australia: A Decolonising Social–Emotional Well-Being Approach

**Robert Brockman and Pat Dudgeon**

> Those who cannot remember the past are condemned to repeat it (Santayana, 1905; p. 284)

## Colonisation and Closing the Well-Being 'Gap' for Indigenous Australians

Colonisation has been defined as '… the takeover of territory, appropriation of material resources, exploitation of labour, and interference with political and cultural structures of another territory or nation' (Loomba, 2005, p. 11). It has often been noted that the impact of colonisation on Australia's Indigenous peoples has been devastating, a fact acknowledged by Australian governments for over 30 years (Australian Law Reform Commission, 1986). Correspondingly, national reports and all Australian governments across the past three decades have identified Indigenous Australians as the most significantly disadvantaged ethnic group on almost all socio-economic indicators, including the key domains of education and health (Department of Prime Minister and Cabinet, 2018).

The gap on key indicators of education, achievement, economic participation, health and emotional well-being for Indigenous Australians is wide. Indigenous Australians have been found to experience the highest school dropout rate of any cultural group in Australia (Steering Committee for the Review of Government Service Provision, 2014) and experience up to three times the mental distress of non-Indigenous Australians (Dudgeon et al., 2014). Rates of intentional self-harm

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among young Indigenous people aged 15–24 years are 5.2 times that of non-Indigenous young people (Dudgeon et al., 2014), while Indigenous youth suicide is reportedly several times the rate of non-Indigenous Australians (Australian Institute of Health and Welfare, 2015). Furthermore, Indigenous Australians are also up to 15 times more likely to be homeless than non-Indigenous Australians. The latest ‘Closing the Gap’ Report (Department of Prime Minister and Cabinet, 2018) summarises the situation that despite solid progress over the past two decades on key indicators, such as Indigenous mortality rates, education and social and emotional well-being, progress has been slow, lagging significantly behind the government’s own targets. All of this despite a steady increase in budgetary outlay for Indigenous welfare topping 33.4 billion dollars (AUD) in the 2015–2016 budget (Steering Committee for the Review of Government Service Provision, 2017). While increased resources may be part of the picture of ‘closing the gap’, there is a clear need to think deeply and innovatively about why these inequities in health and well-being outcomes persist.

## From Colonisation to Decolonisation

One perspective that has gained much traction in the space of Indigenous affairs health and research has focused on the effects of colonisation and the enduring explicit, and often implicit, processes that indicate its continuance. From this position, forms of institutional power and control maintain social dominance structures that continue to support powerlessness and a lack of autonomy and opportunity among Indigenous people. This loss of autonomy and agency includes not only that which is material but also, and perhaps more importantly, a loss of culture, language and identity, indicating a ‘colonisation of the mind’ (Ngugi, 1986). Decolonisation thus refers to an ongoing ‘struggle’, a dynamic and interactive process that aims to disrupt the established (colonial) social hierarchies that have marginalised people and communities since colonisation (Dudgeon & Walker, 2015; Smith, 2013). Decolonisation processes seek to interrupt these hierarchical relationships through the reclamation of self-determination, making use of tools of collective mobilisation, transformation (contextual change) and healing (Smith, 2013). Key to this approach is decolonising the ‘mind’ through ensuring the strong presence of marginalised voices, perspectives and forms of knowledge and increasing agency (Dudgeon & Walker, 2015). Self-determination for Indigenous peoples therefore is central to any concept of well-being, and which has been fundamentally undermined by ongoing processes and institutions of imperialism and colonisation. This links in perfectly with Western understandings of the importance of autonomy support to well-being, development and motivation (Ryan & Deci, 2017) at the individual and at the group level, and the notion of Indigenous Sovereignty (Parker, Bodkin-Andrews, Parker, & Biddle, 2018). Indigenous scholars make the point that for the most part, science, and in the process, medicine and healthcare services are often viewed, from an Indigenous standpoint, as a continuation of colonisation and imperialism (Dudgeon & Walker, 2015; Smith, 2013). Taken seriously, this perspective can explain to some degree why successive government social welfare programmes, healthcare services and 'interventions' have not been able to, with any haste, ameliorate the consequences of colonisation; they are often experienced as a part of it.

## *Indigenous Social and Emotional Well-being (SEWB)*

In the Australian context, prominent Indigenous scholars have taken to conceptualise the experience of Indigenous peoples within an inherently 'colonial' mental healthcare system. These scholars have argued that 'business as usual' (Western) health systems fail to adequately understand and support the well-being of Indigenous patients, which is inherently complex and idiosyncratic (Dudgeon & Walker, 2015). This Indigenous scholarly work and activism has led to several national mental health reforms designed to improve Aboriginal and Torres Strait Islander health and well-being as summarised in the widely accepted

> Ways Forward National Aboriginal and Islander Mental Health Policy Report. (Swan & Raphael, 1995; pp. 19–20)

which asked that all mental health practitioners, including psychologists, practise with recognition of nine core principles as a starting point for the promotion of Indigenous SEWB in clinical practice:

1. The Aboriginal concept of health is holistic.
2. Self-determination is central to the provision of Aboriginal health services. This will be further discussed in a dedicated section below.
3. Culturally valid understanding must shape provision of Aboriginal health (and mental health)care.
4. The experience of trauma and loss contribute to the impairment of Aboriginal culture and mental health well-being.
5. The human rights of Aboriginal people must be recognised and enforced.
6. Racism, stigma, environmental adversity and social disadvantage must be addressed in strategies aimed at improving Aboriginal mental health.
7. The strength and centrality of Aboriginal family and kinship must be understood and accepted.
8. Diversity of groups needs to be recognised.
9. Australian Aboriginal and Torres Strait peoples have great strengths, which should be respected, encouraged and appreciated.

Aiming squarely at Australian Mental Health practices with Indigenous peoples, and having been influenced by decolonising theory, Dudgeon and colleagues (Gee, Dudgeon, Schultz, Hart, & Kelly, 2014) have outlined an Indigenous model of social–emotional well-being (SEWB) that is designed to go beyond this starting point. The key aspects of this model are described below.

## *Contextual Determinants of Indigenous Well-Being*

The SEWB framework depicted in Fig. 8.1 was developed by Graham Gee, Pat Dudgeon and colleagues (Dudgeon, Bray, D'costa, & Walker, 2017; Dudgeon & Walker, 2015; Gee et al., 2014) after extensive participatory action research working with Indigenous communities across Australia. Figure 8.1 outlines the Indigenous collectivist (vs. individualistic) perspective that individuals exist as fundamentally embedded within social, historical and political contexts that could be called SEWB 'determinants of health and well-being'. This places social and historical influences at the centre of our understanding of Indigenous well-being; the three contextual determinants can either support or thwart *seven underlying well-being domains*. Thus, important notions of intergenerational trauma, the experience of racism, oppressive government policies (e.g. stolen generation) and the overall impacts of colonisation (e.g. fragmentation of communities, loss of cultural practices and language) are all acknowledged as occurred as a part of a social/historical/political context. Recent participatory action research with Indigenous people with a lived experience of the effects of suicide has also confirmed the importance of addressing experiences of grief, loss, racism and trauma (Dudgeon et al., 2017, Lived Experience Project).

The seven domains of well-being can be viewed as fundamental needs or nutriments, more or less required to experience well-being, and are unique from, but analogous to, Western notions of core emotional needs (Ryan & Deci, 2017). Conversely, disconnection from these seven domains, driven by thwarting or lack of support in the social/historical/political environment directly, leads to the experience

**Fig. 8.1** Indigenous model of social and emotional well-being. (Gee, Dudgeon, Shultz, Hart, & Kelly, 2014)

of distress, 'ill-being' and poor mental health outcomes (e.g. suicide). As depicted in Fig. 8.1, these domains consist of connection to culture, country, spirituality, body, mind and emotions, family and kin, and community. The model recognises that these seven SEWB domains are artificially separated; individual domains are in fact overlapping and interconnected (see Dudgeon & Walker, 2015 for an extensive overview of each domain).

Central to this SEWB model is that it is situated within a decolonising discourse (Dudgeon & Walker, 2015; Smith, 2013), which seeks to make primary, Indigenous discourses and perspectives of knowledge, culture, experiences of social and economic inequality, intergenerational trauma and traditional ways of healing (Dudgeon & Walker 2015). Dudgeon & Walker, (2015) argues that holistic improvement in Indigenous well-being outcomes is only likely to occur when psychological services are community focused, culturally appropriate and acknowledge the effects of colonialism and systemic oppression. This model has become very influential in terms of government policy, and at the level of service design (PM&C, 2014, 2017, 2018), but little work has been done to explicate the implications of the model in the context of daily clinical psychology practice. How might such a model influence daily clinical practice with Indigenous patients seeking psychological therapy? How can psychologists working clinically reimagine clinical practice from an Indigenous standpoint, using principles of Indigenous SEWB? What follows is a series of considerations relevant to a decolonised view of clinical psychology practice with SEWB principles embedded in practice. These considerations should not be considered exhaustive; rather, an attempt to initiate reflection on how 'business-as-usual' clinical psychology practice with Indigenous peoples may be reimagined.

