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Emotional Management

a series of blog posts
by Stuart Sorensen

*"If you want things to change you must change what you do.
Different causes lead to different effects."*

About the author

Stuart Sorensen's background is mental health nursing and as such he has a wealth of direct experience of working with people suffering from all forms of mental health problems. From early voluntary work with elderly people as a teenager to unregistered care assistant posts and then clinical practice as a qualified nurse Stuart has a real understanding of the issues faced by workers at all levels on a daily basis.

Stuart qualified as a nurse in 1995 and gained his post graduate diploma in Psychosocial Interventions (PSI) from Sunderland University in 2003. His wealth of practical experience allows Stuart to engage with a variety of service-users and learners/ participants in training courses that has the feel of reality about them rather than the 'ivory tower' type of presentations that come from merely reading a book.

Stuart is passionate about recovery from mental disorders and much of his clinical and training work has been based around helping people to recover from serious mental disorders such as schizophrenia. He is particularly interested in ways of ensuring that vulnerable service-users are protected whilst still retaining the right to make decisions.

As a trainer Stuart is keen to help staff 'at the coalface' to find a balance between the conflicting (and seemingly impossible) rights of workers, carers and service-users. Based upon his years of experience as a nurse and clinical specialist, Stuart understands the difficulties and dilemmas facing workers on the front line because he has faced them too.

Stuart has extensive experience of delivering many aspects of training around care provision and human/civil rights including training around Balancing Rights and Responsibilities, the Mental Capacity Act and the Deprivation of Liberty Safeguards, Person-centred Planning and Maintaining Therapeutic Relationships, particularly in relation to Challenging Behaviour. He is also very experienced in delivering training on topics such as Introduction to Mental disorder, Safeguarding of Vulnerable Adults (SOVA), specialist training on mental health related issues and, of course, Deliberate Self Harm.

Stuart is very well versed in the principles of therapeutic risk and enabling activities that carry the risk of harm having written and delivered training nationwide on Risk Appreciation to mixed groups of inspectors from both the Health & Safety Executive (HSE) and the now defunct Commission for Social Care Inspection (CSCI).

The topic of emotional management is one that is very dear to Stuart's heart. Having been less than adept and managing his mood during his first twenty or so years of life he's spent the last couple of decades learning how to do better. This PDF represents a small part of that research together with some links to clinical application in mental health recovery approaches.

Emotional management 1: introduction

I'd like to begin by making the point as clearly and robustly as I can that I believe that serious mental disorder requires more than mere will power to overcome. **I do not believe that people suffering from conditions such as bipolar affective disorder can simply pull themselves together**.

I do believe, however that it is possible to have a major impact upon mood regardless of life events. In the case of people who have no clinical mental disorder it is possible to take almost complete control by psychological and behavioural means. For those people diagnosed with mental disorders other things such as medication may also be necessary but that doesn't make non-medical techniques redundant. It simply means that medications might also have their place.

In order to do justice to this project I'll need to spend some time planning it. There's a lot of underpinning theory to get through as well as different techniques and strategies. I intend to cover aspects of traditional and classical wisdom as well as more modern principles of therapy. There will be posts devoted to anatomy and physiology as well as to the evolution of the human condition.

As well as the aforementioned I'll need to include information on conventional psychiatry and the more recent challenges to assumptions about biological helplessness and genetic determinism. The blog will consider social and cultural expectations together with the ideas of learned helplessness, responsibility and the 'safety behaviour'. Briefly put there's a lot of information to organise.

So this little post is really no more than a 'statement of intent'. I'll try to have some sort of 'contents list' planned out in a day or so. After that I'll start working on the thing properly.

Emotional management 2: Contents

I've tried to plan the sort of ground I'll need to cover in order to elaborate on the emotional management idea. I'm sure that this contents list will change over time but what follows is a rough outline of what I hope to include. I'm not really sure how long it will take to complete and I'm sure there'll be little 'distractions' along the way. Anyway – my intention is to include:

Basic principles, ancient philosophies and traditional wisdom:
Stoicism, cause and effect, determinism, self-fulfilling prophecy, work rest and play, Alfred the Great, Seneca, Socrates, Sophocles, Marcus Aurelius, Buddhism and attachment.

Modern understandings:
Viktor Frankl & Logol therapy, Albert Ellis & Rational emotive therapy, Aaron Beck & CBT, Christine Padesky's hot cross bun, Neuro linguistic programming.

The Cognitive model:
More on Padesky's hot cross bun, Interpretation determines mood, Formulation (basic).

The importance of physiology:
Posture and emotion, physiology and neurotransmitters (serotonin and noradrenaline, clinical depression versus sadness, anti-depressants vis a vis behavioural management of mood, Alfred the Great's notion of balance.

Freeze, fight or flight: The australopithecus and the sabre-toothed tiger:
The limbic system, a call to action, sympathetic and parasympathetic nervous system action, anger and anxiety, blood and nutrients diverted, psychomotor issues.

Emotional control for people without psychiatric diagnoses:
Ellis 12 beliefs in more detail, Michael Broder's anger tree, Earl Nightingale's 'success', The importance of taking responsibility, Steven covey's 7 habits.

Biomedical assumptions and research:
Stress and vulnerability, Anxiety and anger management, the role of anxiolytics, depression, positive-action, antidepressants, psychosis, research and recovery, talking therapies, post psychiatry, CBT formulation in greater detail.

The whole picture:
Relapse prevention, medication in perspective, self-help vis a vis passive patient behaviour, learned helplessness, secondary gain, diagnosis as a self-fulfilling prophecy.

As you can see there's a lot to cover but I hope to have the whole lot completed relatively soon. I'm not intending to write the equivalent of a textbook here (maybe when I retire I'll have time for that).

Emotional management 3:
Basic principles, ancient philosophies and classical wisdom

The idea that people can learn to be happy is not new. In fact it has turned up time and again in literature and sacred writings for millennia. From the ancient writings of the Stoic philosophers such as Seneca, Socrates & Marcus Aurelius to Paul's New Testament musings from his prison cell the same principles appear over and over again.

Ancient philosophers such as Aristotle and the medieval religious philosopher Thomas Aquinas held that cognition (thinking), evaluation and motivation are central to our emotional experience and that an awareness of these can help us to manage our emotional states.

This is reliant upon the principle, important to Sophocles among others of 'cause and effect'. The general idea is that every effect has a preceding cause and that if we continue to do the same things (causes) we get the same results (effects).

If you want things to change you must change what you do. Different causes lead to different effects.

Another principle is to do with the link between mood and expectation. Seneca relayed an excellent illustration of this involving a banquet he attended. A servant dropped some expensive crockery which subsequently smashed to pieces on the floor. The host flew into a rage and had the servant thrown to his death in a pool of lamprays.

In subsequent conversation it became clear to Seneca that the host had expected his great wealth to protect him from misfortune. It was the difference between expectation and reality that brought about his anger with fatal consequences for the servant.

This incident led Seneca to study emotion and eventually to conclude that one of the keys to emotional management is realistic expectation and a realistic acceptance of the fact that the world is imperfect.

Seneca held that while life is infinitely valuable possessions and other 'external' concerns are of far less importance than our internal (emotional and intellectual) life. Seneca was convinced, along with the other 'stoics', that tragedy can be tolerated or overcome by appropriate thought and attention to the inner life – what today we might think of as 'spiritual' life.

Buddhist philosophy holds that emotional distress can result from attachment either to property, to status or to ideas. The more we can 'let go' of our attachments the more control we can have over our emotions.

The Saxon King, Alfred the Great famously divided his day into three sections of eight hours each for equal attention to work, recreation and rest. He understood the value of balance. Alfred also encouraged education because he realised the inherent value in knowledge and, perhaps more importantly, understanding. There is a difference between the two.

As Marcel Proust once said:

> ***"The real voyage of discovery consists not in seeking new landscapes
> but in having new eyes."***

Then we come to the self-fulfilling prophecy and other forms of determinism. This point has been made many times in many different ways but my own favourite is this:

"Whatever you believe about yourself – you're probably right."

I'm not sure who said that – I just wish it had been me.

It's interesting to see how many of these and other ancient principles turn up in modern forms of therapy. However strange the notion of emotional control may seem to modern, Western ears it is an idea that has persisted, probably since before recorded history began.

However there are many reasons why this generation resists the ideas we'll be discussing in this series of blog posts. One reason is the fact that accepting the skill means acknowledging that you've always had the option to influence your mood. This means accepting some responsibility for past problems and many people find that extremely difficult to do. They cannot bring themselves to acknowledge that any part of their unhappiness was either created or maintained by their own actions and thoughts.

Another reason springs from the increasing Western expectation that there ought to be 'a pill for every ill'. This reliance on medical science pathologises human mood fluctuation and encourages dependence upon chemicals rather than developing our own emotional ability. I'd like to stress again that I'm talking primarily about people who have no diagnosable disorder in this instance. They are simply encouraged by Western culture to visit the doctor for antidepressants or anxiolytics (Anti anxiety medication) because of the normal human fluctuations of mood that we all experience on a regular basis.

When people rely solely upon medications to manage their emotions they become helpless, not least because the implication is that they would be unable to cope without it. They define emotional management as impossible and then, understandably enough stop trying to achieve what they have already decided cannot be achieved.
In psychology this is known as a form of 'safety behaviour' – it provides short-term security but exacerbates the problem in the longer term.

I hope to show over the coming weeks that emotional management is a skill that can be learned. Obviously some people need more than just these techniques. People with serious mental disorders have more difficulties than those who are not so afflicted. However I firmly believe that everyone can benefit from developing these skills to a greater or lesser extent.

Emotional management 4: Modern approaches to old ideas

In the last blog post I made the point that emotional management is not a new idea. In fact these ideas date back thousands of years. In today's post I'd like to bring the concept up to date by relating it to more modern therapeutic techniques and understandings.

It's difficult to know where to begin in modernising this stuff. There have been so many incarnations, reinventions and refinements that making sense of them in a relatively short blog post is quite a difficult task. I'm certainly not going to attempt to cover everything – simply the main developments.

There are far more theories excluded than included here. In fact the big decision right now is not 'what to include' so much as 'what to exclude'. Still I have to start somewhere so I've decided to begin with World War II.

Viktor Frankl was a psychiatrist in Vienna at the time of the German occupation. He was also a Jew. Along with his new wife and many others he was crammed into a cattle truck and taken off to the labour camps. He was transferred between several camps until he eventually was liberated in 1945 along with the manuscript of his book 'Man's search for meaning'.

In this, one of over thirty books Frankl wrote until his death in 1997, he outlines the importance of purpose in dealing with adversity. Frankl had worked on these ideas before his incarceration but the experiences in the camps honed his thinking until he was able to publish the basics of what he called logotherapy after the war.

The name comes from the Greek word 'logos' which translates to 'meaning'. The basic idea is that man can cope with any 'what' if he has a convincing 'why'. This idea in itself was not new to Frankl but was a refinement of Friedrich Neitzsche's earlier work on the subject.

The book can be harrowing to read in places but the insights into the human condition are remarkable. We see how the choices people made and the thoughts they allowed themselves to think directly contributed not only to their state of mind but also to their ultimate survival (assuming they had a chance to survive in the first place).

At around the same time an American analyst called Albert Ellis was developing a similair (but not identical) idea. His early model of understanding was based entirely upon using ideas to control emotions and relied upon twelve basic propositions. Ellis identified twelve irrational beliefs that lead to emotional distress and twelve rational ideas that people might choose to believe instead. By adopting a more rational attitude to life, Ellis argued, it would be possible to maintain emotional stability whatever problems the world might throw up.

 Ellis defined two types of solutions:

- The empirical solution relies upon changing the world around us.
- The elegant solution relies upon changing the way we perceive (and therefore feel about) the world around us.

Ellis called his new model Rational Emotive Therapy (RET), a process which, in part, consists of helping people to recognise and eradicate their problematic beliefs and expectations. We'll consider Ellis' twelve beliefs in much more detail later.

One major criticism of Ellis' model was the over-reliance upon thoughts (cognition) without really taking account of behavioural strategies. At least in the early stages of

RET's development behavioural and emotional changes were simply assumed to follow cognitive intervention without any need to address them directly.

For the inclusion of behavioural strategies we turn to Aaron Beck who began work on Cognitive Behaviour Therapy. This technique is less prescriptive that Ellis' RET and instead of providing ready made beliefs to adopt relies more upon techniques of discovery and real-world action to effect change.

Modern CBT relies heavily upon an ancient technique called 'Socratic dialogue' (also known as 'guided discovery') to help people to understand and so manage their distressing emotions. Practical experimentation and homework is emphasised to help people not only to record and assess the evidence of their experiences but also to draw sound, evidence-based conclusions. It is, in keeping with the prevailing ideas of the day, the most scientific approach to emotional control we have yet considered. In fact the scientific technique of evaluating empirical evidence is a key element of CBT.

Essentially Beck posited that the thoughts we think and the assumptions and interpretations we make determine mood. This, in turn affects our physiology through the actions of processes such as the freeze, flight or fight response and all these factors together determine behaviour. Because each behaviour changes the situation we find ourselves in (cause and effect) we develop a new thought in response to that change and so the cycle repeats itself.

CBT holds that by changing the nature of the cycle we can influence emotions and circumstances in both the short and long term.

Christine Padesky uses the analogy of the 'hot cross bun' to illustrate the four stages of the cognitive cycle.

We'll look more closely at CBT and the 'cognitive model' later.
As we near the end of today's blog post I'd like to bring in one more concept. This also mirrors several ancient philosophies and religious writings but the more contemporary term is 'modelling'.

Bandler & Grinder's 'Neuro Linguistic Programming' (NLP) was once described by a close friend of mine as 'rip-off' therapy. This isn't really fair but I know what he was getting at. One of the better known techniques in NLP is modelling. Essentially this means that if you want to learn a skill then it's important to think and behave like the experts do. To be an excellent marksman, for example, you must act and think the same way that other excellent marksmen (and, of course markswomen) do. There's a beautiful illustration of this in the film 'enemy at the gates' in which it is clear that both thoughts and behaviours contribute to the skill of the sniper.

In athletics and other sports the notion of 'autogenic conditioning' relies heavily upon using thoughts and visualisations to enhance performance on the field. In terms of emotional management the same principles apply. By adopting the thoughts and behaviours that contribute to a particular emotion it becomes possible to create and maintain that emotion at will.

Emotional management 5: The cognitive model
(thoughts, feelings, physiology and behaviour)

Imagine that you're a passenger in my car. The weather is clear and there aren't too many other vehicles on the road. It's a good road – one of the country's major motorways and there is ample road for others to overtake, just as we are also able to overtake other cars and lorries in the nearside lane with equal ease. There is nothing wrong with the car and I'm driving just within the national speed limit of 70mph.

The chances are that you are feeling quite relaxed as we speed along having an enjoyable conversation about nothing in particular.

Just as I manoeuvre the car into the outside lane to overtake a heavy goods vehicle I happen to mention how surprisingly easy driving is. After all, even though I have no licence and have never had a driving lesson in my life or even sat in a car until this morning I'm really enjoying myself.