It is also important to recognise that Indigenous psychology is founded on sovereign Indigenous knowledges and is not merely a decolonised form of (white) psychology. A decolonising critique of psychology and Indigenous therapeutic epistemologies has different intellectual and cultural traditions.

## Clinical Considerations for a Decolonised Approach to the Practice of Clinical Psychology: Understanding Commonalities and Differences

Due to our common humanity, it should be acknowledged that Indigenous people share more similarities than not with non-Indigenous people. Thus, the drivers of well-being for Indigenous people are likely to be largely overlapping (e.g. connection to relationships, autonomy). However, there can be critical social, cultural and historical differences that can make the experience of well-being and distress different, and standard Western interventions and approaches problematic and at times inappropriate (e.g. cognitive therapy interventions that challenge valued Indigenous cultural beliefs). Furthermore, in many if not most cases, there is likely to be specific aspects of well-being that are unique to a person's Indigenous identity (e.g. connection to land/country). While we contest that many Western evidence-based therapies and procedures (e.g. exposure therapy principles for anxiety-based problems) are likely to be efficacious for Indigenous people by way of our shared humanity, it should be acknowledged that the varied cultural, social and political experiences of Indigenous Australians will mean that in many cases, a standard 'business-as-usual' approach to clinical practice may not be appropriate or effective. Being able to work cross-culturally with awareness and respect for social and historical influences, and with Indigenous conceptions of well-being in mind will be an important step for clinicians interested in a decolonising approach to clinical practice.

## *The Need for Clinician Self-reflection*

It is highly advisable that Indigenous and non-Indigenous clinicians develop awareness of the social, historical and political determinants of their own SEWB. This would necessitate individual clinicians commit to their own reflective practice and perhaps supervision, taking the time to understand and acknowledge their own world views, attitudes, values and beliefs and how they may correspond or differ from others, particularly their patients (Bennett-Levy, Thwaites, Chaddock, & Davis, 2009; Kilcullen & Day, 2017). 'Cultural competency' or 'responsiveness' is therefore more than simply adapting cultural understandings regarding your patient, rather it must be understood as involving an ongoing process of self-reflection (Kilcullen & Day, 2017), with the goal of identifying and then challenging one's own cultural assumptions, values and beliefs (Walker, Schultz, & Sonn, 2014). From this perspective, cultural competence requires attempts to develop empathy and connected knowledge; an ability to suspend your own world view so that you can connect more fully to the experience of those we seek to help (Walker et al., 2014). What biases, perspectives, assumptions and/or methods might we hold that feed into a more 'business as usual'/colonial form of psychological practice? How might our own histories and perspectives interact with that of our patients? Walker et al. (2014) outline a powerful model of culturally reflective practice to help practitioners be more self-aware and reflective on the interactions between their own histories, assumptions, values and beliefs and those of patients.

## *The Importance of a Strong Therapeutic Relationship*

Establishing rapport and building a genuine therapeutic relationship consistent with the experience of people who have endured grief, loss and trauma, qualitative studies have found that an important prerequisite for working with many Indigenous people clinically is the establishment of a genuine therapeutic relationship (Mullins & Khawaja, 2018). Mullins and Khawaja (2018) found in their sample of non-Indigenous psychologists that little progress seemed achievable unless the time was spent specifically for the relationship to naturally develop, allowing for trust in the therapist as a person. Clinicians found making space for yarning, targeted self-disclosure, establishing safety and stability, using a more casual communicative style (i.e. a less 'clinical' approach) and flexibility in the treatment context (i.e. meeting where they feel comfortable; e.g. in a park, in a community space etc.) were all useful strategies to improve the therapy relationship.

In working with Indigenous patients to establish a strong rapport, be aware that self-determination, or lack thereof, is often central to their lived experience and historical narrative. Many Indigenous people are acutely aware of, and sensitive to, institutionalised forms of control and power. Clinicians need to work hard to make therapy a space where there is abundant opportunity for the support of choice and autonomy.

## *Integrate SEWB Principles into Assessment, Case Formulation and Treatment*

In this chapter, we have exemplified one influential Indigenous model of SEWB (Gee, Dudgeon, Shultz, Hart, & Kelly, 2014) and use it as an appropriate model from which to understand and conceptualise Indigenous well-being. It is not the only such model (for an example, see Craven et al., 2016); we ascertain that clinicians seek knowledge of Indigenous conceptions of well-being and use them to assess, formulate and provide culturally appropriate psychosocial treatment options.

Assess the Impact of social and historical determinants. In assessing and formulating cases, consider the impact of social and historical determinants on your patient's experience/problems (e.g. the impact of trauma across generations). Use this information to inform your formulation of the presenting issues (e.g. the connection between a history of bullying/racism and the development of subsequent core beliefs, 'schemas' or behavioural patterns). This can be incredibly validating for Indigenous patients whose narrative may include a lot of self-blame and stigma about their difficulties. This formulation can be used to formulate and anticipate any potential issues in engagement.

Once an SEWB-informed formulation is derived, this should be used to Improve 'Connections' to SEWB Domains. Use Indigenous conceptions of well-being to underpin psychological interventions and treatment plans whenever possible. Look for themes in 'loss of connection' across the seven domains in the ill-being/distress of Indigenous patients and integrate into your treatment plans. Kilcullen and Day (2017) outline how the seven SEWB domains can be considered and integrated into cognitive-behavioural therapy (CBT) case formulation and treatments. The distinct motivational qualities of the seven domains render them easy to integrate as goals, values or needs, across therapy models, and provide a relevant culturally appropriate context for psychological intervention. For example, using the evidence-based strategy of behavioural activation (Jacobsen & Dimidjian, 2001) can be integrated with the goal of connection to culture by encouraging scaffolded activities towards engagement with increased involvement in community or cultural activities (for an example, see Australian Ministers' Advisory Council, 2017).

## *Diversity of Political and Cultural Worldviews of Indigenous Patients*

How marginalised and powerless does your patient feel as a consequence of their social, historical and political experiences? How important to your patient are the seven domains of Indigenous well-being? It should be remembered that the political and cultural views of Indigenous people are highly diverse. Mullins and Khawaja (2018) report that for many Indigenous clients, there is a merging of Indigenous and Western ideas, depending on the client's level of acculturation. We thus advocate that clinicians assess on a case-by-case basis, the degree to which Indigenous determinants and domains are important for individual patients and implicated in presenting psychological difficulties. Further, those SEWB domains that already serve as well-being support should be identified, supported and respected.

## *Navigating the Issue of Diagnosis*

There is increasing acknowledgement in the general mental health community that diagnostic labelling may in some cases have iatrogenic or other problematic effects (Kinderman, 2014; British Psychological Society, 2014). Given the general high levels of stigma, trauma, abuse, marginalisation and discrimination of Indigenous peoples historically, it stands to reason that considerable caution be observed in the process of diagnosis. While it has been acknowledged that in certain contexts, accurate and timely diagnosis may have several benefits (e.g. clinical communication, treatment planning, access to resources and risk management), research with Indigenous peoples has found that these risks need to be tempered by the fact that such diagnosing may further contribute to stigma and may have limited cultural validity (Mullins & Khawaja, 2018). Particular care should be taken, not to pathologise, what is the norm amongst that person's community (e.g. Belief in spirits). Care should be taken, where possible, to take a normalising, trauma-informed approach that acknowledges the social and historical antecedents of individual problems, and that language be adopted that is de-pathologising. Similarly, Trauma-focused models of care should be utilised where relevant. The acknowledgement of the effects of trauma, including transgenerational trauma, is a key principle of SEWB approaches (Dudgeon & Walker, 2015). As such, trauma-informed treatment approaches are likely to be a good fit in integration with SEWB principles (e.g. Schema therapy, Narrative therapy, trauma-focused CBT, EMDR). Nonetheless, specific evidence of the cultural appropriateness of these interventions is sadly lacking and warrants future research consideration.

## *Engaging with Community and Building an Indigenous Cultural Network*

Being known, accepted and trusted by the local Indigenous community in which one practices has been described as an important step for clinicians, even more so for those working in regional areas and remote communities (Mullins & Khawaja, 2018). Some strategies that have been found to be useful in this vein include making time to introduce oneself to Indigenous community members and organisations, engaging and assisting at community events and, if possible, building reciprocal relationships with local community members who can ‘vouch’ for you (Mullins & Khawaja, 2018).

Similarly, culturally competent practice with Indigenous people must be grounded in cultural knowledge. Non-Indigenous and Indigenous practitioners alike will benefit from engaging and building an Indigenous cultural network to assist in informing their practice. It is advisable that such a network be as diverse as possible to allow the therapist to develop a broader cultural understanding of the social, cultural and historical determinants of well-being across communities and experiences (Paradies, 2016). Seek to make genuine (and reciprocally beneficial) relationships and connections with local Indigenous institutions and communities, which may be able to support therapists in their endeavour to help patients to ‘connect’ to well-being determinants (e.g. cultural activities).

Consider what relevant existing cultural practices may be available that may serve to help the patient open up to understand (e.g. yarning) and overcome his or her problems and ‘reconnect’? Further, what existing social structures (families, communities) could be supported to better support your patient. Those patients with strong Indigenous cultural backgrounds will often adhere to more collective notions of well-being; connection to these sources of support can aid recovery. This connects nicely to a small but growing movement within clinical psychology to utilise more systemic and community-based perspectives in clinical practice (see Rhodes & Langtiw, 2018 for an overview).

## *Advocating for Social and Political Change*

While our own power to help fight social and cultural injustices may be limited, we may on occasion be able to advocate for our patients, along the lines of helping institutions understand the impact of ‘business as usual’ practices. While this may not always directly help, it will signal to the patient, your willingness to ‘see them’ and collaborate on helping them get their needs met, rather than impose ‘interventions’. Taking this a step further, Mullins and Khawaja (2018) argue for an expanded activist role for psychologists working in Indigenous communities that might necessitate a willingness to step outside of what is traditionally considered the role of a psychologist. Examples include, but are not limited to, advocating for changes to government and mainstream services' policies and practices, supporting community-led responses to issues and building capacity in the local Indigenous mental health workforce.

## Summary and Conclusion

Working 'clinically' with Indigenous clients presents several challenges to Indigenous and Non-Indigenous clinicians alike. We espouse that working collaboratively with these patients to help 'connect' them to potentially important, culturally relevant sources of well-being can improve the relevance and sensitivity of a clinical psychology with deep Western scientific roots. As psychologists, we understand and are keen to improve well-being; we just have to be open to working with Indigenous conceptions of well-being. Sitting across from any patient, we must ask the question, what will well-being look like for you? We have discussed that Indigenous Australians are a diverse group; working with them in a 'decolonising' framework requires an idiosyncratic approach with an appreciation for the social, historical and political context of each individual and their respective community. Increasingly, such work is likely to bring us out of the therapy room and into partnership with the families and communities which support our Indigenous patients. Grounded in a model of Indigenous SEWB, this chapter has provided several guiding principles and related examples to reimagine clinical practice with Indigenous clients. Such an approach requires not only a commitment to acquiring and applying new knowledge but also a commitment to a *process* of decolonising, including space for self-reflection, critical practice and an openness to less traditionally Western ways of working.

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# Chapter 9

# Reckoning: Reshaping Clinical Practice by Grappling with Privilege and Colonisation

**Merle Conyer**

## Bystander

> She had sat bolt upright on the edge of the chair during every counselling session that year. I said: 'Something is different today'. She replied: 'I am leaning back in the chair'. I enquired: 'What would be most supportive for you right now?' She said: 'I am exhausted'. I invited her to follow her instincts and she closed her eyes and slept. I sat quietly, deeply moved at her trust considering the years of coercive control by another therapist. Our work together deepened in profound ways from then onwards. My respected supervisor, to whom I was required to provide reconstructed verbatim scripts of sessions, responded: 'She only has 50 minutes with you each week, what a waste of that precious time'. Inner turmoil followed as I continued to comply with her guidelines about how a therapist is expected to practice.

### *From Apartheid to the Lucky Country*

Growing up in apartheid South Africa my nationality, religion and gender conditioned me to fear. I was part of a white-skinned privileged minority carrying the impacts of the Holocaust and patriarchy in my lineage. I grew up within a caring family who lived in a house secured like a fortress. Because of this unique constellation of identities that positioned me both inside and outside of privilege, I was socialised to feel and behave superior to some people and inferior to others. This shaped my sense of self, the lenses through which I interpreted the world around me and understandings of power. When electrified barbed wire and guns were on their

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way to becoming a neighbourhood fixture I farewelled all that was familiar and migrated to Australia.

Settling into Sydney in the mid-1980s I was lulled by the rhetoric of the 'Lucky Country'. Sixteen years later complacency was shattered in conversation with a man from Sri Lanka. He had been recognised by Australia as a refugee and issued with a temporary protection visa. His only child had died in Sri Lanka and this visa left him with the irreconcilable choice between safety in Australia alone or returning to the place where he was tortured to grieve with his wife. He pleaded: 'Is there anything you can do to help us be together at this terrible time?' This man does not know that hearing his story changed the trajectory of my life. Over the next years I traded the security and comforts of senior corporate and government positions for volunteer and then professional work with asylum seekers and refugees. In parallel, I experienced a journey of awakening as notions of power that had been instilled into my cells at birth underwent deconstruction.

## *The Bystander Awakens*

Encountering the work of social psychologists Ignacio Martín-Baró (1989) and Philip Zimbardo (2004) cracked open understanding about how political structures and social systems set up polarised groups to view the other as the dangerous enemy. This reinforces individualism and passivity and weakens social bonds so that people become hesitant to collaborate to resist oppressive structures due to the threat of doing so. My stand against this was ignited during the 'Children Overboard Affair' in 2001 when government ministers expediently accused asylum seekers of throwing their children into the sea (Raschella, 2013; Slattery, 2002), and I became more alert to propaganda and manipulations aimed at dehumanising marginalised groups to serve dominant political interests.

Ten years later serendipity graced me with the opportunity of working closely with two Aboriginal communities. I spent much of the first year grieving as I heard intergenerational stories of racism, dispossession, stolen children, incarceration, and shattered connections to family, culture, language and ancestral lands. I awoke from the 'Great Australian Silence' (Stanner, 1969). The year after the 1967 referendum which recognised Aboriginal people as part of the Australian population, William Stanner (1969) described the absence of public discourse about Aboriginal culture and history as being like 'a cult of forgetfulness practised on a national scale'. The lived stories shared with me that year pierced that deafening silence and with mortifying shame I came to appreciate that here too I was a privileged bystander benefitting from profound systemic injustice.

## *Destabilising Compliance*

My style of therapeutic practice mirrored the preceding unquestioning naivety. Somatic and energetic therapies in which I was trained were disparaged in the organisation where I was working and so I sidelined them for psychoanalytic and psychodynamic orientations despite an unease that did not yet have words. I diligently followed assessment, formulation and intervention protocols and complied with guidelines intended to support optimal therapeutic outcomes such as an abstinent stance, 50-minute sessions, and not offering a glass of water in order to signify this was a different type of relationship. I struggled with the relevance of some of the principles and wondered about their applicability to the multifaceted complexity of people's lives.

Resigning from that organisation was a liberating moment that irrevocably dislodged the power relations into which I had been conscripted growing up under apartheid. I had internalised from infancy that degrees of power were associated with the position one occupied in racial, social and political hierarchies, and if people in higher echelons were challenged they would use their power to humiliate, compromise, crush, exile or annihilate. This translated into internalising that challenging anyone in authority was dangerous and swayed me towards conformity with the expectations of others. Through extricating myself from the power dynamics of that organisation I experienced how personal power is derived from agency and that it can be applied in generative ways. Whilst dissent felt scary in my body, my mind was open to challenging the status quo.

## Witness

> We were born in the same year into two very different stories. She had been ripped from her Aboriginal father's arms as an infant due to the colour of her skin and moved between orphanages and white foster families. A couple of days before our first appointment she left two folders on my desk stuffed full of documents obtained under Freedom of Information laws. They detailed the multiplicity of ways in which bureaucrats had controlled her first 18 years. I read every word on every page and looked at every signature thinking: 'Let me witness that each of these people were complicit in what was done to her'. She spoke for almost three hours the first time we sat together, sharing her story laden with unimaginable abuse, unresolvable grief, dignified courage and pragmatic resourcefulness. How to honour her and her history? Two days later I attended Yabun Day for the first time which commemorates the invasion and theft of sovereign Aboriginal lands. I sat on the grass holding her story close to my heart and vowed to address the ignorance and fear that had been instilled into me about this vibrant community.

## *Colonising Gaze*

Sitting with Aboriginal people I learned of the many ways that multi-generational racism, oppression, discrimination and marginalisation impacted them, their families and communities. I began to appreciate that colonisation was not an event limited to the arrival of the first settlers and attuned to how 'Australian racism has manifested itself as fear and loathing of all who might be perceived as racially or culturally different. But the first and longest suffering victims of White Australian racism have been the Koori peoples … and that contempt has been transmitted culturally from generation to generation to this day' (Foley, 2000, p. 76).