It occurs to you, not unreasonably, that you're in a speeding car on a major motorway that is being driven by an untutored unlicensed novice and you have no access to the brakes or steering wheel.

How do you feel now?

What effect will this new emotion have upon your body, your physical reactions?

What will you do?

Different people will react in different ways depending upon a range of factors but the following might be fairly typical….

Thought: *This is not safe*

Feeling: *Anxiety/fear*

Physiology: *'Freeze, flight or fight' symptoms (heart rate and breathing changes, muscular tension, churning stomach, shaking, sweating etc)*
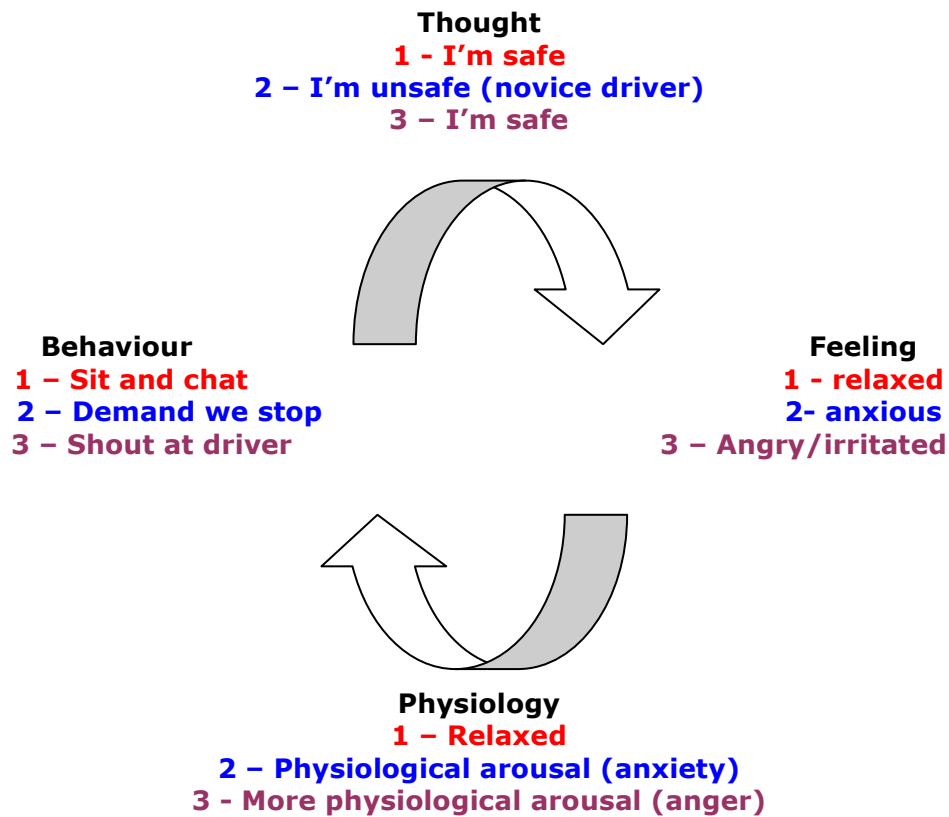
Behaviour: *Demand that I (the driver) pull over and stop the car as soon as possible.*

At this point I begin to laugh loudly and I ask you to look in the glove compartment in front of you. Inside you find my clean driving licence, my insurance documents with many years 'no claims bonus' and I point out that I've driven several hundred miles each week without incident for years.

It is entirely possible that you may feel aggrieved al my little joke but you're unlikely to feel frightened for much longer. Your physical symptoms will subside (unless you turn them to anger instead) and you will probably stop demanding that I pull over.

The point here is that nothing has changed in the outside world at all. The road is still clear, the weather is still fine and I've been driving perfectly well all along. The only thing that has changed is your perception, your beliefs and expectations. That's what triggered the physiological, emotional and behavioural differences you experienced.

We can 'plot' these events as follows:

Thought
1 - I'm safe
2 – I'm unsafe (novice driver)
3 – I'm safe

Behaviour   **Feeling**
1 – Sit and chat   **1 - relaxed**
2 – Demand we stop   **2- anxious**
3 – Shout at driver   **3 – Angry/irritated**

Physiology
1 – Relaxed
2 – Physiological arousal (anxiety)
3 - More physiological arousal (anger)

By controlling not only our thoughts but also our expectations and assumptions we can decide whether the emotional/behavioural 'cycle' we're in is helpful to us or unhelpful. We can make changes starting at any point in the cycle to alter the outcome.
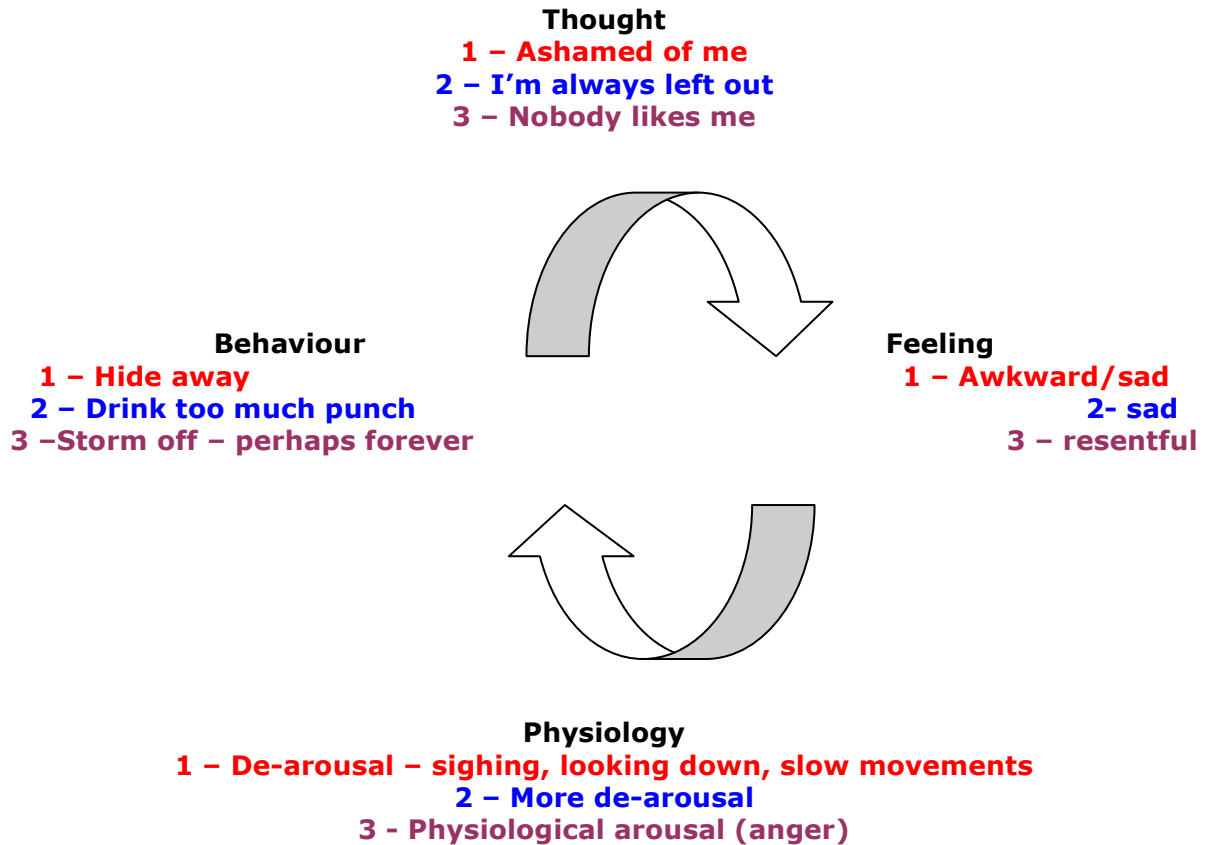
Another example, perhaps a more familiar one for many people involves interaction with friends. It's easy for people to misinterpret each other's behaviours or intentions and that can lead to major problems if allowed to develop unchecked. This is what Professor Robert Bramsom called the 'negative interaction cycle.

Imagine you're at a party where you see a good friend. Your friend acknowledges you but then spends the rest of the evening talking and laughing with others without even bothering to introduce you. As it happens you're arrived at the party on your own having been let down by the person you'd intended to go with.
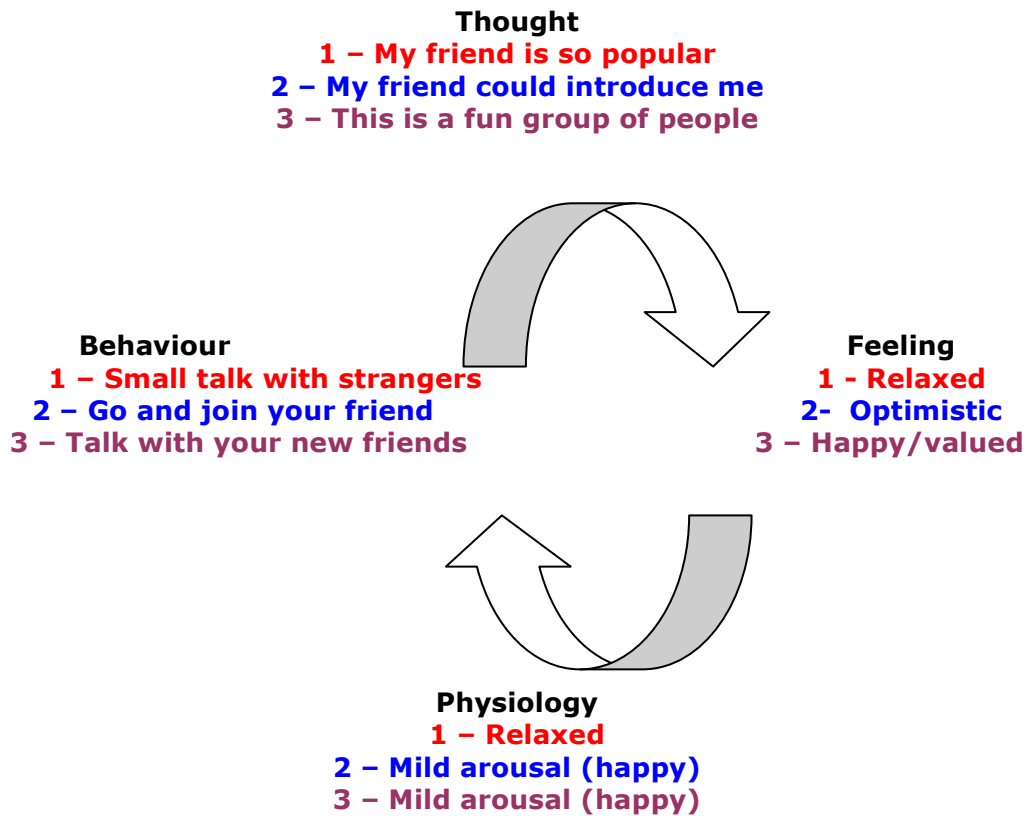
There are many possible thoughts you might have. We'll consider only two:

My friend is ashamed of me;
My friend is really popular.

In the first case this thought is unlikely to have a helpful impact upon your mood or your subsequent circumstances:

Thought
1 – Ashamed of me
2 – I'm always left out
3 – Nobody likes me

Behaviour
1 – Hide away
2 – Drink too much punch
3 –Storm off – perhaps forever

Feeling
1 – Awkward/sad
2- sad
3 – resentful

Physiology
1 – De-arousal – sighing, looking down, slow movements
2 – More de-arousal
3 - Physiological arousal (anger)

Overleaf we'll consider the possible outcome if you choose the alternative thought:

Thought
1 – My friend is so popular
2 – My friend could introduce me
3 – This is a fun group of people

Behaviour   **Feeling**
1 – Small talk with strangers   **1 - Relaxed**
2 – Go and join your friend   **2- Optimistic**
3 – Talk with your new friends   **3 – Happy/valued**

Physiology
1 – Relaxed
2 – Mild arousal (happy)
3 – Mild arousal (happy)

The model is simple enough as you can see – at least at this level. When we consider the needs of people diagnosed with serious mental disorders such as schizophrenia we'll need to get more complex but for now this is enough.

The real trick at this level is being able to tell the difference between a feeling and a thought. I realise how odd that may sound but it is surprising how many people can't tell the difference. A very general rule (not always accurate but not bad either) is this:

Feelings can be expressed in a single word.
Thoughts tend to be expressed in a sentence or more.

One of the basic skills in developing emotional control is the ability to understand the difference between thoughts, feelings, physiology and behaviours and the way that they affect each other.

Emotional management 6: The importance of physiology

Physiology is, in broad terms, the study of how the body works. It is different from anatomy which refers to the structure of the body. In today's blog post I want to consider how the way we use the body affects emotion just as emotion affects the way we use the body in return.

We know, for example that when people feel sad or miserable they tend to hold their bodies in particular ways. Muscles become more relaxed and breathing and posture change. When we're sad we tend to look downwards or stare into space and over time our movements and even our thought processes slow down.

We also know that these physical changes produce chemical alterations. The neurotransmitters serotonin and noradrenaline, or rather the lack of them seem to be most closely associated with low mood and inactivity (so far as medical science can ascertain). Inactivity appears to reduce levels of both these neurotransmitters in the central nervous system. We also know that reduction of noradrenaline and serotonin appears to bring about a deepening of our misery in return.

The result is a 'chicken and egg' style cycle which, if unchecked can result in such extreme debilitation that people actually lose the ability to move or even to organise their thoughts. One depressed person I nursed described this as a feeling of 'wading through treacle' whereby everything seemed to require gargantuan effort and even speaking to others took an effort, not just of will power but of exhausting physical work as well.

This is why in clinical depression (when biological symptoms occur) it may be necessary to boost the levels of brain chemicals with antidepressants.

However there is much that people can do to stimulate their physiology naturally before they reach the stage of clinical depression. Prevention is better than cure and boosting levels of serotonin before the onset of depression is much easier than dealing with biological illness later on. So another of the principles we need to develop emotional management skills is that of early intervention.

A stitch in time saves nine.

If you want to avoid sinking into clinical (biological) depression then intervene at the first sign of sadness and take positive steps to boost your physiology. Get active, take exercise, go for a walk, do something – and do it 'briskly'.

It's also important not to sabotage serotonin by over use of other chemicals such as alcohol which destroys serotonin and also depletes the body's supply of vitamin B. Develop a routine along the lines of Alfred the Great's 8 hour 'clock'. Divide the day into three equal parts devoted to work, rest and recreation.

Even if you don't feel like doing fun things, act as if you do. That will affect your physiology and begin to boost serotonin, thus preventing a deepening of your problems long before you reach the stage of clinical depression. The increased activity also aids sleep. Sleep disorder is another problem associated with serotonin depletion so stick to the routine, force yourself to get up when the alarm goes off even though you may not want to and get active. You can have a day off when you're feeling better. Let's face it – if you stay in bed when you're feeling down you're not going to enjoy it anyway so you might as well do something positive instead.

Some people, I'm sure will object to the idea that serotonin levels can be affected by any means other than pharmacology. I absolutely understand that. However, in writing this series of posts I cannot avoid making this fundamental case for non-medical

interventions, particularly when (at least so far) we're only talking about a general sadness or perhaps mild clinical depression.

The belief that only medication can affect brain chemistry is a leap of faith that is not supported either by the scientific evidence or by the less formal experiences of those people who have mastered the skill.

I'm proposing the same belief in emotional management that prompts parents daily to encourage their children to go out and play when they're upset. This is the same process of physiological change that makes exercise or even dog-walking so helpful.

Emotional management 7: Freeze, flight or fight
(the Australopithecus and the sabre-toothed tiger)

No matter who we are, what religion we follow or what culture we belong to we all have at least one thing in common. All of our ancestors, from the earliest single-celled life forms right through to our own parents survived. I'm not suggesting that nobody ever dies but it is an inescapable fact that all of our forebears, human or otherwise managed to remain alive long enough to breed.

This may not seem very remarkable in the modern industrialised West but there was a time when our prehistoric ancestors represented little more than a mobile buffet to every passing predator. Like other animals, living and dead, our pre-human ancestors were blessed with an automatic survival protocol without which it is unlikely that modern humans would have evolved at all.

According to the fossil record one of these early pre-human species lived alongside the watercourses of Africa. It was a small, hairy ape that archaeologists know as Australopithecus robustus. It walked upon two legs like us and presumably spent long periods of time on the ground, away from the relative security of the treetops.

It seems likely that faced with predators that were attracted to movement just as modern predators such as the big cats are the ancient Australopithecus would have evolved the same survival protocol that protects modern primates. This is also the basic, automatic survival protocol employed by our own, modern human species.

That protocol is 'freeze, flight, fight' and it's not difficult to see how and why it evolved as it did.

If the majority of Australopithecus' predators were attracted to movement then there's a good chance that an immobile hominid might go un-noticed amid the tall grasses of the Savannahs. This is an involuntary reaction that in today's world we might describe as being 'paralysed with fear'.

If that doesn't work and our ancestor is spotted by a predator then the next best option is to flee. As the saying goes:

He who fights and runs away
Lives to fight another day.

Only if there was no escape would the cornered Australopithecus finally risk injury and death by fighting off the attacker. As my good lady, Gill remarks:

We are descended from a long line of cowards!

Had we not been it seems doubtful that we'd have descended from anything at all. The sabre-toothed tigers would have been well fed though.

This elegant survival protocol is still with us today. It is regulated by the most primitive area of the brain and requires no sophisticated thought or consideration to operate it. The freeze, flight or fight response is a function of the brain's ***limbic system*** which evolved in reptiles before mammals even came on to the scene at all and is still unchanged today.

We know this because the limbic system in the human brain is essentially the same as the limbic system of other creatures including reptiles so it must have evolved before these species diverged and followed differing evolutionary paths. The ancient ancestor

common to us all had already evolved a limbic system that operated not by sophisticated reasoning but through a simple premise: the perception of threat.

Whenever we become aware of danger the limbic system 'kicks in' just as it has for many millions of years. Adrenalin is sent coursing around the body and the familiar symptoms of physiological arousal begin to appear. We sweat, we shake, heart and breathing rates alter and muscles begin tense. All these changes evolved to help us to run faster or to fight harder and so, as well as increasing the flow of blood, oxygen and nutrients to the large muscles needed for strength and speed nutrients are diverted away from less urgent needs such as digestion and the higher functions of the brain. After all you don't need to be able to solve the Times' crossword to run fast or fight hard.

All of these changes, together with the perception of threat amount to what we think of as anxiety. They can also lead to anger which is physiologically identical but for now let's think only about anxiety. As you can see it is a call to action, to protect us from harm and it does so without thought.

This very elegant survival protocol would have been absolutely appropriate for Australopithecus on the African savannah but unfortunately it's not usually anything like so appropriate today.

Many of the threats we perceive today require more than just freeze, flight or fight. It is true that some people face violence routinely and for them the old protocol has real value. It also works very effectively in the event of an out of control car speeding onto the pavement because it prompts us to move out of the way and gives us enough energy to do so quickly and effectively. For most of us though, what we usually need to do in times of threat is think – the very thing that the freeze, flight of fight protocols prevents by reducing blood flow to the higher, more rational areas of the brain. That's all very well if we're facing a violent attack but there really isn't much point in running away from an overdue telephone bill.

Sigmund Freud divided anxiety into two essential categories which he labelled 'appropriate' and 'inappropriate'.

Appropriate anxiety is a call to action that keeps us safe by motivating us to avoid harm and at the same time enhances our ability to do so.

Inappropriate anxiety is a response to something that may not be a threat at all or that keeps us from dealing effectively with a genuine threat by preventing us from thinking clearly enough to solve the problem we're facing.

Briefly put appropriate anxiety keeps us safe whereas inappropriate anxiety just gets in the way.

The trick then is to learn to control the physiology of anxiety as well as the beliefs that lead us to imagine danger where none exists. The same physiological techniques can be used to combat feelings of anger too although the cognitive techniques, the beliefs and thought patterns are different.

There are many specific principles around cognition and physiology which we'll begin to consider in greater detail as this series of posts progresses.

Emotional management 8: Unhelpful thinking

I think therefore I am.
And all that I am is dictated by my thought.
Thought breeds opinion, opinion belief,
Belief engenders attitude and attitude: behaviour.

Therefore in order to live well
A man must first strive to think well.

His thought must be fluid and well conceived.
It must be as a strong fortress to withstand the onslaughts of derision and dogma
And yet welcoming enough to admit the arguments of reason.

Thought must not be fixed but it's foundations must be strong.

And thought belongs to us all.

There are many theories, principles and specific thoughts associated with emotional management – far more than I could even attempt to cover in these blog posts. So I've distilled them down to those concepts that I think have the greatest impact. Even so, it's going to take several posts to cover this section on thinking and I'll still be leaving out far more than I put in.

Let's begin though with some of the most common cognitive problems or 'thinking errors' as they're often called. According to the late Albert Ellis there are three 'general' thinking errors that crop up time and time again in the development of emotional distress. These are much less specific than his famous collection of twelve irrational beliefs and are more to do with thinking 'style' than with any specific belief but they are, nevertheless a reasonable place for us to begin this section on cognition.

The three 'general thinking errors' are….

Ignoring the positive

Whether you tend toward anxiety, anger or depression you'll find it much harder to maintain emotional stability if you ignore the positive aspects of life. Like many of the thinking errors we'll consider this simple truth is both obvious and depressingly common (pun intended).

Exaggerating the negative

As if ignoring the positive wasn't bad enough, many people have developed the thinking habit of exaggerating the negative. The net result is that not only do they see the bad in their lives but they also have an even more negative view because they blow things out of all proportion until it seems as though they are overwhelmed by negativity.

Overgeneralisation

This thinking error becomes habitual and remarkably destructive. This is the thinking habit that prompts people to believe that all aspects of their life are unsatisfactory when in fact only a small part of it may be. This is the sort of thinking error that prompts people to expect 'one of those days' simply because they spill the milk at breakfast. The misfortune is generalised to include the whole day.

On a related point I often wonder why people choose to generalise only to the whole day. Why not to the whole week or month? Maybe even their whole life. Either one makes as much sense as the others.

Or maybe they could try relating the misfortune to the whole of the time it takes them to clean up the spilled milk and then move on. After all:

There's no use crying over spilled milk!

Yes – I know. I couldn't resist that!

Of course, we've already discussed the destructive power of the self-fulfilling prophecy in an earlier post. Other errors that psychologists have identified include:

Catastrophisation

An inevitable result of Ellis' 3 general thinking errors above is the way that people take a minor problem and blow it out of all proportion. This is what happens when a person argues with their partner and then convinces themselves that the whole relationship is over. Most of us have done this at one time or another – especially during our teenage years but by the time we become adult we should have plenty of evidence to show us that it's not inevitably so. Yet – by ignoring the positive evidence and exaggerating the negative implications of the situation we convince ourselves that the worst is about to happen.

Arbitrary inference

Catastrophisation often relies upon this process of arbitrary inference to make it happen. This is the way we draw conclusions from very limited evidence to support our basic assumptions.

The problem is compounded by the extremely common habit of inference chaining where a series of arbitrary inferences are linked together to create anxiety, depression, anger or even psychotic states such as paranoia and other delusions. For example:

Joan and David live together and have done for eight years. They are happy and regularly go out as a couple to the local cinema as well as restaurants and other places. They have two small children, Anna and Michael who they adore.

This afternoon David tells Joan that he is planning to go to the cinema with some male friends from work. Joan becomes distressed by this, much to David's confusion because he doesn't understand the arbitrary inference chain that has developed in Joan's head. It goes something like this:

David's going to the cinema without me
That means he doesn't want my company
That means he doesn't love me
That means he will leave me soon
That means I'll be on my own with two children
That means I'll never find anyone else. Nobody will want to take on the kids as well
That means I'll be alone
That means I'm a failure because I couldn't keep him
That means I'm useless

Obviously this chain of ideas may well be distressing but they don't really reflect reality. This thinking style of arbitrary inference is extremely destructive and unnecessary. It often has the feel of predicting the future, one of Ellis' beliefs which we'll discuss in more

detail later. One simple trick to get to the bottom of inference chains that therapists use a lot is to keep asking:

If that were true, what would it mean for you?

It is truly amazing to discover the assumptions people make based upon the flimsiest of evidence or the most innocuous of events.

Determinism

Determinism comes in many forms but they all have the same 'feel'. This is the assumption that the outcome is inevitable because of some other, often irrelevant, circumstance. Determinism makes us powerless because it tells us that there is no hope. This belief discourages us from trying to improve our situation. Common examples of determinism include:

- I'm bad tempered because my parents were Irish;
- I failed at school so I'll never make anything of myself;
- I'm unemployed so I must be miserable
- I was traumatised as a child so I'll never be happy;
- Of course I can't look after myself – I've been diagnosed with schizophrenia.

Selective abstraction

This thinking error is very similair to arbitrary inference. The difference is that it's often a more conscious process of 'self-censorship'. It's the process by which people ignore evidence that doesn't fit with their preferred beliefs and opinions. They acknowledge only the evidence that supports their preconceived notions and so they fail to grow, to develop and ultimately to learn how best to survive in the world. In everyday language this is what we mean when we say that someone is 'burying their head in the sand'. This is the sort of thinking error that allows:

- Racists to ignore the evidence that people from other racial groups are just the same as people from their own;

- Politicians to draw different conclusions from the same evidence;

- People to blame others for their emotions in spite of their own destructive thoughts and behaviours.

Global thinking

This is one of the most common thinking errors. It's the habit of applying a single principle to a total situation. It's one of the most destructive thinking habits, especially when people apply it to themselves.

- The man who finds himself out of work following a spate of redundancies is not a total failure.

- The girl who finds herself taken advantage of after a drunken night out is not a whore.

- The woman diagnosed with depression is not completely unable to function in the world.

All of these people may face some very real difficulties but that, in itself, does not negate all the other aspects of their personalities and circumstances that make up who they are.

Global thinking, when applied to ourselves or others, is always far too superficial. It's the sort of thought process that leads people to write off small children as evil and a host of other, equally superficial judgements with no real understanding of the complexity of human beings and their capacity to behave in a variety of ways given the right circumstances.

Dichotomous thinking

Also known as 'black and white' thinking, this is the belief in extremes. The world is full of shades of grey but the dichotomous thinker can see only definites. Dichotomous thinking is common among children – in fact it's a vital stage in cognitive development but it isn't the end result. Dichotomous thinking gives rise to attitudes such as:

- With us or against us

- Good and evil

- Us and them

- Good people and bad people

The reality is much more complex than that.

Magical thinking (the Wizard did it)

Magical thinking is the opposite of the 'cause and effect' principle we discussed in an earlier post.

Rather than take the time to understand how the world works people assume a magical connection or a guiding force instead. They put their faith in a form of wishful thinking and trust to 'luck' or to 'God' instead of doing the work needed to make lasting change. The irony is that when they don't get the job or the advice of the pendulum they swung turns out to be false the same magical thinking provides them with some sort of solace through the belief that:

It wasn't meant to be.

Magical thinking prevents people from taking responsibility because they attribute success or failure to the magical force of their choice. Consequently they stop trying to understand and ignore the real cause and effect lessons that would actually help them to achieve their goals.

Personalisation

Some people go through life believing so completely in their own importance that they think everything is about them. The majority of people really aren't all that important and most people we come across are far too wrapped up in their own lives to devote much attention to us, our characteristics or the state of our hair.

One excellent thing to keep in mind is this:

I'm not special – I'm unique, like everybody else!

Emotional management 9: The sticks we use to beat ourselves

"Imperatives and injunctions are the sticks we use to beat ourselves."

I first heard that statement as a student psychiatric nurse way back in 1992. The tutor, a 'wise old bird' by the name of Juliet Crumb was struggling to introduce another group of students to 'the basics'. The reason she was struggling so hard was not because the idea is particularly complex – actually it's very simple. Nor were we a particularly slow or 'dim-witted' bunch of people. What made this so difficult for us to grasp was the fact that it went against so much of our prior conditioning.

Like most people, we students grew up believing that some things simply 'had to be' and others were just taboo. It didn't matter that we'd never bothered to wonder why this was the case – we just 'knew' it to be so. For example we believed that we **must** do and feel certain things (imperatives) even though they hurt us. A good illustration of this is the belief that people **must** feel unhappy if they don't get what they want.

We also believed that the world and other people **should** treat us in certain ways and so when people behaved in ways that we defined as wrong we felt justified in becoming angry. We thought that we **should** be angry. These imperatives are what therapists sometimes call 'musterbation' or 'musterbatory thoughts' and as Juliet insisted, they really are some of the sticks we use to beat ourselves. However – when Juliet first announced, calmly, clearly and emphatically that this simply wasn't true we took some convincing.

Then she attacked the other side of the equation. If imperatives refer to what we think **must** be then injunctions are the **must nots**.

Beginning with *big boys don't cry* or *good girls don't climb trees* we are socialised into a whole range of injunctions and imperatives that govern our lives. Of course there's nothing wrong with socialising children and the rules of social behaviour are vital to maintaining relationships. However many of the emotional, psychological and behavioural injunctions and imperatives, the *musts* and *must nots* are both trivial and unnecessary. Many are actually damaging.

It's worth remembering that many of these imperatives and injunctions, in common with traditional values, religious beliefs and family customs really amount to nothing more than 'somebody else's rules. That does not, in itself, make them inappropriate but it is OK to reserve the right to make our own decisions about them.