Observing whose voice and knowledge was legitimised or invalidated in the places where I worked and modalities in which I was trained led to questioning if it was possible to offer a therapeutic service which would not be used or perceived as another vehicle of colonisation. The objectifying gaze of the clinician as a mechanism of social control (Foucault, 1973) is echoed by Mick Dodson's description of colonisers: 'Since their first intrusive gaze, colonising cultures have had a preoccupation observing, analysing, studying, classifying and labelling Aborigines and Aboriginality. Under that gaze, Aboriginality changed from being a daily practice to being a problem to be solved' (2003, in Sherwood, 2013, p. 29). As this gaze placed me at risk of reproducing similar power relations I began to wonder: Whose interests does psychology ultimately serve?

## *Cultural Construction of Mental Illness*

Joseph Gone (2007, p. 290) challenges the idea of psychology being an objective and neutral discipline. He contrasts the 'culture of the clinic' which promotes a discourse of distress with the 'culture of the community' of First Nations peoples where the primary discourse is one of hope. Neutrality is also challenged when mental health disorders are viewed through the lens of history. For example, in the mid-1800s in the Americas the mental health disorder of drapetomania classified defiance to oppression as a disease, applicable to black slaves running away from their white captors. Prescribed treatments included 'whipping the devil out of them' (Olmsted, 1856, p. 191) and amputation of both big toes (White, 2002).

Questions must be raised about the extent to which current mental health disorders are similarly culturally constructed to serve dominant interests. The majority of contributors to the fifth edition of the globally influential Diagnostic and Statistical Manual (DSM-5) were funded by the pharmaceutical industry and this edition 'created a firestorm of controversy because of questions about undue industry influence' and the codification of disorders that 'have a large public impact in a diverse set of areas ranging from insurance claims to jurisprudence' (Cosgrove & Krimsky, 2012). Notable too is what is omitted from the DSM. For example, complex developmental trauma has not been included as a diagnostic category despite extensive advocacy for its inclusion (Sar, 2010; Van der Kolk, 2005), the pervasiveness of child abuse in western societies (American Society for the Positive Care of Children, 2018; Lalor & McElvaney, 2010; Puddy, 2018; Ronken & Johnston, 2015) and wide-ranging long-term mental health effects attributable to abuse (Herrenkohl, Seunghye, Klika, Herrenkohl, & Russo, 2013; Jorm & Mulder, 2018).

Wetiko is another example of an exclusion. This Algonquin word was used to describe the white colonisers in the Americas who pillaged, poisoned, destroyed and acquired people, land and other species for their exclusive use and to generate private wealth. This was assessed as a sickness of the mind consisting of a chronic inability for empathy, combined with a cannibalistic tendency driven by greed, excess and selfish consumption (Ladha & Kirk, 2016; Winiecki, 2016). Michael Yellow Bird (2014) uses neuroimaging to explain this 'colonial brain disorder' which he locates in under-development of the orbital frontal cortex. My hunch is this disorder won't make its way into the DSM despite the widespread prevalence of similar symptomology today.

## *Reconfiguring the Therapeutic Frame*

Growing awareness about cultural and clinical conditioning led to refining how I worked therapeutically. I began viewing the therapeutic space as a place of hospitality and was accepting of daily life complexities, scheduling sessions of varying durations with gaps between them to provide some flexibility. Conversations took place in a private room, on a bench outdoors or walking in nature, as preferred by the client. It became apparent that mindful self-disclosure, together with yarning as a culturally safe, reciprocal and consensual way of communicating (Bessarab & Ng'andu, 2010), supported the establishment of rapport and trust. I began talking less and listening more, heeding wise guidance such as from Bindi Bennett to white people working with Aboriginal communities: 'They need to sit in the dirt and keep their mouths shut and their ears open. And then they might learn things they didn't know' (2015, p. 29). In time listening deeply began feeling like an offering in support of healing (Atkinson, 2017).

I came to appreciate that there never was just a therapist and a client sitting together - with us too were our community, cultural and intergenerational lineages. Aunty Betty Connelly (2014) guided me towards the importance of the 'three-way approach' which incorporates indivisible connections between individual, family and community when considering trauma and healing. This interconnectedness is expanded upon by Pat Dudgeon in her response to the Australian Psychology Society's apology to Aboriginal and Torres Strait Islander peoples for historical and ongoing mistreatment: 'You've got family, community, country, land, culture and spirituality. A patient sitting in front of you – you can't just see them as an individual removed from that' (Hall, 2016).

I dusted off unused modalities and started weaving an integrative approach drawing upon somatic, focusing, humanistic, energetic, ecological, creative and Buddhist informed therapies. Social, physical, spiritual, cultural and emotional wellbeing were holistically incorporated (Gee, 2016b) and varied conceptions of health and healing were respected. A trauma-informed lens shifted the gaze from diagnosing what was wrong with a person to seeking to understand how they had responded to what had happened to them. The risk of retraumatisation was reduced by centring safety, collaboration, choice, empowerment and trustworthiness as antidotes to abusive relational dynamics (Kezelman & Stavropolous, 2012). Psychoeducation supported clients to understand impacts of trauma to brain development and nervous system arousal, and together with neurosensory practices resourced them to recognise and stabilise overwhelm (Henderson, 2003; Kerr, 2015; Lyon, 2018; Ogden & Fisher, 2015). Embodied insight and self-soothing skills which cannot be provided by talking therapies alone nourished wellbeing, empowerment and hope. This way of working was augmented with diversity of supervision, both clinical and cultural, from a psychologist, psychotherapist and psychiatrist. I observed that clients appreciated the availability of many perspectives and not imposing one way of knowing.

## Activist

> ‘Aboriginal and Torres Strait Islander peoples have experienced genocide’. This statement by Felicity Ryan (2014) ricocheted through my mind and body. From many years of working with asylum seekers and refugees I knew that only one of five criteria was needed to meet the definition of the Genocide Convention (Office of the UN Special Adviser on the Prevention of Genocide, 2009). I ticked off each of the five as I thought about the personal stories that Aboriginal people had shared – massacres, theft of lands, assimilationist policies, involuntary sterilisations, removal of children to white families, medical experiments, enforced poverty, poisoned food, and more (Australian Human Rights Commission, 1997; Sherwood, 2013; Taylor, 2010; The University of Adelaide, 2002). Mortification and shock washed through me – how was it possible that I had walked this land most of my adult years and never recognised this?

### *Unpacking Whiteness and Privilege*

Bindi Bennett (2015) suggests that professionals are not equipped to work effectively with Aboriginal and Torres Strait Islander peoples until they understand whiteness and how race operates in Australia. The humble bandage was an important springboard into such an exploration. Consider for a moment - are you able to buy bandages that more or less match the colour of your skin (Tannoch-Bland, 1998)? It had never occurred to me that the only colour available is for white skin tones and thus a bandage is a symbol of race privilege. This ignorance shone a light on how I took unearned structural privileges for granted and opened an exploration into how this was reproduced in objects, systems and institutions which disproportionately privileged white people (Dudgeon, Milroy, & Walker, 2014).

I began observing how I and other people who benefit from privilege rarely recognise this and how easily and mindlessly discriminatory practices are reproduced. Recognising privilege requires scrutiny of the standards around which society is generally organised such as related to race, gender, sexuality, ability, class and religion, and awareness that some people must work much harder to access and experience things that others take for granted, or may not be able to access at all (Carroll, 2014; McIntosh, 1998). Whilst I as an individual white person may be against racism in principle, I continue to benefit from unequal systemic and institutionalised racial power. One example of this is how I was recruited into the concept of Terra Nullius, the assumption of an empty land at the time of European occupation in Australia. Despite living a few kilometres from where the First Fleet of colonisers docked and knowing that Aboriginal people in this area were decimated from massacres, introduced diseases, environmental degradation and other harsh conditions (Willoughby City Library Services, 2014), I took for granted that I lived on neutral land. Now I cannot un-know that the enjoyment of my home is possible only because of this annihilation.

Exposure to ideas of intersectionality became the springboard for unravelling other socialisations into which I was recruited, such as living as a woman in a western patriarchal society and a worker and consumer in a neoliberal capitalist culture. I stopped seeing race and culture as being separate from broader issues like border imperialism, climate change denial, and the struggles for rights and justice by marginalised groups. I learned more about the history of resistance and protest by Aboriginal people and began immersing myself in community events. A seminal experience was walking in the remote Western Australian desert and being guided by Aboriginal rangers in traditional ways of caring for the land. Sitting around sandalwood fires beneath the diamond-encrusted sky we learned about protecting culture, resisting linguicide and the struggle against uranium mining which was decimating fragile ecosystems, blocking access to sacred sites and fuelling disasters such as the Fukushima Daiichi meltdown (Conyer, 2015; Sweeney, 2012). Those 2 weeks cracked open an awareness of my urban industrial separation from nature that had never before been conscious.