For example, millions of Christians all over the world have chosen to reject traditional biblical imperatives around stoning sinners to death or refusing to associate with non-believers. Many pastors and preachers choose to ignore the injunctions in Leviticus and continue to 'approach the alter' even though they have an 'eye defect' and even wear glasses whilst performing religious rituals. These things would have scandalised the religious society of Moses but we know today that it's just 'somebody else's rules' and that these injunctions and imperatives have no place in modern society. Consequently they have been rejected.

It is important throughout our quest for emotional management skills that we are able to choose our own values, appropriate to our own situations. It is equally important that we acknowledge the right of other people to do the same for themselves, even when they arrive at conclusions that differ from our own.

This is not to suggest that 'anything goes'. Society needs rules and laws and I'm certainly not advocating anarchy. What I am suggesting is that not everything is governed by law

and it is absolutely reasonable for people to choose their own opinions, feelings and (within the law) behaviours.

Some people do not understand this equality. They see themselves as perfectly within their rights to tell others what to do, to say and to think and consider themselves to be perfectly justified in forcing their opinions on to other people. They might assault, prevent or simply insult others who do not conform to their particular viewpoint. They will give the other person 'a piece of their mind' in other words.

Generally speaking these people are very aware of their own right to their opinions but are less clear about the fact that others have the same rights. That's why some people try so hard to force others either to agree with their opinions or to behave according to their values. If their victim does not fully understand their own right to have a different view then they become easy prey for the type of emotional blackmail we call 'guilt-throwing'.

Guilt throwers and guilt catchers all have one thing in common – they fail to understand that people are allowed to be different and that it's OK to disagree. To impose your values upon someone else is just another example of the damage that injunctions and imperatives can do to both parties.

Another way to understand this idea of imposition is to consider the most basic principles of assertiveness. Broadly speaking there are three essential styles of interaction:

- Aggression: My rights and choices are most important.
- Passive: Your rights and choices are most important.
- Assertive: Our rights and choices are equally important.

I'm always amazed, even after all these years in nursing, at the amount of people who think they're being assertive when actually their behaviour represents nothing more than plain old aggression. This creates conflict and resentment on all sides – hardly a good start in maintaining emotional equilibrium.

Some people go so far as to take differences of opinion personally. It's as though they believe that only they know the truth (whatever that is) and then they go further. They assume that any difference of opinion, any information that doesn't fit their preconceived ideas is directed at them personally and so they feel obliged to be 'hurt' by it.

That is an illustration of irrational imperatives and injunctions combining to make that person miserable. Imperatives and injunctions really are, as Juliet said, the sticks we use to beat ourselves.

They might even go further and attribute their pain not to their own faulty thinking but to the other person who has simply expressed an opinion. This attitude is much more damaging than it looks.

***If you believe that your pain is caused by your own attitudes
then you have the power to change it.***

***If you attribute the source of your pain to someone else
then you are powerless to do anything to prevent it.***

Actually this theme of 'attribution' and the notion of 'internal' and 'external' locus of control is also something we'll pick up on when we discuss serious mental disorders because it's a major contributor that goes a long way to determine how effectively the individual can take control of their own mental health.

Emotional management 10: All about me

I've talked about the issue of specialness before in this series and I want to pick up on it again. By now it should be becoming clear just how much misery and conflict is caused by an inflated sense of our own importance. Just as other people's opinions and values are their own business then our opinions are also ours – and ours alone.

Most of us are really rather unimportant to most other people. They don't have any duty to control us and our private thoughts are none of their business either. Interestingly enough this works both ways.

Not everything that happens is this world is about us. We're not that special – nobody is but until we realise that we'll be vulnerable to all sorts of emotional distress.

This notion of 'specialness' is a major problem. It's unfortunate that it has become commonplace in Western society to tell our children that they are special. This just sets them up for a fall. After all special people deserve special treatment. The world owes special people special favours.

In a much earlier post I talked about the problems that arise when the world doesn't meet our expectations. If we think we're special then we'll be perpetually disappointed.

The world doesn't owe any of us any favours.

Interestingly enough I had a conversation today with the mechanic who services my car. We talked about the miles I cover and he asked me how the car is holding up. I said that it was doing fine – the car seems as though it'll run forever.

Bill, the mechanic, instantly remarked that I should be careful not to tempt fate. My reply was automatic but none the less true for that. I explained that I was not that important and that the fates, assuming they exist, are not likely to take much notice of my witterings.

To put it another way – I'm not that special and I certainly don't have the ability to 'jinx' anything. It's a good illustration of the combination of specialness and magical thinking that leads people to believe that they can tempt fate. We may be able to set up self-fulfilling prophecies but that's to do with our own actions, not some magical judgement because the universe hangs upon our every word.

The idea of specialness is also very important when dealing with serious mental disorders. After all – if you believe yourself to be the second coming of Christ or that the aliens from Venus are reading your thoughts then the obvious question must be:

"Why you? What makes you so special?"

For now though it's enough simply to acknowledge the dangers of believing yourself to be special. As we've said before:

It's better to be unique like everybody else.

Emotional management 11: Socratic dialogue and 'the razors'.

Socrates was a philosopher and educator in ancient Athens. He developed a method of using questions to help people reach new insights or knowledge. Each question helps the other person to move a little closer to a clearer understanding of their situation.

In posting this I am most certainly not suggesting that this is all that is needed in order to 'do therapy'. Rather I'm simply outlining some of the interactive skills that are used in the process. If we understand the process we can, at least to an extent, become our own therapists and ask ourselves the questions that help us to find resolution before we ever need help from professional therapists.

Socratic questions are not so complicated as one might first suppose. They follow a fairly simple pattern and broadly follow a handful of rules which are listed below.

Socratic Questions

- Socratic questions are used to help people connect information from one part of their experience with another.
- Socratic questions should be easy for the client to answer – they must know the information.
- Socratic questions build 'step by step' upon information the client already knows.
- Socratic questions are used to bring to light examples which do not fit the client's beliefs about the current situation or problem.
- Socratic questions are used to help people re-evaluate their situation or problem.
- Socratic questions are very different from 'information giving'.
- Socratic questions are often 'open-ended' although not always.
- Socratic dialogue typically includes lots of summaries to make sure that both client and therapist are 'on the right track'.
- Socratic dialogue typically ends with the therapist asking the client how the new information affects the way they think about the situation at hand.

The technique is very simple in theory but it does take practice to perfect. In many ways the questions follow the principles of the famous poem by Rudyard Kipling,

6 serving men:

"I had six honest serving men
Who taught me all I knew
Their names were when and why and how
And where and what and who."

It is always better for a person to see the truth for themselves than simply to be told what to believe by someone else. In fact, if there is a significant flaw in Ellis' RET for many people then this is it – the beliefs are presented 'ready made' and people are encouraged to adopt them as they are. Socratic technique is used to help people to draw their own conclusions instead.

Another principle is known as Ockham's razor. William of Ockham lived in the 14th Century and suggested that:

If one thing is true then other things should also be true.

For example if it is true that the man next door sings louder than the sound of a jet aircraft taking off then it should also be true that we can hear him from our sitting room. If this second statement (that we can hear him) is false then the first statement (louder than a jet) must also be false.

Another way to use Ockham's Razor is to consider the most simple proposition. This is not to suggest that the simplest explanation is always the correct one, but it does give us a sense of how to prioritise most likely explanations for things. For example, if one theory suggests that water pushes a water wheel and another suggests that the water wheel is actually pulled around by unseen ghostly hands then the simplest explanation is that the force of water is what makes the wheel move.

Both theories have the same outcome – the wheel turns – but one involves the creation of and belief in a whole new set of circumstances (ghosts obsessed with mechanics) whereas the other provides a perfectly adequate explanation without such imaginings.

Ockham's razor would, in this case, direct us not toward a belief in ghostly drivers but to the far simpler explanation that the force of the river causes the wheel to turn. This is the case irrespective of ethereal entities that we may choose to imagine or not. Only if the simplest (water driven) theory proves unsatisfactory (ie not correct) should we turn our attention to the ghostly hands explanation.

In a sense this is very similair to the other 'Razor' rule – known as 'Hanlon's razor' which effectively says that we ought not to assume ill intent or malice where the same situation could equally be explained by mere stupidity or incompetence. To put it another way – the fact that my actions hurt you could just as easily be the result of my careless stupidity than any intention to cause you pain. I might not have meant you any harm.

So before you rush off and give your neighbour (or that hapless internet blogger) a piece of your mind just stop and think. They may not have meant any harm at all and may not actually intend to offend you personally or even be aware that they did.

Realistically most people don't go around dreaming up ways to hurt others – they have too much to do just sorting out their own 'stuff'. There are exceptions to that, clearly but malice isn't usually the norm. Indifference is far more plausible in most situations.

By combining Socratic technique with the basic principles of Ockham's and Hanlon's razors we have a perfect blueprint for assessing and responding to the world reasonably and for the most part without distress. And all we need to do is ask ourselves the right questions.

- ***If this is true would this also be true?***
- ***What is the evidence?***
- ***How does this evidence fit with this assumption?***
- ***What other explanations might there be?***
- ***Which explanation is the simplest (and most likely to be true)?***

Remember Rudyard Kipling's other little couplet:

A man convinced against his will
Is of the same opinion still.

It's much more effective to ask questions than to tell another person what to think. Let them come to their own conclusions. That way they just might believe them.

Emotional management 12: The need for universal approval

Throughout this series of blogs I've consistently returned to Albert Ellis' collection of irrational beliefs without ever really identifying them. In today's 'chapter' I'll begin to address the specific beliefs individually. Some of them are expressions of principles already mentioned, however briefly in other blog posts and some will be new topics in themselves.

The fact that I'm devoting a lot of time to these 12 beliefs does not mean that I think they're all that's need to manage emotions but they are so fundamental, so integral to the bigger picture that they do warrant further consideration. As I go through these beliefs I'll do my best to provide realistic illustrations to clarify the points made.

Ellis' first irrational belief is the idea that we need the universal approval of others for much if not all of the time. Any single person, stranger or otherwise who disapproves of us is sufficient to cause emotional distress.

This is the belief that causes people to become upset if a stranger 'gives them a funny look' (the cause of many a bar fight) or if they suppose that others may be thinking or saying defamatory things about them. I still remember the sense of relief I felt when I realised that the opinions of other people, particularly those whom I didn't know, didn't need to have any impact upon the quality of my life.

Other people's thoughts and opinions are really none of my business and for the most part none of my concern either. I don't need to care what most other people think just as they don't need to care what I think.

For all those reasons Ellis defined the belief that we need such consistent, universal approval as irrational.

The more rational, antithetical belief is that we can concentrate upon maintaining our own self respect and winning approval where it matters from the people who matter to us. We can also spend time and effort much more usefully by concentrating upon loving rather than being loved. This seems to be a much more helpful approach to life and to the world around us and to others than the impossible attempt to win the approval of everyone we meet, even though they may have very different values and opinions from our own.

As Shakespeare wrote in Hamlet:

> *"This above all, to thine own self be true,*
> *And it must follow as the night the day*
> *Thou canst not then be false to any man"*

Emotional management 13:
The good, the bad and the urinating student

Late in 2009 a young man by the name of Phillip Laing was caught on CCTV urinating on a war memorial in the middle of Sheffield. This was inappropriate and insensitive but no more so than the actions of countless other drunken students the world over.

At the time this unfortunate student was threatened with imprisonment, a punishment that would have resulted in his expulsion from university and a serious block to his career. More remarkably than that (let's face it imprisonment does seem a tad severe) the tabloid press and innumerable internet commentators were calling for anything from life imprisonment to death by torture. I recall commenting on this situation at the time:

"Philip Laing is 19 years old. Like many 19 year old students he sometimes drinks too much – a lot too much. Like many drunken teenagers he sometimes acts inappropriately when he's 'in his cups'.

It's true he did wrong. It's true he should be called to account for his desecration. But is a jail sentence really appropriate?

We have veterans from various conflicts facing real poverty and nobody's going to jail for that. Why should one drunken teenager be scapegoated for what really amounts to a minor offence coupled with a nation's anger about current conflict in the middle East?

After all, as my good lady Gillian has incessantly exclaimed throughout this evening:

"It's not as if he weed on a Chelsea pensioner!"

Can we have a little perspective here?

I'd hate to think how many teenagers would fill our jails if custodial sentences became routine for this sort of adolescent drunken stupidity."

http://stuartsorensen.wordpress.com/2009/11/06/any-chance-of-a-bit-of-perspective-on-this/

All this because he urinated on a piece of marble and a handful of plastic poppies.

Now I'm not trying to excuse this act of desecration. Philip Laing's actions were insensitive and disrespectful, not to mention illegal. But did this misdemeanour really warrant being tortured to death as one blog I read demanded?

It seemed for a time that the whole nation had lost all sense of proportion and I'm sure that, at least in part, this lack of perspective was the result of Ellis' second irrational belief. This is the belief that brings people to define themselves and each other on the strength of a single act or character trait instead of seeing the whole person as they really are. This is the belief that is responsible for vendettas and vigilantism, for feuds and 'punishment' beatings and a host of other unpleasantries. It's also a ticking time bomb that can result in extreme feelings of guilt and worthlessness when people apply it to themselves.

The belief, quite simply is this:

People who do bad things are bad people – they should be punished.

Regular readers of this blog will, I'm sure, recognise the combination of global thinking, misunderstanding of Hanlon's razor and of course 'musterbation' represented here.

When we think about Philip Laing we can acknowledge that he did an inappropriate thing but does this really mean that he is a 'bad' person? Can we honestly say that one inappropriate act of ablution negates all the positives and achievements in his life and personality? I wonder if this is what the writers of the New Testament had in mind when they wrote:

"Let he who is without sin cast the first stone"

Of course there are many types of 'bad' behaviour (if we can use that term) and they're not all just thoughtless. Sometimes there's real malice and/or deliberate intent involved. Yet even then the act cannot define the whole person.

History is full of examples of real villains who changed their ways precisely because they were more than merely a catalogue of crimes.

- William Wilberforce went from slave trader to abolitionist.
- John McVicar went from armed robber to youth worker.
- Who knows what Philip Laing might achieve?

So instead of defining people as 'bad' the antidote to Ellis' second belief is this:

Sometimes people behave inappropriately or our of ignorance.
It is best to help them to understand how and why to do better in the future.

This is not to suggest that punishment is unnecessary. Sometimes the reality of punishment is a consequence that helps people to learn the error of their ways but there has to be some sense of purpose and perspective behind it. Gratuitously hurting another is far from appropriate in a civilised society.

I wonder how many over the top 'punishments', how many long-standing feuds and how many broken friendships might be averted if people would only understand this simple principle. I suspect that having had compromising pictures of himself published in the national press, not to mention death threats and a general rejection from the rest of society young Mr. Laing has already learned any positive lessons about appropriate behaviour that might arise from this unfortunate event.

What then would be the point of hurting him further unless simply for others to take pleasure in his suffering. And if we really do delight in the suffering of others then, ironically enough, what might that say about us?

It seems that the more we start believing in this concept of 'bad people' the closer we come to the point when we have to turn the same flawed reasoning against ourselves.

Emotional management 14: Broken bridges, tantrums and tears

We're having interesting times here in West Cumbria. Last November we experienced the most serious flooding in living memory. In fact it's estimated that we had more rainfall than had descended over the English Lake District for a thousand years.

One of the many consequences of this event was the destruction of a series of bridges spanning the river Derwent as it makes it's way to the sea. My home town of Workington has effectively been sliced in two by this natural disaster. A short trip that used to be just a mile or so into town from one of the nearby villages has now become a 17 mile journey fraught with traffic jams that takes well over an hour at peak times. Of course for many people living in more densely populated areas of the UK this doesn't really seem like a big deal but West Cumbrians aren't used to such a lengthy commute.

One little girl I know leaves the house at around 7am each morning in order to get to her school on time. She has become so fed up of the hours of travel at the start and finish of every school day that she actually cries when she gets in the car. It's not that she doesn't want to go to school – she likes school. She just doesn't want to have to spend so long in her Mummy's car.

Of course the little girl's Mummy would prefer not to have such a long drive too. However, as an adult she understands that there's no point in getting worked up about what can't be avoided. Unfortunately though the little girl herself hasn't yet learned that lesson. Perhaps this very experience will be the one that teaches her. After all, the only thing tears will achieve is a headache and a snotty nose – it won't alter the fact that school is now over an hour away.

I'm proud to be able to say that both my stepsons aged 7 and 14 have already 'got' this. It's true that they get upset and it's true that they have been known to cry when in pain but neither of them cry 'for the sake of it' anymore.

This isn't because they don't feel things – nor is it because they can't express themselves emotionally. It's just that they've realised that all crying achieves is a headache and a snotty nose – and let's face it, when you're feeling bad to start with that just makes everything worse. So rather than cry into their respective pillows they talk instead. It's not about injunctions preventing them, from crying – they can cry all they want to if that's what they choose. It's simply about the awareness that crying is only one option of many and they have the right and the ability to choose for themselves.

For now though – this particular little girl is still captive to Albert Ellis' third belief:

It is horrible when things are not the way we want them to be.

This is a very common belief among children until they develop what we call 'frustration tolerance'. Most adults wouldn't dream of crying over a 17 mile journey because they've learned that they can simply accept the situation and 'get on with it' without distress.

However the belief underlying this little girl's distress over the extended commute to school is the same belief behind adult distress at more grown-up problems such as:

- *The broken relationship;*
- *The lost job;*
- *The mislaid wristwatch;*
- *The missed train.*

Acknowledging dissatisfaction is one thing - becoming distressed is quite another.

All these things and many others like them reflect the reality of life. There's no point in adults becoming upset by a 17 mile journey because that's just the way it is and crying won't change it. This is equally true of the situations listed above. In fact it's hard to think of any situation (with the possible exception of bereavement and what Freud called 'grief work') that is actually improved by emotional distress.

An alternative way to deal with such situations would be to adopt Albert Ellis' antithetical belief:

Things happen. The world is imperfect. We can work to change unsatisfactory situations, to equip ourselves to deal with them or, if that is not possible, to accept them without distress.

Earlier in this series of posts I mentioned Viktor Frankl's incarceration in the Nazi camps. I could equally have mentioned the resignation with which the stoic philosopher Seneca met his death at the orders of Nero, his emperor who demanded his suicide.

History is brimful of examples of people who have faced all sorts of calamities without feeling the need to make things worse for themselves. Let's face it – it's bad enough when things go wrong – we don't have to make the situation worse by sabotaging our emotional life as well.

Emotional management 15:
Acknowledge the past or sacrifice the future

Ellis' fourth irrational belief is a bit of a double-edged sword. On one hand it offers an emancipatory sense of control over our own emotional well-being. At least the antithetical or rational belief that accompanies it does. However it also demands that we acknowledge our own part in creating and maintaining our own previous unhappiness. Without that understanding the idea of future emotional management becomes an unworkable nonsense.

We cannot truly appreciate the reality of future emotional management
without also acknowledging that this has always been so.

So before we go any further I'd like to put this information into the context of human development.

When we were first brought into the world we knew nothing of its workings and nothing about how to run our own emotional and psychological state. Everything we ever come to know has to be learned.

Unfortunately human beings don't come with a 'users' manual' and so we have to rely upon the experiences we have to teach us about life. Everyone is different and we all have different experiences at different times but this much is certain:

Everything must be learned.

If these ideas are new to you that doesn't mean you are stupid, useless or anything else. It simply means that this is your moment to learn these particular things. You've learned plenty of other things – just not very much about emotional management yet. There's no crime in not having used skills and information in the past that you didn't yet know.

Please don't jeapordise your future happiness merely trying to
defend and justify past misery. That really wouldn't be a good deal.

Just remember the famous quotation from LP Hartley

"The past is a different country – they do things differently there."

In the next post we'll look specifically at Ellis' belief number four. Until then – watch this space……

Emotional management 16: Who's driving the bus?

This is, or at least was, a favourite question that an old psychiatric nursing friend of mine used to ask. His name is Simon Bradshaw and in his own quiet and unassuming way he has an uncanny ability to get to the root of an amazing array of problems with the questions he asks. What he really wants to know when asking the 'bus' question is just who is really calling the shots. Who is in charge here?

Earlier in the blog I briefly mentioned the idea of 'locus of control'. As we elaborate upon Ellis' fourth belief we need to expand upon this. Locus (location) of control means essentially the 'seat of power' or of 'decisive influence'. As a general rule peoples' emotional locus of control can be either 'internal' or 'external'. There is more to it than this simple dichotomy but for our purposes the general principle is sufficient.

The external locus of emotional control is where most of us begin. Children usually respond in very predictable ways to events and to the actions of other people. They become frustrated when parents say 'no'. They become impatient when they need to wait. They become sad and upset when bullies taunt them.

This external locus of emotional control essentially means that events and other people are 'driving the bus' as Simon would say. They have surrendered their own emotional management to the whims of every passing bully. They make themselves helpless victims, essentially because they don't yet know any better.

It takes time to learn and to develop the skill of emotional management and most people instinctively understand that. This is why most of us will accept philosophically the tantrums of toddlers but are far less tolerant of the angry outbursts that emanate from uncontrolled adults. We're expected as adults to know how to deal with our frustrations without stamping our feet or taking our inability to control our tempers out on other people. We're expected to drive our own bus.

Some people however reach adulthood without learning how to manage their moods and this really does leave them at the mercy of other people. They still haven't learned to drive their own bus. These people are victims of Ellis' fourth irrational belief:

Human emotions are caused by events and by other people.

As I hope to demonstrate with this series of blog posts it's a belief that is not only false, it's also extremely damaging. This one belief, more than any other, prevents people from trying to develop emotional management skills because they see no point. After all, if emotions are caused by others and we can't control the actions of others then there really isn't any way to influence our moods by working on ourselves – that's not where the problem lies.

Fortunately for us that's not the case at all. Our emotions are not caused by others and so are entirely within our sphere of influence. As Albert Ellis' put it:

Human emotions are largely caused by the view we take of events

To put it another way, it's not what happens top us that makes the difference – it's what we think about what happens.

Hopefully by now it's becoming clear that, while emotional management takes more than simply positive thinking it is a real skill and it can be learned.

Who's driving your bus?

Emotional management 17: Getting a 'grip'

It was only around 7.30am but the morning sun was already warming the city air as I descended the short stairway that led to Piccadilly Circus underground station. Moments later I passed though the automatic barrier, oyster card in hand and was on my way to the platform. Already the station was filling up.

Soon after the train arrived and I found myself in a half-full carriage being carried through the dark, underground tunnels toward Holborn station. There I changed trains to take the central line to Gants Hill. I had training to deliver in a care home in Redbridge, a fair distance to walk from the station with all my equipment in bags slung over my shoulders.

I was deliberating whether or not to take a taxi from the station when a young man in his early twenties entered the carriage at Liverpool Street. He wore traditional Muslim dress and his jet black beard seemed to match his eyes perfectly.

I must have been staring because he looked at me from the seat opposite, half smiled and then from his rucksack he pulled a small book with Arabic writing on the cover. He began to read. My thoughts suddenly became not only irrational but remarkably insistent too.

I've seen similair young men on tubes, buses and a host of other places before and since without so much as batting an eyelid but this time it was different. This time it was July 14th 2005 – and it was a Thursday.

One week earlier on July 7th there had been a terror attack on a tube train. That was at rush hour. That was also a Thursday (it always seemed to be on Thursdays). The bomber had been a young Muslim man and his explosives had been contained in an ordinary looking rucksack – just like the one beside the young man opposite me on the tube.

Rationally speaking there was absolutely no reason to assume that this young man was doing anything other than going to work. Certainly a terrorist would most likely have boarded the train at least thirty minutes later for maximum effect and would be more likely to travel into the city centre than away from it. Unfortunately though I was anything but rational that morning. I was becoming increasingly neurotic with every passing moment.

I'm uncomfortable in having to admit that I'd already fallen victim to Ellis' fifth irrational belief, fuelled undoubtedly by the anti-Islamic media frenzy so prevalent at the time.

Looking back it seems clear to me that the young man in question was simply going about his business as he presumably had done day in, day out for years. There was and still is a threat from radical terrorists but it wasn't anything to do with him.

This man was simply on a tube in culturally appropriate dress carrying a rucksack. I don't know whether or not his book was a copy of the Koran but let's face it – that's his business anyway. It has nothing to do with me. Everyone has to be somewhere and this apparently devout Muslim man had as much right to be there as I or anyone else had on that July morning.

I understand now that I'd fallen foul of a media driven hysteria that gripped the nation at the time. We had blown the risk of terrorist attacks so far out of proportion that we saw danger everywhere. It seems that human beings have long been susceptible to this sort of group neurosis.

It is the same mindset that created an international frenzy over swine flu in spite of the fact that many more people die each year from ordinary influenza. It's the mindset that prompted McCarthy's 'reds under the bed' witch hunts in cold war America. It was responsible for the literal witch hunts of the 16th and 17th centuries. The same folly prompted the widespread persecution and murder of Jews in the middle ages when Europe's Christian population decided that they were responsible for the Black Death epidemic.

The irrational belief that underlies all of these situations is this:

If something may be dangerous or fearsome we should be terribly upset and obsess endlessly about it.

It was this irrational belief, this tendency to become disproportionately upset by perceived danger that led me to fear an ordinary man going about his business. The irony is that I run a greater risk of being run over by a car than I do of being harmed by one of the very few Muslims intent on committing acts of terrorism. This loss of perspective actually causes even more problems than the threat to which it responds.

Ellis' rational belief about responding to risk is this:

We would better frankly face it and render it non-dangerous and, when this is not possible, accept the inevitable.

When we think about the amount of time people spend distressing themselves by worrying about things that never actually happen we can see that this really is sound advice.

Emotional management 18: Mama's gonna help build the wall

One of the first albums I ever bought was Pink Floyd's 'The Wall'. It was on a school exchange trip to France and I treasured that record. Partly because I liked Pink Floyd's music (I still do) and partly because of the memory it held for me of my teenage adventure in the French town of St. Pourcain.

One of the tracks on this excellent double album contains the line:

"Mama's gonna help build the wall"

To put it another way - Mama will keep you safe.
I can think of no better way to express the sentiment behind Ellis' 6th and 7th beliefs. They are all about dealing with life's difficulties and the notion that it's easier if someone else sorts it out for us.

I remember when I first took the plunge and became a self-employed trainer some four years ago now. I didn't have a clue about the UK tax system and instead of taking the time to learn about it I'm afraid I simply buried my head in the sand. I was a victim of Ellis' 6th irrational belief:

It is easier to avoid life's difficulties and self responsibilities.

I should say that there was never any intention to defraud or avoid the taxman. I just didn't understand the system and like, I'm told, many new businessmen I just put the whole issue to one side and got on with building my business instead.

Eventually, of course, the income tax officials caught up with me and I was presented with a bill that, quite frankly, I had no idea how to pay. Fortunately the tax office was understanding of my stupidity and they gave me a chance to pay it off in stages rather than drive me into bankruptcy but they didn't have to. I will be forever grateful to the young woman who took my call and was prepared to spend time working out an arrangement with me.

Since then I've changed my belief about life's problems and have adopted Ellis' antithetical belief:

The so-called 'easy way' is usually the 'hard way' in the long run.

Now I put a little aside every month to prepare for the inevitable tax bill and face the issue head on. After all – tax isn't a problem – it's right that we pay tax. It's not right, however to ignore the issue of tax until the end of the financial year and then wonder why we get a bill we can't possibly pay.

This lack of preparation and responsibility (let's be honest I was pretty irresponsible) links in extremely well with Ellis' 7th belief which is:

We absolutely need something or someone
stronger than ourselves upon which to rely.

In my case that someone was the accountant who helped me through the financial mess I'd created by my refusal to work on the problem. But therein lies the rub.

If we ignore the problems we are facing then we will ultimately need to rely upon others to bale us out. But we don't need to. By facing our problems head on and working to solve them in good time we can remove the need to rely upon others.

The ancient Japanese Samurai tradition valued the principle of 'no surprises' in life. According to the Samurai code it was important to be able to look along the road a little way, to anticipate what was coming next and to plan in advance to deal with it. That was my failing with the tax man and it is also the mistake that leads many other people into all sorts of difficulties in their own lives.

The antithetical belief to Ellis seventh irrational belief is:

It's better to take the risk of thinking and acting independently.

But remember that Ellis included the word 'thinking' in this. It's not enough to bury your head in the sand. To think rationally about a problem must begin with the acknowledgment of that problem. That's where I went wrong back in 2006. I wasn't rational.

The rational thinker needs no wall and certainly needs no 'mama' to help build it. Instead he or she meets the world head on and works to understand and to survive in it. This sort of independent (or more Accurately 'interdependent') approach to life is more rational and more successful than any form of reliance upon others.

A good friend of mine once Emailed me a wonderful poem by an anonymous author. It talked about how safe the tall ships are in the harbour – how the ocean storms cannot harm them and how the harbour walls protect them. It talked about the gentleness of the breeze barely lifting their big, white sails. But the last line of the poem said it all:

"But that's not what tall ships are built for."

We can rely upon other to keep us safe for our whole lives if we wish – but that's not what human beings are built for.

Emotional management 19: The best you can be

When I was a young man all I wanted to do was act. I dreamed of a life 'treading the boards' and my most specific ambition was to play 'Kent' in Shakespeare's King Lear at Stratford-upon-Avon. There was just one problem – I wasn't good enough.

So far as I can remember I first went on stage at the age of five in a Sunday School gang show. I didn't have much to do – join in with the chorus on a couple of songs and stand around making up the numbers really. That was the limit of my involvement but it was enough to inspire me. I caught the 'bug' for performing and was hooked.

As I grew older I volunteered for every school play, joined two separate amateur dramatic companies and even played the lead in a play that won first prize in a county wide theatre competition. I toured Germany with Cumbria Youth Theatre & spent a whole summer with the National Youth Theatre of Great Britain. I was a very good amateur.