## *Discursive Therapies*

An interest in finding therapeutic frameworks that honour varied worldviews, cultural diversity and resistance to oppression led me to liberation psychology and narrative therapy. These are ‘positioning’ rather than ‘personality’ theories which suggest we come to know and experience ourselves through relationships located within specific histories, cultures and political systems (Winslade, 2005). This orientation requires from the therapist an attuned discursive empathy which senses into the external conditions and dominant discourses that shape a person’s identity, experiences and ways of understanding (Sinclair & Monk, 2005). The intention of discursive empathy is thus quite different to empathy informed by humanistic psychologies which centres on a person's inner thoughts and feelings. How we apply empathic resonance is relevant as this is one of the common factors across therapeutic modalities that correlates more highly with client outcomes than any modality, treatment or intervention (Lambert & Barley, 2001; Wampold, 2015).

When applying such ideas in practice, the therapist is not positioned as an authority in how another person functions and does not impose labels due to a particular way of thinking or behaving. Instead their intention is to foster a collaborative relationship where clients are respected as experts in their own lives and are supported to deconstruct external and internalised oppression. This enables exploration of problems from multiple perspectives and generates possibilities for a person's thinking to become untangled from dominating discourses, which is a very different orientation to reframing thoughts and feelings within the same discourse (Fish, 1993, in Parker, 1999; Madigan, 2011; Romero & Afuape, 2015).

This stance resists cultural norms of holding people responsible for the consequences of the cultural, economic and political contexts in which they live. An example to the contrary is the response of the mayor of Albury, Kevin Mack, to the gang rape of a teenage girl on her way home from work. He cautioned women not to walk alone at night, saying that to do so was 'an invitation for someone to take advantage of you' and this attack was a 'salient reminder' (Olding, 2015). What the mayor said in effect was that women are not free to walk in public spaces and if they do and are attacked they are to be held accountable. Very different assumptions would have been at play had his response been to tell men not to rape. When responses similar to this occur in the therapy room Lyndsey Moon (2011, p. 194) refers to this as 'the gentle violence of therapists'. This suggests that in order to safeguard against similarly pathologising and marginalising people subjected to oppression and abuse, it is relevant to expose violence and contributing systemic factors, attribute responsibility to perpetrators, articulate the efforts of survivors to resist (whether or not these were ultimately successful) and challenge victim blaming (Coates & Wade, 2007). Whether clinicians choose to do this or adopt a supposedly neutral stance, therapeutic work is always political since it is informed by taking a position in spaces where different meanings are contested.

## *Attending to Relationships of Power*

These are some of the practices I introduced in an effort to safeguard against abusive relationships of power. I actively consult with people with lived experiences that are different to my own and who hold cultural authority to scrutinise and inform my practice. I hold myself accountable to these teachings so generously shared and have stopped doing work that I know to be culturally unsafe or disrespectful. I am actively curious about liberative stories and healing traditions within clients' cultures and histories and how these might inform responses to challenges and open spaces of hope, sustenance and strength (Campbell, Tamasese, & Waldegrave, 2001).

When introducing myself I locate myself and my privileges. For example, when leading a workshop, I might say something like: ‘I am a white able-bodied cisgender woman who lives on Cammeraygal country’—which is quite different from the more usual: ‘I am a psychotherapist from Sydney’. Self-disclosure like this opens conversations about otherwise unacknowledged power relations and how people are impacted in their lives by being inside or outside of privilege.

My approach to writing reports and case notes substantially changed. I make visible to clients my thinking about the positioning of documents and invite a collaborative relationship for working with them. If different opinions arise then both are included so it becomes a collection of perspectives rather than an imposed homogenous view. When the use of pathologising terminology might be supportive, such as with advocacy to gain access to a service, the reason for inclusion is explicitly discussed and agreed. This way of working shifts my positioning from an outsider acting on a person to a partner working collaboratively in a lateral relationship (Madsen, 2007).

## Accountable Ally

> Being an Aboriginal woman, to hear the word ‘decolonise’ thrown around in a different context to what I see colonisation as … had taken away what has actually happened to our culture, to generations of Aboriginal people. … I really got the essence of what people were trying to convey and that was they know the system sucks, they know people have been hurt, they see that psychology has a downside and it is not always helping someone, it is actually hindering people. So I get the concept of what is trying to be said. … Decolonising – I don’t refer to it in any sense to do with psychology. To me it is about genocide (Holmes, 2018).

### *Dialectical Dilemmas*

It was during a discussion exploring strategies to decolonise psychology that Jenny Holmes (2018) suggested decolonisation is not possible. I never fully understood what she meant at the time but the idea was nevertheless disruptive. A few years prior I had located myself as someone who stands in solidarity for decolonisation and who offers to be an ally in the quest for healing and the struggle for justice. It was an enlivening moment when these words had come to me and theories of decolonisation had been a bedrock on which I had since stood. By decolonisation I am referring to practices of resisting and breaking free from a way of thinking informed by power structures that have benefited settlers and discriminated against First Nations people (Sherwood, 2009).

I received Jenny’s views with curiosity and, in a spirit of assuming responsibility for educating and conscientising myself, began considering ideas critical of decolonisation. I came to appreciate colonisation as a structure that each of us is complicit in reasserting every day we occupy unceded land and elevate colonised discourses and practices above those of First Nations peoples. I was struck by the assertion that good intentions to alleviate some of the impacts of colonisation within one's own sphere of influence is not equivalent to decolonising, and may be another form of appropriation that primarily serves the settler by relieving feelings of guilt or responsibility (Tuck & Yang, 2012).

These reflections also opened a review of the word 'ally' which can justifiably be contested when used by a person with privilege. Aspirational descriptions define allyship as a lifelong 'active, consistent, and arduous practice of unlearning and re-evaluating, in which a person in a position of privilege and power seeks to operate in solidarity with a marginalized group' (PeerNetBC, 2011). It is not an identity nor something self-defined, but rather a process that is recognised by the people with whom we seek to align, centred around values of accountability, humility, sacredness, respect, justice, co-operation and love (Tamasese, Waldegrave, Tuhaka, & Campbell, 1998). I grappled with alternative descriptors such as 'collaborator', 'accomplice' or 'conspirator' but these seemed to carry even greater presumption. My hope is the phrase 'accountable ally' used in this account conveys an intention for respectful solidarity, committed responsibility and trustworthy contribution.

I currently hold a dialectical position informed by these perspectives, together with a commitment to furthering awareness about internalised colonisation and anti-oppressive and emancipatory practices.

## *Cultural Humility*

The concept of cultural humility was introduced by a client at a time when flaws were becoming apparent in conceptions of cultural competency. Cultural competence is considered a new form of racism when it defines cultures in stereotypical ways that reinforce systemic and structural racism. It does this by conflating culture with 'non-white' racial identity, assuming it is possible to master knowledge about another's culture, and ignoring intercultural and other power structures (Fisher-Borne, Montana Cain, & Martin, 2015; Pon, 2009). The contrasting intention of cultural humility is to reflexively examine one's own culture, appreciate diverse ways of being in the world, recognise the influences of intercultural power, and take steps to redress personal, positional and structural imbalances (Fisher-Borne et al., 2015; Hook et al., 2016). Cultural humility requires people such as myself who hold unearned privileges to respectfully defer to people with cultural authority and willingly forgo privilege to create opportunities for people within marginalised communities to claim space within their own right (Green & Bennett, 2018). It also requires the hard work of 'reckoning with complicity' (Land, 2015, p. 230) in how one has and continues to keep oppressive systems intact.

By way of example, I was engaged by an organisation to undertake work associated with Aboriginal communities. After revaluating the ethics of accepting this assignment, I introduced several Aboriginal people to the organisation to do this instead. I withdrew from this work following the subtle yet unambiguous counsel of an Aboriginal colleague who pulled me up for intending to do work 'about us without us'. Her generosity of spirit in naming this transgression, locating it in a system built on white privilege, and staying in relationship as I redressed this with her generous support carries my gratitude. From this experience I recognised that 'being called out for making a mistake is a gift—that it is an honour of trust to receive a chance to be a better person, to learn, to grow, and to do things differently' (PeerNetBC, 2011). One learning was feeling how it feels to give up privilege, albeit in a small way. Another was not to expect recognition for confronting issues that other people have to endure daily. Of great significance was acceptance of the limited possibility of transcending how I have been socialised and that whiteness and privilege will continue to trip me up as 'the colonizer within can never be shed, only disrupted, over and over again' (Suchet, 2007, pp. 883–884). Accepting I will make mistakes ongoing and being committed to honestly acknowledging and learning from them has freed me to engage with more presence and authenticity.

## *Where to Direct Efforts*

Gary Foley (2000, p. 87) articulates where efforts of allyship should be directed: 'Rather than seeking to come into our communities and 'help' us, you have a much more important role in your own community. You should be daily challenging the ignorance and fear that constitute the greatest obstacle to Koori self-determination and independence. We can solve our own internal community problems, therefore it is up to you to change your society, not ours'. More often I now raise or confront ideas about whiteness, racism and systems of oppression with people who hold similar privilege. There have been times when I have felt confronted and challenged from vociferous responses and I am learning that, when engaging in contested spaces, this sometimes requires me to stand in opposition to and break allegiances with people with whom I would usually be expected to show loyalty (Kendall, 2003). Peer support with others who seek to account for privilege in their work and lives more broadly is supportive for dealing with difficult feelings that inevitably arise from challenging the status quo.