However I didn't have what it took to make it as a professional. I tried – don't get me wrong. I worked for a couple of repertory companies and even started my own theatre in education concern called 'Class Theatre' but it was never going to happen. It became clear to me that 'good amateur' really translates to no more than 'mediocre professional'.

These days I'm happy to do other things. I'm still very interested in performance and occasionally return to amateur dramatic productions although I know I'll never win that Oscar. I'll never play Kent at Stratford either. That doesn't matter though – I can still enjoy immensely what I do as an amateur. At work I play to my strengths now. I'm a good nurse and a good trainer. I'm not perfect, no-one is but this just happens to be what I do best. That's enough.

Ellis' eighth irrational belief is the one that left me devastated when I finally had to admit that I wasn't the world's greatest actor:

We should be thoroughly competent, intelligent and achieving in all possible respects"

I thought that my efforts only had value if they produced excellence in all things. Those were the days when I used to berate myself for every little failing as if perfection was actually possible in all (or even any) aspect of my life.

These days I'm content to do my best. I no longer feel bad about the fact that I'm fallible. What would be the point? Fallibility is part of being human and feeling upset about it won't improve anything – in fact it will probably only make things worse. In any case fallibility is often surprisingly good for us – it's how we learn and develop. It's also how surprises come our way and many times the surprise is better than what we'd planned. These days I'm very happy to be able to say:

"I'm a good amateur."

I've realised the value of Ellis' eighth rational belief:

Do rather than do well and accept yourself as imperfect with general limitations and specific fallibilities.

That doesn't mean stop trying to improve but it does mean a healthy awareness that perfection is impossible – and that's OK. To put it another way:

Let yourself off the hook – it's OK to make mistakes from time to time. Actually it's inevitable.

Emotional management 20: Letting go

Because something once strongly affected me it should indefinitely affect me.

Ellis' ninth belief is the source of many peoples' unhappiness drawing on for years or even decades. I remember as a teenager I volunteered to help out at a local day centre for older adults. I began with an extremely inaccurate and patronising view of 'old folks' as rather sad, inadequate and essentially needy people with nothing of value to offer.

The reality was, of course, extremely different. I was amazed to discover people who could not only regale and amaze me with their stories but also impart wisdom based upon decades of experience.

I was equally amazed at the easy laughter and genuine love of life among the members, many of whom experienced real hardships ranging from poverty, disability and isolation to bereavement, pain and illness. I went there expecting to help these 'poor, dependent people' and began learning how to put my own problems into perspective instead. The stories I heard and the hardship I saw these ordinary, elderly people deal with has stayed with me for almost thirty years so far.

But there were also some individuals who took a different stance. These were the people who thought that problems from the past were still worth worrying about in the present. The stories these people told centred around who had hurt them, what they'd lost in their lives, when they'd been cheated or treated unfairly and how 'anyone' would feel bad if they'd been through all that. They justified their misery this way even though they were surrounded by people who represented living proof of the exact opposite. No matter how many years they'd spent already making themselves miserable one thing was abundantly clear. They were on course to remain bitter and resentful for the rest of their days. It was a kind of emotional life sentence that they'd imposed upon themselves.

One of the reasons for this was a basic failure to distinguish between a problem and a fact.

Problems require solutions and they demand our attention. Problems can be solved and so, by keeping them in mind we can work to make things better.

Facts are different. If problems can be solved then facts require nothing more than acceptance. Facts are unchangeable truths such as:

- Everybody dies eventually;
- Nobody is perfect;
- The past cannot be changed.

If we accept the past for what it was then we can move on. It doesn't need to destroy the present or future unless we let it. It is true that some people can become so traumatised by events that they develop post traumatic conditions that require greater intervention than others but this is not the norm.

For many of us what makes the difference is the intention to move on from our past troubles and enjoy life coupled with Ellis' ninth rational belief:

I can learn from past experiences without being overly affected or prejudiced by them.

If we believe that we can never get past earlier traumas then we really have created for ourselves an emotional life sentence.

If we believe that we can get over past troubles 'in time' then it's worth asking ourselves a simple question:

How long is long enough to put my happiness on hold because of an unchangeable past?

Alternatively we could just decide that enough is enough without making ourselves wait. We could learn the lessons that come from the experience and then move on.

This is what we mean by 'letting go'.

Emotional Management 21: Control freaks have no life

Do you enjoy making mistakes?

How do you feel about experience?

I remember reading a cliché many years ago on the back of a matchbox of all places. The simple sentence read like this:

> *"Experience is what you get when you don't get what you want"*

The implication was that the word 'experience' represented something negative but actually few things could be further from the truth. On the contrary experience, especially the experiences we didn't expect or plan for are the lessons that help us to grow. The things we cannot control are the things that broaden our horizons. Ellis' tenth belief is the idea that:

> *We need to have certain and perfect control over things.*

Even if this actually were possible it wouldn't be a good thing. To have perfect control is to have no surprises. To put it another way we could never experience anything we didn't already know about. We could never have any new experiences and never know the wonder of life. Perfect control impoverishes our quality of life.

There is, of course, a need for balance here and it would be very wrong to suggest that control is never helpful but complete and perfect control is not only impossible it would also be very limiting. Even when the experience we have appears to be negative it can have some positive aspect. To quote another cliché:

> *"Whatever doesn't kill me helps me grow"*

Sometimes of course the positive aspect is difficult to find and sometimes the disadvantages can certainly outweigh the advantages but since complete control is impossible Ellis' tenth rational belief seems much more reasonable:

> *The world is full of probability and chance*
> *but we can still enjoy life in spite of and often because of this.*

The tenth pair of beliefs go together very well with Ellis' twelfth couple. Both relate to the idea of control and together they begin to define the boundary between what we can control and what we can merely influence.

In training people to deal with 'challenging behaviours' one of the fundamental principles we begin with is the fact that we can never really control another person's behaviour unless we work in maximum security establishments. Even then their emotional life is beyond our control. All we can do is take control of our own behaviours and in doing so with thought and planning make it more likely that the other person will respond in predictable and appropriate ways.

In order to control our own behaviours we must first learn to control our own emotional life. This is what we see in police officers, paramedics, prison officers, athletes, actors and top flight salesmen every day. These people are living proof that Ellis' twelfth irrational belief is false:

> *We have virtually no control over our emotions*
> *and cannot help feeling certain things*

If we really were unable to control our emotions it would be impossible for battlefield soldiers to maintain discipline. It would also make training in issues such as anxiety or anger management useless and yet the evidence is that such training can be extremely effective.

Ellis' twelfth rational belief is:

We have real control over our destructive emotions if we choose to work at changing the 'musturbatory' hypotheses which we often employ to create them.

When we compare these two sets of beliefs we begin to understand the limits of control and the meaning of 'influence'. By taking control of our emotions and behaviours we can influence others and the world around us. An understanding of our situation and the reality of 'cause and effect' as discussed in an earlier post can help us to make certain outcomes more likely but all we can really control are our own thoughts, feelings and behaviours.

Emotional management 22: Happiness is a by-product

The last of Ellis' 12 irrational beliefs we'll cover is:

Human happiness can be achieved by inertia and inaction.

Actually the less we do the sadder and ultimately the more depressed we become. Activity brings physical, psychological and emotional benefits that simply aren't accessible by sitting around with little more than daytime TV or the internet to keep us occupied.

In clinical practice one of the most important aspects of working with depressed people is what we call 'positive action'. The more we can engage people in meaningful activity the more likely they are to make a speedy recovery. This is true whether their depression appears to be reactive or endogenous. This seems to demonstrate the reality of Ellis' eleventh rational belief:

Humans tend to be happiest when they are engaged in creative pursuits or devoting themselves to people or projects outside themselves.

So in part happiness is a by-product of some other pursuit. The late personal development guru, Earl Nightingale once defined success as:

"The progressive realisation of a worthy goal."

I think that this is another expression of the same basic principle. To work on a project is to shift focus from our problems to a more positive process of working toward solutions.

Emotional management 23:
Michael Broder's 'Destructive Emotion Tree'

Having outlined several of the basic principles of cognitive and emotional management it's time to develop a more practical and encompassing context. Shortly we'll examine Zubin & Spring's 'stress and vulnerability' model of mental health and disorder but first we'll consider Broder's 'destructive emotion tree'.

The basic principle is simple enough…..

All distressing emotions are the fruits of the tree and can only thrive if the nutrients that they need are provided by the roots. These nutrients travel along the trunk of the tree and so long as that happens the fruit, the destructive emotion, will thrive.

The fruits are such emotions as anger, rage, sadness, bitterness, guilt, shame and resentment. Emotions related to fear and anxiety are not included here because although they may become overwhelming or be inappropriate in certain situations they are essentially helpful and have evolved as a vital defence mechanism. As we outlined much earlier in this series anxiety is what keeps us safe.

http://stuartsorensen.wordpress.com/2010/02/10/emotional-management-7-freeze-flight-or-fight-the-australopithecus-and-the-sabre-toothed-tiger/

Arguably the same can be true for anger but for most modern occasions anger is more likely to be destructive than constructive.

The trunk of the tree, the basic food source and the common factor for all these destructive emotions is blame. Without blame these emotions cannot develop and, having developed they can only be maintained so long as the sense of blame is maintained as well.

Austrian abduction victim Natascha Kampusch was kidnapped at the age of 10 and locked in a cellar for eight years until she managed to escape. Her remarkable composure seems to be due to her refusal to focus upon blame but rather to acknowledge her experience and then move past it. It is blame that feeds the destructive emotions.

Blame must be based upon something and this is where the roots of the tree come in. There are three basic roots that provide the tree's nutrients – three areas of blame:

- The self;
- Other people;
- The 'system'.

Let's consider these in relation to Ellis' beliefs as we discussed previously.

Ellis' rational beliefs show us that it's OK for us to be fallible, to be unable to control the whole world, to make mistakes and to disagree with others. If we accept these things, these fallibilities, then we can avoid blaming ourselves for our inevitable human frailties. If we disagree with Ellis we lay ourselves open to feelings of guilt and shame that can blight the rest of our lives.

It is one thing to learn from and acknowledge our mistakes but to blame ourselves for the inevitable frailties of the human condition is quite another.

Ellis' beliefs also relate to others. If it's OK for me to be fallible then it's OK for others to be fallible too. If the behaviours of others cause me harm that doesn't mean that they're

'bad' people. I'd do better learning from the experience and improving my future defences than wasting energy blaming them.

In an earlier post we described Hanlon's razor, the idea that incompetence is more common than malice. Even if the hurt was deliberately caused that really is just evidence that the other person is acting from a form of moral, ethical or philosophical ignorance. They're not 'bad' people – they simply are fallible and have some stuff to learn.

To recognise their mistaken belief that they have the right to hurt other people and then to take steps to protect ourselves from them is one thing. To waste energy on blame and anger or resentment is quite another.

The 'system' equates to the world, nature and the environment. It might mean the weather, genetics, social organisation, religious doctrine, the effects of illness or the fact that all people die. There really is little point in becoming outraged at the weather or attributing malicious intent to genetic predisposition. However doing so is a very effective way to induce resentment and bitterness to come into our lives.

As ever it's better to choose beliefs and attitudes that will help us to feel positive and behave effectively than those that serve only to make us miserable and impotent. Don't feed the destructive emotion tree. Remove the blame, the food source and it will wither and die.

Emotional management 24: Introducing 'Stress and Vulnerability'

I have covered Zubin & Spring's 'Stress & Vulnerability' model of mental health and disorder (1977) before in this blog but I'd like to revisit it in rather more detail here. Over the next few posts we'll explore the principles and in doing so dispel the myth that some people are susceptible to emotional and mental disorders whilst others are not. The reality is that we are all vulnerable to differing degrees and that there is a great deal that we can do to mediate the risks we face. The logical conclusion to the model is that the vast majority of people diagnosed with serious and enduring mental disorders (SEMI) can recover and become just as able to function in the world as the rest of us.

It's over thirty years since the model was first published in 1977 although only in recent years has it begun to enjoy mainstream popularity. In part this may well be due to the inability of the medical model to demonstrate that the psychiatric assumption of an organic brain disorder and biological illness alone can explain mental disorders.

'Scientific' evidence previously heralded as 'conclusive' can be called into question with hindsight. The previously accepted 'evidence' of ventricular enlargement in the brains of 'schizophrenics' is far less significant than was previously believed (Van Horn J.D. & McManus I.C. 1999). In fact the ventricular size of so-called 'schizophrenics' overlaps greatly with that of the general population (Chua S.E. & McKenna P.J. 1995) So far as modern science is aware, there are no reliable biological markers for schizophrenia (McGrath J. & Emmerson W.B. 1999).

Moncreiff dismisses arguments supporting genetics as the sole cause of schizophrenia pointing out that the concordance of pathology in twins, siblings and other relatives is insufficient for a solely genetic cause. Additionally she rails against the "disingenious" argument that genetic understanding reduces social stigma, citing the experience of people with Alzheimer's disease as contradictory evidence (Moncreiff J. 1999).

Part of the problem lies in the subjective nature of the diagnostic criteria. Both the ICD-10 (WHO 1992) and the DSM-IV (American Psychiatric Association 1994) seem to be relatively vague. Furthermore the diagnosis actually assigns meaning retrospectively to symptoms which have not adequately been demonstrated to share any common aetiology or to follow any particular physiological process.

All this notwithstanding the psychiatric establishment seems reluctant to explore these difficulties of validity. Instead, clinicians seem to rely on what Hickling F.W. and Hutchinson G. (1999) describe as the:

> ***"…dubious succour of standardised diagnostic instruments and internal
> classification systems which have been generated
> entirely by Euro-American perspectives."***

The idea of an organic brain disorder in serious mental disorder has yet to be verified. Although it does appear likely that neurotransmitters such as serotonin and noradrenaline play a part in depression it is clear that treatment requires much more than merely medication.

Experience also shows that it is entirely possible for people with mild to moderate depressive disorders to overcome their problems without medication so long as they intervene early enough. Medication has a place in the treatment of all forms of mental disorder but it's far from the whole story and cannot even reliably be said to be any more important than any other.

The basic idea behind the Stress & Vulnerability model is that all people are at risk of developing mental disorders if they are exposed to enough stress. Stress comes in many different forms including:

- Biological;
- Psychological;
- Environmental;
- Socio-cultural;
- Developmental.

Different people are vulnerable to different degrees and in different ways but all of us, if faced with enough stress will develop emotional and psychological symptoms. This is why (to focus upon the medical concept of biology for a moment) some people are relatively unaffected by substances such as cannabis whilst others become psychotic almost immediately. They have different degrees of biological vulnerability.

It is this 'biological' vulnerability that underpins the biomedical model of psychiatry. That's why medications are prescribed – biological/chemical treatments for biological/chemical problems. For those people who have a predominantly biological vulnerability medication is likely to be very effective but for those who have predominantly psychological or environmental stressors a different emphasis is needed. That does not mean that biomedical psychiatry has no value but rather that it is a relatively small and essentially limited approach to a much bigger set of problems. That's why many people show no improvement with medication alone and increased doses merely tranquilise and cause distressing, sometimes permanent or even fatal side effects.