## *Sustaining WellBeing*

Part of the privilege I carry is the option to turn away from injustices that do not directly impinge on my day-to-day life. Instead I choose to walk alongside people whose life experiences are so different from my own – racism, police harassment, judicial injustice, torture, immigration detention, seeking asylum, child removal, dispossession from ancestral lands, institutional abuse, medical experiments, brain injury from partner violence, rape, domestic violence, strangulation, murder of a loved one, stalking, captivity by an intimate partner, forced marriage, child sexual assault, poverty, homelessness, debilitating injury at work, inequitable health care, chronic unemployment, imprisonment, and more.

Refusing to turn away from such violations and injustices carries a cost, but not in the way that is commonly described. Vicarious trauma is generally positioned as a professional risk due to cumulative exposure to other people's traumatic experiences, based on ideas of contagious transmission from client to clinician (Boulanger, 2018). My experience is different from this explanation. I have been hurt by the work I do, however the people who share their pain has never been one of the causes. Quite the contrary—I am humbled and moved witnessing what people have had to face and the capacity for survival, adversarial growth and healing. Sometimes stories break my heart which opens deep feelings of tenderness and compassion. This is quite different to two things that do challenge my resilience.

Facing the effects of violence and injustice effectively positions a clinician as an intermediary between systems of oppression and the arising suffering in people's lives. Overlaying this exposure with toxic 'parallel processes' (Bloom & Farragher, 2013, p. 14) in the workplace has been a source of stress and exhaustion due to cultures and leadership practices which enable ethical failures, passive aggression, breakdown of trust and isolation to thrive. Whilst turning towards self-care practices such as yoga, bushwalking and mindfulness are necessary and helpful, they are not sufficient to ameliorate the weight of these effects.

Trusted relationships with a 'solidarity team' (Reynolds & Hammoud-Beckett, 2012, p. 60) of people with aligned values and reciprocal support, nurturance and honest feedback is invaluable. I am inspired by the work of Vikki Reynolds (2013, p. 276) who says: 'Our resistance to this political violence, degradation, heartbreak, and terror is to hold each other in sacred and revolutionary love, and to work for justice: that's what solidarity is. Solidarity is belonging. You just need to figure out the best use of you … and work in solidarity with others'.

Activism and allyship are binary in nature—there is struggle and reward, despair and hope (Acharya, 2010, p. 34). This was perceptively reflected by an Aboriginal psychologist Graham Gee (2016a) the first time we met when he said: 'Tell me about joy in your life, Merle. We cannot sustain ourselves doing this type of work without joy in our lives. Joy is your birthright. How do you experience joy?' I admit to you dear reader that this is a work in progress. I turned towards wisdoms of the Dalai Lama and Archbishop Desmond Tutu who discuss how joy is different and more substantial than happiness as it is not dependent on external circumstances. They suggest that at the heart of joy is the freedom to choose our responses to suffering and 'as we discover more joy we can face suffering in a way that ennobles rather than embitters. We have hardship without becoming hard. We have heartbreak without being broken' (Lama & Tutu, 2016, p. 12). They suggest this way of being is supported by cultivating positive states of mind and actions of kindness, generosity and gratitude. I am touched too by ideas of 'radical joy' which encourage 'finding and making beauty in wounded places' (Ryan, 2016, p. 13).

Another helpful practice is 'active hope' (Macy & Johnstone, 2012). This is being clear about what we hope for and stepping forward to actively play our role in the process of bringing that about. This is not the same as wishful thinking or turning away from suffering, rather it is a caring response and a way of acting in alignment with one's values when realities are hard to face and confusing to live with. Active hope is not something we have; it is something we do and can practice even when there are no clear grounds for holding optimism. This activates a sense of purpose as, even when no difference may be apparent with redressing injustices in my lifetime, my efforts are a contribution towards improving possibilities for the next generation.

## *Where to Next*

My attention is turning towards three areas of exploration. The first is to identify organisations with governance frameworks informed by intercultural accountability and anti-oppressive practices. I am inspired reading about The Family Centre in New Zealand which addresses both culture and gender power in its organisational structures, values and practices (Tamasese & Waldegrave, 1994).

Another area of interest is healing-informed practice which is oriented towards strengthening the wellbeing foundations of individuals, organisations and communities. Whilst trauma-informed care will continue to be a central element of my practice, its focus on harm and injury renders it incomplete. A healing centred approach to addressing trauma requires moving beyond the question of 'what happened to you' to 'what's right with you', and engaging with people as 'agents in the creation of their own wellbeing' (Ginwright, 2018). Integrating healing-informed frameworks into organisational governance is protective and strengthening of both staff and clients (Aboriginal and Torres Strait Islander Healing Foundation, 2015).

I am interested to explore more about love as activism. Sara Motta (2017) centres an anti-oppressive stance in what she calls the decolonisation of love that resists an ethic of violence: 'It is decolonising love that sustains and nurtures the will to act, and to carry on when our bodies, communities and families are under constant siege. … We need to rethink the ways in which our emotions, practices and knowledges are limited by the violence of the dehumanizing system we are in. We need to think about rebuilding the wisdoms and power that can emerge from connection, solidarity and care and which support us to become free'. I am inspired in this ethic from the men languishing in Australian-run detention complexes on Manus Island. By way of example, for 3 weeks in late 2017 the regime cut off their access to food, water and medicine as part of an effort to force the men to move to another location. The men withstood resorting to violence by staying close to principles of love, friendship and brotherhood. When brutally bashed by guards, some placed flowers behind their ears despite their bodies being emaciated; when intimidated by a group of police officers they recited poetry and told them they only had love for them. Behrouz Boochani (2017) said of this: 'Our resistance is a new manifesto for humanity and love … our resistance was an epic of love'. How might therapeutic spaces inspire and support such ways of being in the world?

## *Gratitude*

The spirit of so many people interwoven in these words has changed me and shaped how I walk in the world today. I close this story with an offering of love for all who have sat with me and shared stories of heartache and courage, and who have extended warm welcomes into their communities, homes and hearts. I hold much gratitude for generous cultural mentoring, wise supervision, treasured collaborations and uncountable acts of kindness. This story has been written on Cammeraygal country on the northern banks of Sydney harbour in Australia. I pay my respects to the Elders past, present and emerging and acknowledge their custodianship over millennia of this unceded land.

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# Chapter 10
# More Than Mechanics: Injury, Running, and Healing

**Leanne Hall**

## Why Ultra-Running?

Ultra-runners represent a particular subculture of runners. They train for events exceeding the marathon distance of 42.2 km, ranging from 50 km to events of several hundred kilometres over several days. Many ultra-running events take place on trails, with challenging altitude and terrain. For many of these runners, being confronted with the question "why?" is common. Understanding why a person would endure running for these distances equates to a comprehension of the purpose, or seeking to understand the meaning that these athletes ascribe to their running. While on the surface, many identify concepts such as a sense of achievement, learning about physical limits, and demonstrating mental "toughness" as possible reasons (Roebuck, Fitzgerald, Urquhart, Ng, & Cicuttini, 2018), Billy Yang, ultra-runner and filmmaker, suggests something much more in his documentary about competing in the Leadville 100-mile race in 2018.

> There was a time where we didn't know where our next meal was coming from. I wonder how far removed we have become from who we once were; such as hunter and gatherers. Bodies and will hardened by constant movement. Driven by the simple need to survive. How far have we softened? Yet here I am surrounded by hundreds of runners, my like-minded tribe about to set forth into the mountains for 100 miles, seeking something through the discomfort. The unknown. But what exactly are we seeking? (Yang, 2018)

How far have we softened? What are we seeking? For those of us living in neoliberal society, how much of our day-to-day existence involves *avoiding* both physical and emotional discomfort? In fact, it could be argued that this "avoidance" along with other maladaptive emotional regulation strategies, is part of a modern neoliberalist epidemic, contributing to mental health issues, especially anxiety (Salters-Pedneault, Tull, & Roemer, 2004), relationship breakdown, and even poor physical

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health outcomes, including lifestyle diseases such as type 2 diabetes, obesity, and heart disease. This is suggestive of an overvaluing of individualism, driven by capitalist values, which has evolved into social narcissism, whereby the individual need for comfort and "happiness" trumps everything.

## Individualism: A Global Health Crisis

According to Romanian Sociologist Professor Dan Ioan Dascalu (2014), the globalization of mass communication has led to a widespread increase in the values of individualism. Although globalization and individualism on the surface appear contradictory, Dascalu argues that globalization in contemporary society is based on the values of capitalism and democracy, both of which have an individualist ideology at their foundation. While globalization is perpetuated by mass media, and in particular by social media, the prioritization of individualistic values in neoliberal society has become the norm. The associated avoidance of discomfort is therefore framed by a broader social and political discourse, which is perhaps in part a response to the economic prosperity and indulgence of the 30 years after World War II—a time where emotional, financial, and physical suffering was abundant.