As this series progresses to cover 'serious and enduring mental illness' (SEMI) such as schizophrenia or bipolar affective disorder (formerly known as 'manic-depression') we'll draw upon all that has gone before and pull it together through Zubin & Spring's original model.

This is the essence of Psychosocial Interventions (PSI), a growing field not only in UK but also throughout much of the rest of Europe.

It is through the techniques and the philosophical, essentially 'normalising' perspective of PSI that the biomedical model of psychiatry is becoming less dominant and recovery is becoming increasingly a realistic possibility.

I would like to reiterate though that I am not denying the role of medication. However over the next few posts I will attempt to show that recovery requires much more than that and that over-reliance upon medication actually maintains illness, dependence and a sense of helplessness. This is what we mean by 'iatrogenic' (physician-created) damage.

"Iatrogenesis is a general term for any kind of medical treatment which makes people ill or adds problems to their original troubles."
(Gomm R., 1996, p.82)

A number of articles outlining the iatrogenic damage caused by psychiatric treatments can be accessed by clicking the links below.

http://www.politicsofhealth.org/main/brain_disabling_treatments_in_psychiatry

http://www.mindfreedom.org/kb/psychiatric-drugs/antipsychotics/neuroleptic-brain-damage

References

47

American Psychiatric Association (1994)
Diagnostic and Statistical Manual of Mental disorders
American Psychiatric Association
Washington, D.C.

Chua S.E. & McKenna P.J. (1995)
Schizophrenia – a brain disease? A critical review of structural and functional cerebral abnormality in the disorder
British Journal of Psychiatry
Vol. 166, pp. 563-582

Gomm R. (1996)
Reversing Deviance in:
Heller T. et al (Eds.) (1996)
Mental Health Matters (a reader)
The Open University
Macmillan Press Ltd.
Basingstoke

Hickling F.W. & Hutchinson G. (1999)
Roast breadfruit psychosis: disturbed racial identification in African-Carribeans
Psychiatric Bulletin
Vol. 23 pp. 132-4

McGrath J. & Emmerson W.B. (1999)
Treatment of Schizophrenia
British Journal of Medicine
Vol 319. pp. 1045-8

Moncreiff J. (1999)
Critical review overstates genetic case for human behaviour
British Journal of Medicine
Vol 319. p.1498

Van Horn J.D. & McManus I.C. (1999)
Ventricular Enlargement in Schizophrenia
British Journal of Psychiatry
Vol 160, pp.687-697

WHO (1992)
The ICD-10 Classification of Mental and behavioural disorders
World Health Organisation
Geneva

Zubin J/ & Spring B. (1977)
Vulnerability – a new view of schizophrenia
Journal of Abnormal Psychology
Vo. 86, No. 2, pp. 103-124

Emotional management 25: Stress & Vulnerability in PSI

In order to place the Stress & Vulnerability model in the context of working with people suffering from Serious & enduring Mental disorders I think the most straightforward approach is simply to post one of my old assignments. This was the first assignment for my Post Grad Diploma and was written back in 2002. As such the references cited are a little dated but the point still holds.

Actually the model has become much more mainstream since then and has garnered support from several different quarters including mainstream psychiatry. This isn't quite so surprising as many people think since the model does incorporate the biomedical model as well and modern applications do recognise the validity of appropriate medication.

Where it may differ from traditional psychiatry is where it asserts that medication is not the only solution and that mental disorders are at least as likely to be the result of psychological, social and environmental factors as the result of biochemical imbalances.

**With reference to contemporary literature,
discuss the Stress Vulnerability model and the implications of this for PSI**

Stuart Paul Sorensen

"Psychosocial treatments can be divided into three general categories which have a separate set of clinical procedures and aims. These are:

Family intervention;
Cognitive Behaviour Therapy for psychotic symptoms; and
Early signs monitoring and Early Intervention."
(Tarrier N. et al (1999)

There is a growing body of evidence in support of both the Stress-Vulnerability model of schizophrenia (Zubin J. and Spring B., 1977) and the use of psychosocial interventions (Mortimer A.M. 2001) as an effective therapeutic tool. This assignment seeks briefly to examine the model itself and then to discuss its' implications for Psycho-Social Interventions (PSI). References will mainly be drawn from 'contemporary' literature, which has been interpreted as literature published within the last ten years.

'Stress reactions' can be defined as emotional expressions of biological reactions to challenging circumstances.

 "When emotional arousal is present for a prolonged period, or when it reaches a very high level, this reaction is described as 'stress'." (Barker P. 1993)
According to the Stress-Vulnerability model of Schizophrenia the degree of stress experienced by clients is a major determinant in the development of episodes of mental disorder (Craig T.K.J. 1996). In particular the stress associated with living in an environment of High Expressed Emotion (EE) is an extremely important contributor to psychotic episodes among vulnerable clients (Hirsch S.R. & Bristow M.F. 1993) (Moorey S. 1996) (Leff J. 1998), (Haddock G. 1999) (Bradley S.J. 2000) (Morrissey M. 1999).

It is interesting to note the findings of one comparative study which suggested that the improved outcome in psychotic patients in India, as opposed to in London, may largely be due to the Indian families being more accepting of their relatives than their English counterparts (Leff J. et al 1990).

However not everyone is convinced that EE has any significant impact upon psychosis at all. Indeed it may be no more than a marker which points us to other issues such as poor cognitive ability or familial coping strategies (Hall M.J. & Docherty N.M. 2000) but that, in itself, has no direct correlation with mental illness. In one recent study it was found that familial EE level was much less important than the quality of interaction between client and case manager (Tattan T. & Tarrier N. 2000). If so then the concept of high familial EE and by extension the Stress-Vulnerability model itself may be no more than a return to the family scapegoating of earlier days (Wuerker A.K. 2000). This view is echoed by Tennant (Tennant D. 1993) who argues that the drive toward family therapy as a positive intervention can easily lose its way and become little more than a method of blame attribution. This can further exacerbate the guilt many families feel when faced with the emotional turmoil of living with serious mental disorder.

Whatever the truth of the matter it is certainly the case, as shall be demonstrated later, that direct work upon the levels of EE in families has been repeatedly linked to better outcomes in schizophrenia.

High Expressed Emotion environments feature unusually high degrees of criticism and hostility (Kavanagh D.J. 1992) and emotional over-involvement ((Hooley, J.M. 1998). This is remarkably similair to the work on 'Invalidating Environments' (Linehan M.M. 1993). The 'Invalidating Environment', it has been suggested, is a significant factor in the development of 'Borderline Personality Disorder', which also has marked psychotic features. Indeed the transient psychotic episodes so characteristic of Borderline Personality Disorder have been likened to Post-Traumatic Stress Disorder (Kroll J. 1988).

However any form of stressful experience, if sufficiently intense, can precipitate relapse (British Psychological Association 2000) (Norman R.M.G. & Malla A.K. 1993). And it seems that the intensity, or rather the individual's ability to cope with that intensity - their vulnerability - is the other half of the equation.

"Vulnerability is defined as a factor's ability to raise the risk of onset only in the presence of a provoking agent." (Craig T.K.J. 1996)

According to Zubin and Spring (1977) individuals vary in their ability to withstand stressful events. They postulate that in sufficiently stressful circumstances each and every one of us would be at risk of psychotic episodes and that the frequency, duration and intensity of these episodes are functions of our individual degree of vulnerability. They suggest that this vulnerability is both genetically and developmentally determined which explains why people respond differently to similair stressors.

"…it is an individual's own perception of the stressfulness of an event that ultimately defines the severity of the load." (Zubin and Spring 1977)

It is the twin approach of environmental stressors and genetics, of nature and nurture, which makes the stress vulnerability model so compelling. Since the early nineteenth century the hereditary aspect of disorders such as schizophrenia has been recognised (Gottesman I. 1991). However the hereditary or genetic model alone is clearly insufficient.

"Such familial clustering of schizophrenia, while supporting a genetic basis for the disease, does not rule out a shared environmental aetiology." (Scourfield J.E. & McGuffin P. 1999)

The concept of stress vulnerability is further supported by the finding that the objective level of stress is less important than the subjective ability of schizophrenia sufferers to deal with it (Norman R.M.G. & Malla A.K. 1993).

Today the stress vulnerability model is widely accepted (Goldberg D. 2001) (Barker P. 1993) (Kerwin R. & Owen M. 1999) (Royston M.C. & Lewis S.W. 1993). However, it must be acknowledged that so far the theoretical basis for the model has not been clearly established. Clinical observation provides extremely strong grounds for accepting the concept of Stress-Vulnerability but to date research has not established any definitive proof of the existence of a genetic component (Bradley S.J. 2000) (Norman R.M.G. & Malla A.K. 1993a). Indeed, should such a link be proven this will not, in itself, necessarily provide us with a definite cause for schizophrenia.

Within the concept of genetic vulnerability there may well be several discrete genetic factors, which we are still unable to identify (Bradley S.J. 2000). The hunt for the specific genes implicated in Schizophrenia continues (Kerwin R. & Owen M. 1999) and yet this specific awareness is perhaps less important to current sufferers than an understanding of sound clinical interventions based upon the increasingly plausible model:

"….treatment can often not await a thorough knowledge of aetiology.."
(Zubin J. & Spring B. 1977)

The model's implications for treatment and therapeutic clinical practice are manifold. If we accept the genetic vulnerability hypothesis then we must, by definition, accept that the psychological playing field in respect of psychotic episodes is far from level. There are individuals within our society who are at far greater risk than the average of serious mental disorder. Perhaps this, in part, explains the current targeting of mental health resources toward those individuals with serious mental illnesses.

If we accept, as the model proposes, that environmental stressors also play a major part in the development and maintenance of these disorders then the logical response must be to find ways to reduce environmental stressors and also to help vulnerable individuals to deal with them. (May R. 2000)

Furthermore, given that the stress experienced by families dealing with serious mental illness tends to escalate and become a vicious cycle (Whyte W. & Robb Y. 1999) (Bradley S.J. 2000) there is clearly a need for early monitoring and early intervention.

"Psychosis may be toxic to the brain. Also, social and psychological damage done may be irreversible. The 'critical period' hypothesis suggests that given these new insights into the illness there may be a window of opportunity for intervening early." (Whitwell D. 2001)

It is unfortunate that this remains largely undone almost twenty five years after Zubin and Spring's passionate call for clinicians and researchers alike to focus their efforts upon finding ways to reduce vulnerability instead of searching for an elusive 'cure' for a disorder which, they argued, in many cases actually is 'self-curing' (Zubin J. & Spring B. 1977).

The relatively recent concept of 'Psycho-Social Interventions' aims among other things to address precisely these issues. In fact it is arguable that rather than thinking of the Stress-Vulnerability model as having implications for PSI, we may consider PSI to be the direct descendant of the model, following its' lead just as the proverbial cart follows the horse.

Let us briefly examine some of the ways in which PSI has taken this model and used it to shape clinical practice.

Family interventions

The concept of high Expressed Emotion, particularly among families, is central to the implementation of Psycho-Social Interventions. As we have already noted there is a wealth of research suggesting that high expressed emotion within the family is a major determining factor in the development of psychotic episodes (Fisher D. 2000).

"All children, even those who were believed to be carrying some genetic vulnerability, did well in 'healthy', adaptive families. In other words, families seemed to play a crucial role both in increasing and protecting against, genetic risk." (British Psychological Association 2000)

For this reason a large element of the PSI approach is focussed upon helping the family with interventions such as training in problem solving (MacDonald E.P. et al 1998) and other coping strategies (Meuser K.Y. et al 1992) as well as specific education about the disorder itself (Beck R. 1999).

The provision of anxiety management training for both service-users and their carers is extremely effective in reducing the level of Expressed Emotion in a family and this is another aspect of Psycho-Social Interventions which relates directly to the stress-vulnerability model (Baker P. 1999).

In particular Cognitive-Behavioural interventions have been found to be of immense value both with families and with individual clients who are vulnerable to psychosis. There is good evidence from randomised, controlled trials which demonstrates that people suffering from schizophrenia who also inhabit high Expressed Emotion households generally have significantly better outcomes with CBT than their counterparts in Low Expressed Emotion families who don't have access to CBT (Haddock G. 1999).

Individual therapy

"Real help, I know now, would have consisted in acknowledging my suffering as real, and in guiding me toward ways of living with disappointment, rather than stamping out its existence with drugs." (Chamberlain J. 1999)

As we have already noted the value of CBT based approaches should not be under-estimated. In the context of individual therapy it has a major impact upon the client's ability to deal with stress, thus heightening their stress-vulnerability threshold (Haddock G. 1999) (British Psychological Association 2000). This is reportedly extremely effective, in part because of its emphasis on collaboration which seeks to foster a sense of ownership and control in the client by the use of experimentation, reality testing and Socratic questioning techniques (Turkington D. & Siddle R. 1998).

Hodel B. et al (1988) used a package called 'Emotional Management Therapy' (EMT) to teach relaxation and enhance coping skills and noted an increase in cognitive functioning in both 'early' and 'chronic' patients with psychosis.

Early monitoring and intervention

Given the detrimental effect which repeated episodes of psychosis can have on both individual and group functioning (Whitwell D. 2001) the concept of early monitoring and early intervention is central to PSI (Jackson C. 1998). It is envisaged that early intervention will be a major factor in the prevention of relapse (Falloon I.R.H. et al 1998) (McGlashan T.H. 1998).

As is the case with more chronic sufferers and also in family interventions Cognitive-Behavioural strategies seem to be extremely effective in the area of early intervention

(Jackson H. et al 1998). However, according to at least one clinical psychologist (Haddock G. 1999), research evidence for the use of CBT strategies in early intervention (or with dual diagnosis patients) is insufficient to date. She does however, acknowledge the likely benefits of this approach. Tarrier et al (1999) make the point that the evidence for individual CBT in early intervention is currently weaker than it is for family intervention. Tarrier also points out that the long term benefits of this approach are, as yet, unknown but early evidence is extremely promising.

Medication management

According to the Stress-Vulnerability model there is a major genetic and organic aspect to psychotic disorders. For this reason PSI is also interested in the use of medication to control symptoms and in ways to ensure safe administration and appropriate use of/compliance with drugs (Mortimer A.M. 2001) (Leff J. 1998). It has been found that a collaborative approach to medication administration, along with other interventions is helpful in maintaining mental health (Tarrier et al 1999) (Gourmay K. 1999).

Yet PSI remains a tripartite model of intervention and it is important that medication is not seen as substantively more important than the other interventions. Whilst it is clear that medication has its place in mental health care it is far from the only option. As discussed above the multi-faceted approach of medication, family intervention and CBT has been demonstrated to be far more effective than any single approach.

Conclusions

Having considered the core assertions of the Stress-Vulnerability model of Schizophrenia we have identified the main areas of clinical need which the model suggests. We have also considered the implications of these areas of needs for Psycho-Social Interventions and have found that there is a high correlation between the needs identified by the model and the clinical application of PSI. We have further evaluated the efficacy of PSI techniques in the light of the Stress-Vulnerability model's implications.