In symmetry with Dascalu's research, Frank (2013) suggests that the idea of conquering physical and emotional unease constitutes the culturally preferred narrative. He states that the restitution story of returning the sick person to the socially acceptable status quo has been woven through our social and cultural fabric since the biomedical revolution. Perhaps our persistent quest for health and wellness is a representation of our repressed fears regarding mortality and the fragility of our human existence. Is it, perhaps, this existential crisis which is highly individual that feeds the broader social and political discourse? Either way, the net result is that many of us have become disembodied, and have splintered off that very part of ourselves that ironically *connects* us with our mortality, giving us meaning and purpose. In other words, we have softened and moved away from who we once were.

## Running and Neoliberalism

Sociologist Kristin Owen Westfall states that "running gives us many experiences besides being tired, with a special intensity that is unusual among the comforts of modern life" (Westfall, 2012, p. 5). She states that running is more than just a pastime, but it is a reflection and representation of our society. In investigating how the environment has influenced the way running is participated in and perceived, she suggests that heightened periods of running coincide with the rise in neoliberalism in the 1970s and the rise of the capitalist class. Neoliberalist ideals can be seen in the power structures established through running and sports, and coincide with the "ideal" capitalist worker who is okay with inequalities, and believes individual competition is natural (Westfall, 2012).

Westfall's (2012) research is also somewhat supported by statistics which demonstrate that ultra-running has experienced exponential growth over the past decade with much of this ascribed to athletes from Japan, Italy, Poland, and the USA. Interestingly, master athletes account for the greatest increase (>40 years of age). One study by Hoffman and Foggart (2012) analyzed the demographic characteristics of 161-km ultra-running events and found that participants were mostly middle-aged (>45 years) married men, who were highly educated. They concluded that athletes with a higher income were more likely to attend an ultra, than athletes from economically underdeveloped nations, for example, Africa (Foggart & Hoffman, 2012). In other words, ultra-running appears to be experiencing considerable growth among populations who best fit the capital class.

## Ultra-Running: Political Resistance and Social Healing

However, is ultra-running a *reflection* of, or *resistance* to, capitalist values? While certain power structures established through *competitive* running and sport may reflect capitalist ideology, cultural historian Martha Verbrugge (1988) has a very different view about what running represents in society. She suggests that running is a reaction to social dys-ease—an uneasiness or anxiety about social change. She adds that the 1960s counterculture that embodied a rebellion against middle-class values led to the prioritization of inner life and personal experience over politics. In this sense, running is interpreted as a personal experience, and a rebellion against capitalist power structures. According to Lasch (1978), it is this turn "inward" that has led to a narcissistic preoccupation with the self.

Perhaps 40 years of this preoccupation with the self has led to a realization and a search for meaning and purpose that extends beyond our narcissistic and shallow self. It could be argued that we are at the forefront of a *new* wave of globalization, a shared realization that we need to reconnect with who we once were in order to heal both as a society and as individuals.

In his book, *Born to Run*, McDougall suggests that "when things look worst, we run" (McDougall, 2010). He refers to three occasions in American history where running experienced a boom in popularity. The first being the Great Depression, the second during the recovery periods after the Vietnam War and the Cold War in the 1970s, and the third being 1 year after the September 11 terror attacks. It was during this latter "crisis" that trail running became the fastest growing outdoor sport in the USA (McDougall, 2010). This aligns well with Verbrugge's views on running as a response to social dys-ease. Both McDougall and Verbrugge seem to agree that running is perhaps one way in which people seek individual healing from social "injury" or dys-ease.

## Running as Embodied Healing

The production of healing beyond scientifically measured health is in danger of being forgotten and ignored (Sointu, 2006). Theories of embodiment can provide a way to analyze how experiences of healing are created through complex connections between social ideals, constructions of the body, and the performance of embodied health practices (Sointu, 2006). Although Sointu (2006) refers primarily to alternative health practices, her research could certainly be applied outside the clinic, to activities like running. Embodied running, as opposed to competitive performance-based running, in particular challenges social and cultural discourse by focusing on *reconnection*, both between mind and body and to who we once were. In other words, it makes us whole, forcing us to confront our own embodiment.

In addition to representing a form of political resistance, and a *healing* response to social dys-ease and uneasiness, running in particular is a demonstration of what Merleau-Ponty describes as a pre-reflective habitual activity where a kind of "body knowledge" is recruited (Merleau-Ponty, 2002). Runners experience the world through their body. Running itself represents a body-focused activity that is freely available to anyone, and not at all constrained by the walls of a health professional's office or clinic. As a body-led experience, it also represents an *interconnection* between mind and body, erasing the culturally defined line between the two so often seen in biomedicine. It is suggested that interconnectedness, in this case achieved via running, provides a vehicle for healing through self-reflection (Sointu, 2006). It also provides an antidote to the disembodiment and disconnection between mind and body that has existed since the biomedical revolution, perpetuated through capitalism and neoliberalism.

Ultra-running is an extreme form of running. Its rise in popularity is occurring during a time of political and social extremes. Terrorist and anti-terrorist discourse, the globalization of war, political instability, the global refugee crisis, constant threats to our cybersecurity, and global financial crisis and poverty are just a few of the broader current social and political discourses of our time. Perhaps in a climate of social and political "extremes," healing takes on a different meaning, requiring extreme methods such as ultra-running.

Not coincidentally, this rise in social dys-ease exists alongside an increase in lifestyle diseases and mental health issues suggestive of an interconnectedness between social forces and individual well-being. We are suffering both individually and socially. So while running, and in particular ultra-running, can be considered one form of social healing, can it also provide individual healing? The rising popularity of alternative and complementary medicine has been suggested to be due to the emergence of a "proactive" and "empowered" client who no longer wants to be treated like a biomedical patient and instead desires to be treated as a "whole person" (Sointu, 2006). Perhaps we are seeking healing through embodiment? If so, ultra-running is a vehicle through which this can be achieved.

There is a broad consensus that regular exercise reduces the risk of lifestyle diseases such as heart disease, obesity, and type II diabetes. In addition, research consistently demonstrates the mood-enhancing effects of regular exercise (see Bernstein & McNally, 2017; Biddle, 2001; Thayer, 1994), and enhanced cognitive control (Giles et al., 2018). However, the exact mechanisms through which running promotes emotional healing is less clear. In her qualitative study involving in-depth interviews with five female runners who reported that they had used distance running as a mechanism to help them cope during a time of emotional stress, Leedy (2009) identified themes around empowerment and sustained well-being as well as running as an active coping strategy to improve mood and reduce stress. Although running does not *prevent* uncomfortable and distressing emotional experiences, it does appear that for some, it helps them "recover" (Bernstein & McNally, 2017), which suggests that running may promote healthy emotion regulation, perhaps by allowing runners to sit with their emotions, grounding them in their body providing embodied healing.

Embodiment refers to human action and interaction with the world, which is guided by the body. An ultra- runner is for the most part not consciously directing their legs and arms to move. Their actions exist on a pre-reflective level. They are habituated actions, guided by the body. This pre-reflective dimension is an experience that is bodily anchored and difficult to grasp in a scientific sense (Stelter, 2000). Emotive and cognitive processes have their roots in the body because they are interlinked and exist to guide action itself (Fuchs & Schlimme, 2009). This suggests that the emotional healing that may take place for many runners is *body led*.

## The Injured Runner

> The self we think we are is a gestalt of foreground realizations and background possibilities. Illness and injury shifts the gestalt. (Frank, 2013)

Ultra-runners may seek emotional and social healing through running. However, running as a body-led activity relies on the able-bodyness of the runner. This can be problematic, given the fact that injury is common in the world of ultra-running (Hoffman and Krishnan 2014). The demands of their sport arguably place ultra-runners at a greater risk for developing exercise-based problems and injuries. In one of the largest studies of ultra-runners, over half (77%) were found to have experienced a running-related injury in the past year that interfered with training (Hoffman, 2014).

When a runner experiences an injury, they feel sensory pain and their experience of their body is shifted. Pain exerts a "centrifugal" force by gathering space and time inward to the center – the here and now body (Leder, 1990). The runner's attention moves from their world and surroundings to their body and a specific part of their body. This dramatic attentional shift alters not only their relationship with themselves, especially their body, but also their relationships with others. While pleasure tends to maintain our intentional links with other people, pain disrupts them and instead induces self-reflection and isolation (Leder, 1990). This can negatively impact the runner's connection with their support system, and ultra-running subculture, leading to further isolation.

Injury strikes at the very heart of “I am” because it is a disruption of the lived body, and the lived body is not extrinsic to the self. As such, a threat to the body incorporates a threat to the very sense of self (Toombs, 1988). *Otherness* is the phrase used to describe a foreignness that permeates life when a lived body takes on alien qualities – in this case, an injury (Heidegger, 1996). However, according to Svenaeus (2015), this concept of otherness or alienness needs to be interpreted in relation to the *whole world* of injury or illness as opposed to just the lived body (Svenaeus, 2000, 2011). An injury therefore cannot only cause the body to feel alien, but in certain circumstances leads to the whole world feeling alien. For a runner, the world they live in and how they experience it is altered when they are injured. Potentially, they no longer fit into the running subculture that provides them with their interactive identity.

Not only is the world of the runner disrupted at the time of injury, for runners who recall past injuries, they are remembered with such arresting lucidity because it is not being experienced as the past; the injury experienced that are being told are unassimilated fragments that refuse to become past, haunting the present and future (Frank, 2013). This is especially the case when the injury continues to impact running. Perhaps the runner’s body has indefinitely altered, and as such, so has their experience of their world.

One strategy athletes use to make sense of pain resulting from injury is depersonalization (Young, 1995). They become disembodied as they talk about their bodies as being distanced from themselves, emphasizing that it is the body not the self that has given out (Young, 1995). By submitting to a disembodied and dualistic notion of injury, the athlete can preserve their fractured running identity, which is aligned with the broader cultural discourse relating to competition-based running and ultra-running; stoicism, endurance, normalization of pain, and discomfort (Collinson and Hockey, 2007). As a result, when injured, the embodied ultra-runner is at risk of returning to a state of *disembodiment*, perpetuated by an overreliance on biomedicine, and the “narrative surrender” (Frank, 2013) that occurs when the health professional’s narrative becomes dominant.

Narrative “surrender” represents a *crisis of control*. This apparent struggle or crisis brought about by injury is exacerbated by the wider discourse around “health,” as conceptions of “health” are grounded in biomedical definitions that focus on the absence of disease or physical malfunction (Crawford, 1993); as such, the injured person is always the “other” to a society that defines health as its norm (Frank, 2013). In this sense, the injured runner’s experience of their body as unfamiliar and alien is perpetuated in this discourse, causing them to seek expert advice in the hope of returning to running as soon as possible. Of course, this also reignites existential anxieties around mortality, driven by an awareness of the body as fallible, which results in further help seeking and bodily avoidance.

Having said that, an embodied definition of “health” suggests that health is an experience that enables or limits the capacity of individuals to meet the challenges and demands they face in specific social circumstances (Theberge, 2008). Here, capacity refers to a broader context; however, for injured runners, the primary frame of reference in which they consider their capacity is their running. However, what does capacity really refer to in the context of running? Does it refer to a return to pre-injury running capacity? What about the runner who can continue to run with a reduced capacity to meet pre-injury expectations? Perhaps their injury has resulted in physical limitations, or perhaps having extended time away from training means that they are required to build strength and endurance to return to their former running ability. Either way, returning from injury is progressive and capacity is relative to this progression, and to the subjective experiences of the runner. "Health" in this context refers to a return to pre-injury functioning. However, this experience is entirely subjective and is based on a combination of external and internal factors: external measures of performance as well as internal indicators triggered by discomfort, pain, or simply an inability to perform at pre-injury level.

## Injury as Resistance

For some runners, an injury can be career ending, triggering a life-altering adjustment process. Identity is best described as a constructed interaction between the lived body and the experiencing world. Sparkes (1988) refers to identity as a *reflexive project of the self*. He suggests that identity is not unified around a coherent self, rather it is formed and transformed continuously. This suggests an alternative to the somewhat static and singular reference to "identity," in favor of a fluid concept representing several identities continuously responding to social and cultural influences. This is good news for the ultra-runner who can no longer run, it that their running identity has the potential to move with fluidity in response to *their* changing world. However, this internal process involves challenging and even *resisting* the comparatively *less* fluid cultural discourse that may require considerable internal resources and support.

The ultra-runner's relationship with their body, and with it the meaning they ascribe to their running, shifts at the time of injury by bringing it back into awareness in an unfamiliar way. Of interest is how this develops over time, both through the injury process and afterwards, especially when running recommences. Does the body return to the background and dys-appear as Leder (1990) suggests? Or does it remain in the foreground, with the disembodied runner constantly scanning for signs of discomfort out of a fear of reinjury? Perhaps this is dependent on how the runner chooses to respond/react to the injury, as well as the nature and extent of the injury itself. However, while a culture of *risk* frames the way clinicians and athletes negotiate treatment, Safai concludes that a culture of *precaution* frames the ways individuals view their health and well-being (Safai, 2003), which is perpetuated by medical professionals tasked with directing the athlete back to sport. This suggests that the biomedical model contributes to a culture of risk in two ways. The first, by perpetuating a disembodied view of injury (the body as a machine), leading to an overreliance on the medical profession, and secondly, by perpetuating a sense of "otherness" and encouraging risk-taking by facilitating a return to able-bodyness and "wellness," and sport/running. This forms the biomedical focus on recovery, where the body becomes objectified (Toombs, 1988).

It has been suggested that athletes often talk about their bodies as being distanced from themselves, experiencing a heightened sense of body awareness because they are hypersensitive to injury (Young, 1995). This is especially the case for runners who have experienced injury in the past. Through depersonalization (Young, 1995), the injured runner emphasizes that it is *the body* and not the self that has given out. Preserving running identity is a significant motivator for injured runners. Brock and Kleiber (1994) in their work with respect to athletes with career-ending injuries suggested that it is important for the athlete to be able to show, with the help of a narrative about the injury, that the injury was caused by sport. In that way, it is possible for the athlete to maintain their athletic identity and their relationships with significant others in their sporting world. This process is made easier with medical dualistic approaches to injury treatment, which objectifies the body. However, what are the implications of this strategy on reinjury? It could be suggested that depersonalization leads to further body alienation and "other-ness," and an overreliance on others, especially medical professionals and coaches. This may cause the injured runner to *suffer* with their injury, and the language of suffering is the language of loss (Charmaz, 1995). As such, these runners are more likely to experience suffering, as they remain in a restitution narrative (Frank, 2013) focused on restoring their injured body and the loss of their former able-bodied self.

## Embodied Healing

Having said that, an injury presents a unique opportunity to resist traditional discourse. While biomedical approaches to healing rely on dualistic notions of the mind and body as separate with the health professional as an "expert," an embodied approach to healing involves the ultra-runner reclaiming their narrative, and reconnecting with their body and lived experience. It also provides an elegant reframe of the *meaning* of running, moving away from a performance discourse to a more embodied one; running for the love of running, rather than striving for a performance-related goal. The injury response therefore involves a corporeal intuition, or a body-led *knowing*, whereby decisions are not consciously made by the injured runner, rather the body leads the healing process. Embodied healing involves the runner learning to reclaim their narrative, and confront their own embodiment, while at the same time creating space for the medical narrative to *inform* their experience as opposed to reconstructing and "claiming" it. According to Annandale, health and illness are not polar opposites, as someone can be "healthy" but still refer to functional limitations (Annandale, 2014). A runner with an injury therefore does not necessarily represent "other."

A runner who confronts their own embodiment through injury draws on their own internal resources to re-story their injury, taking into account the social and cultural discourses that frame their experience, and perhaps even shifting the lens to a more adaptive and fluid discourse, in support of their *reflexive identity* process. While sports medicine practitioners should remain an important component of injury “recovery,” adopting a more social model of care, involving the individual in the process and acknowledging what it is like to be injured, could well reduce the sense of vulnerability of self and the risk-taking behavior related to guilt and other emotional responses (Charmaz, 1995).

With the injured runner adopting a much more active role in their health care, and having their narrative validated by the health practitioners involved in their care, a much broader treatment and/or rehabilitation program can be developed. The athlete can explore approaches that facilitate embodiment, as opposed to surrendering their narrative to “experts” who perpetuate the mind–body disconnect. Methods such as acupuncture, yoga, light therapy, and cryotherapy, while not considered “evidence based” from a medical perspective, may in fact help some injured runners to reconnect with their body. By increasing the available resources and drawing on multiple methods of mind/body healing, the injured runner may be able to shift their narrative, and *adapt* to their body as opposed to engaging in a “battle,” a fight to restore the body to its former functioning.

Liminality (Gennep, 1960) refers to the ambiguous and uncertain (identity) state between a previous status and a new status yet to be defined (Collinson, 2005). Perhaps this is the place that many injured runners need to sit and accept. With an able body that was perhaps once considered infallible, their “new” body may need some getting used to. Its unfamiliarity and perceived flaws or weaknesses somehow need to be reintegrated and internalized. This luminous state provides an opportunity to reflect on the broader discourses that frame the injury experience, encouraging a resistance to neoliberal discourse with a focus on biomedical approaches to healing – to a more embodied process. Perhaps in time, as this individual resistance grows, a new discourse will evolve, creating a more collaborative and integrative healing process, which is led by and centered around individual narrative and embodied experience.

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