In conclusion it appears that there are many implications within the model for the clinical care of mentally vulnerable people and that PSI in particular emerges as a direct response to the earlier work of Zubin and Spring (1977) which aims to build upon the model in a practical and constructive way.

References

Baker P. (1999) <u>Can You Hear Me?</u> Handsell Publishing, Nottingham, Section 7 (no page number).

Barker P. (1993) in Wright H. & Giddey M. (Eds.) (1993) <u>Mental Health Nursing</u> Chapman and Hall. London. p.103., p.107.

Beck R. (1999) <u>Support for the carers of people with schizophrenia</u> *Nursing Times* Vol 95, No. 2 pp.46-47.

Bradley S.J. (2000) <u>Affect Regulation and the Development of Psychopathology</u> The Guildford Press, New York. p.76. p.262

British Psychological Association (2000) <u>Recent advances in understanding</u> <u>mental illness and psychotic experiences</u> British Psychological Society, Leicester. P.24, p.25, p.29,

Chamberlain J. (1999) <u>The Medical Model and Harm</u> in:
Barker P., Coleman R. & Davidson B. (1999) *From the Ashes of Experience: Reflections on madness, survival and growth* Whurr Publishers, London pp.170-177

Craig T.K.J. (1996) Adversity and Depression *International Review of Psychiatry* Vol. 8, pp.341-353.

Falloon I.R.H. et al (1998) Early intervention for schizophrenic disorders: implementing optimal treatment strategies in routine clinical services *British Journal of Psychiatry* Vol. 172 (supplement 33) pp.33-38.

Fisher D. (2000) Hope, Humanity and Voice in Recovery from Mental Illness in:
Barker P., Coleman R. & Davidson B. (2000) *From the ashes of experience: reflections on madness, survival and growth* Whurr Publishers, London pp.127 - 133.

Goldberg D. (2001) Vulnerability factors for common mental illnesses *British Journal of Psychiatry* Vol. 178 (supplement 40) pp.69-71.

Gottesman I. (1991) Schizophrenia Genesis: the origins of madness W.H. Freeman & Co., New York pp. 12-16

Gourmay K. (1999) Management of Schizophrenia *Mental Health Practice* Vol. 2, No. 9, pp.33-38

Haddock G. (1999) Cognitive-behavioural treatment of psychosis *Continuing Professional Development Bulletin - Psychiatry* Vol 1. No. 3, pp.84-88.

Hall M.J. & Docherty N.M. (2000) Parent coping styles and schizophrenic behaviour as predictors of expressed emotion *Family Process* Vol. 39, No. 4, pp.435-44

Hirsch S.R. & Bristow M.F. (1993) *Current opinion in Psychiatry* Vol. 6, pp. 53-57.

Hodel B. et al (1998) Emotional management therapy in early psychosis *British Journal of Psychiatry* Vol. 172 (supplement 33) pp.128 - 133.

Hooley J.M. (1998) Expressed Emotion and Locus of control *The Journal of Nervous and Mental diseases* Vol.186, No.6, pp.374-378.

Jackson C. (1998) Catching them young *Mental Health Care* Vol. 1 No. 9 pp. 288-290.

Jackson H. et al (1998) *British Journal of Psychiatry* Vol. 172 (supplement 33) pp.93 - 100.

Kavanagh D.J. (1992) Recent Developments in Expressed Emotion and Schizophrenia *British Journal of Psychiatry* Vol. 160, pp.601-620.

Kerwin R. & Owen M. (1999) Genetics of novel therapeutic targets in schizophrenia *British Journal of Psychiatry* Vol 174 (supplement 38) pp. 1-4

Kroll J. (1988) The Challenge of the Borderline Patient Newton & Co., New York

Leff J. (1998) Needs of the families of people with schizophrenia *Advances in Psychiatric Treatment* Vol. 4, pp277-284.

Leff J. et al (1990) Relatives' expressed emotion and the course of schizophrenia in Chandigarh *British Journal of Psychiatry* Vol 156 pp.351 - 356.

Linehan M.M. (1993) Cognitive-Behavioral Treatment of Borderline Personality Disorder The Guildford Press, New York pp.56-58.

MacDonald E.P. et al (1998) Stress and coping in early psychosis *British Journal of Psychiatry* Vol 172 (supplement 33) pp. 122-127.

McGlashan T.H. (1998) Early detection and intervention of schizophrenia: rationale and research *British Journal of Psychiatry* Vol. 172 (supplement 33) pp.3-6

May R. (2000) Psychosis and Recovery *OPENMIND Magazine* No 106 pp.24-25

Meuser K.T. et al (1992) An Assessment of the Educational Needs of Chronic Psychiatric Patients and their Relatives *British Journal of Psychiatry* Vol. 160 pp. 674-680

Mortimer A.M. (2001) First-line atypical antipsychotics for schizophrenia are appropriate - with psychosocial interventions *Psychiatric Bulletin* Vol.25, pp.287-288.

Morrisey M. (1999) Fellow Feelings *Nursing Times* Vol. 95, No. 21 pp.38-39.

Moorey S. (1996) Cognitive Behaviour therapy for whom? *Advances in Psychiatric Treatment* Vol. 2, pp. 17-23.

Norman R.M.G. & Malla A.K. (1993) Stressful life events and schizophrenia 1: A review of the research *British Journal of Psychiatry* Vol. 162 pp 161-166.

Norman R.M.G. & Malla A.K. (1993a) Stressful Life Events and Schizophrenia 2: Conceptual and Methodological Issues *British Journal of Psychiatry* Vol. 162, pp. 166-174

Roystom M.C. & Lewis S.W. (1993) *Current Opinion in Psychiatry* Vol. 6, pp.70-73

Scourfield J.E & McGuffin p. (1999)*Advances in Psychiatric Treatment* Vol. 5, pp.39-45

Tarrier N. et al (1999) The dissemination of innovative cognitive-behavioural psychosocial treatments for schizophrenia *Journal of Mental Health* Vol. 8, No. 6, pp. 569-582.

Tattan T. & Tarrier N. (2000) The expressed emotion of case managers of the seriously mentally ill: the influence of expressed emotion on clinical outcomes *Psychological Medicine* Vol. 30, No. 1, pp.195-204

Tennant D. (1993) The place of the family in mental health nursing: past, present and future *Journal of Advanced nursing* 18: p.755

Turkington D. & Siddle R. (1998) Cognitive therapy for the treatment of delusions *Advances in Psychiatric Treatment* Vol. 4 pp.235-242.

Weurker A.K. (2000) The family and Schizophrenia *Issues in Mental Health nursing* Vol. 21, No. 1, pp.127-41

Whyte W. & Robb Y. (1999) Families under stress: how nurses can help *Nursing Times* Vol. 45 No. 37, pp. 50-52.

Whitwell D. (2001) *Psychiatric Bulletin* Vol. 25, pp.146 -148.

Zubin J. & Spring B. (1977) Vulnerability - a new view of schizophrenia. *Journal of Abnormal Psychology* Vol.86, No.2, pp.103-124.

Emotional Management 26: Pathologising Personality

I had an interesting telephone call last night. It was from a man I've known for many years who, among other things, was concerned that he has 'obsessive-compulsive personality disorder'. I should say from the beginning that I do not for one moment think that he is correct in this but he's been on the internet and looked up all the personality disorder classifications until eventually he found one that he thinks 'fits'. There's a certain inevitability with this kind of self-diagnosis.

Whatever you look for you can find if you search long enough.

This man is successful and hard-working. He's been able to remain in a stable marriage for several decades and has managed to maintain a number of good friendships too. He is a respected member of his community both in the 'real world' and on line and is generally well thought of.

He does have a number of personality traits that feature in the criteria for personality disorders of one type or another but then again – so do we all. These traits are not in themselves sufficient to justify diagnosis and they are not 'all encompassing and pervasive'.

I'm not sure I managed to make these points sufficiently well to reassure him but that's not really the focus of this post anyway. Rather I'd like to witter on a bit about the other thing he said which was about appropriate treatment. Please bear in mind that his personality traits (which essentially revolve around attention to detail and methodical working) have helped to make him the respected professional person he is today. In my Northern English culture we'd say that he has a good 'work ethic'. He would have said the same until recently.

Now – because he thinks he recognises himself in a list of ICD-10 criteria he has decided that rather than having certain character traits he has a disordered personality that must be treated. He has devalued himself in an instant and begun to think of himself as somehow faulty as a person. This is interesting.

*So where does the diagnostic category of
personality disorder come from anyway?*

Essentially the diagnostic manuals used in UK (ICD-10 and increasingly DSM-IV) classify personality disorders as collections of personality traits that differ from the 'norm' and that leave people open either to distress (sometimes called the secondary PDs) or create problems for others (sometimes known as the primary PDs). Obsessive Compulsive Personality Disorder falls into the category of 'secondary' personality disorders.

Essentially then the diagnosis suggests that this man is prone to anxiety related symptoms revolving around perseverant thoughts and disproportionate reactions to situations that don't meet his standards. But there are various problems here:

- What criteria can be used to say that a person's character traits are unsatisfactory or disordered?
- Who has the right to say what personality traits are or are not disordered?
- If this man's personality has helped him to be successful then what's wrong with that?

If a personality disorder diagnosis simply reflects the likelihood of mental health problems (basically anxiety, depression or psychosis) then should we be trying to treat personality at all or rather should we simply concentrate on treating the symptoms of anxiety, depression and psychosis.

In truth most people don't try to treat personality disorder itself because that's neither useful nor (arguably) possible. In that sense we do work on symptoms of distress and use the personality disorder criteria to help us to anticipate likely issues that may come up. In that sense there is value in the diagnosis of personality disorder.

Where it becomes less helpful is in the way that the diagnosis is considered. Rather than talk about a personality disorder which does, of course, imply a faulty person it seems to me much more reasonable to talk about susceptibility to certain symptom groups and perhaps open up a wider discussion about personality traits that may be worked on as particular issues. This is far more useful and person-centred than simply establishing diagnostic pigeon holes to try and fit people into. It is also far more helpful in assisting people to move past the diagnostic criteria and develop different coping skills.

This doesn't mean that they have changed their personality – simply that they no longer meet the diagnostic criteria.

You'd be forgiven for thinking that not meeting the criteria for personality disorder and changing your personality are the same thing but I don't think that they are at all. You see the diagnostic categories in ICD-10 and DSM-IV are based very much upon behaviour as an expression of personality and behaviour can be changed by developing new coping. This doesn't mean the personality has changed but then the psychiatric criteria don't reflect personality nearly so well as many people imagine. They reflect coping skills and the effectiveness of an individual's coping in dealing with distress.

In short many personality disorder diagnoses simply mean that the panels of psychiatrists who developed them think your coping skills are unacceptable. It may well be that a group of middle class and wealthy professionals will behave and think differently from the majority of people they come into contact with. That's hardly surprising. But is it really appropriate to judge the behaviours of ordinary people by the standards of a privileged group of senior professionals?

Even if it is OK to make that (inevitably biased) value judgement that only means that the person has some problems with certain areas of coping. The obvious next step then is not to write off the individual as hopeless but rather to help them to develop different coping styles and strategies.

In terms of the stress and vulnerability model we described earlier it becomes clear that personality disorder criteria do not so much imply a faulty person as highlight specific areas of vulnerability to work on. Unfortunately that is not how most people view them. In the public domain those people who have heard the term personality disorder think of it as something terrible and unmanageable. Many professionals have an equally hopeless attitude toward these diagnoses.

> ***In fact a little game I like to play when professionals tell me that someone has a personality disorder is simply to ask them which one.***

Try it – you'll be amazed at how many of them don't understand the question. They haven't ever bothered to learn about the many forms of personality disorder that exist in the diagnostic manuals, how they differ or what the different problems are that are associated with each one. They simply see 'personality disorder' as the term we use for the hopeless cases that really cannot be helped.

For these poorly educated psychiatric professionals the term personality disorder really means:

> ***'people we don't like and with whom we can't make a difference'***

Please don't misunderstand me – I'm not saying that all psychiatric professionals are poorly educated – far from it. But those who have not even bothered to learn the meanings of the labels they so easily stick on to their fellow men and women most certainly do fit that description. A really useful yard stick is to ask them what 'borderline personality disorder' means.

If they talk about 'half a personality disorder' or differentiate between the 'borderline' and the 'full blown' then it's a very safe bet that they don't really know what they're talking about.

It's unfortunate that this idea of hopelessness is such a prevalent attitude because with a little thought and an awareness of the value based nature of the diagnosis itself we can get past the red-herring of personality disorder classification and begin working on genuine coping strategies instead – just as we do with everyone else.

If we delve a little deeper into the implications of stress and vulnerability we quickly hit the inevitable conclusion that all mental health problems are exacerbated and in many cases caused and maintained almost completely by personality traits. It is our ability to cope, our habitual behaviours and thought patterns that contribute most to our distress. These are the basic sources of diagnostic evidence for the personality disorders.

So then if all distressed people have personality traits that contribute to their problems why do we need to single some of those traits out as 'disordered' and not others? Isn't the task of mental health care to help people to work on their vulnerabilities, whatever they are, without getting into pejorative labelling and value judgements about faulty people?

It may well be that the man I spoke to last night would benefit from examining and evaluating some of his habits and thought processes - the things that personality assessments are based upon. It may be that this would help him to feel more relaxed in some situations. However that doesn't mean it's fair to label his personality as disordered – he simply has some vulnerabilities that he can choose to address or not. So have we all.

Many of us argue that it's better to consider symptoms and work on specific problems than write people off simply because their habits and values don't match what a group of psychiatrists considered to be 'normal' or 'acceptable' when they devised their diagnostic manuals. Additionally, in the case of my friend, it may be more appropriate to remember that a psychiatrist's classification of acceptable and unacceptable personality types isn't necessarily relevant to his circumstances or situation.

After all – who is a psychiatrist to pronounce upon the **acceptability** of personality types? Psychiatrists are trained in medicine – they're not equipped to make social value judgements and their diagnoses don't always take into account the needs of different people in different circumstances.

For example Antisocial Personality Disorder may well be a major advantage in certain branches of the armed forces, Histrionic Personality Disorder may be hugely helpful in the service industry or entertainment and Obsessive Compulsive Personality Disorder has major advantages in my friend's line of work where attention to detail and the ability to stick with a project until it's completed makes the difference between success and failure on a daily basis.

Sometimes it's better to remember the old adage:

If it aint broke – don't fix it

Emotional Management 27: The baloney detector

When addressing psychological vulnerability for people with or without psychiatric diagnoses one of the most important steps is helping them to understand evidence and how to make sense of their perceptions as well as the information that comes from others. This is particularly important when working with people who have diagnoses of psychotic disorders such as schizophrenia because it is a huge element in relapse prevention work. However it is equally important for other disorders such as anxiety or depression.

In essence we teach people to understand and use scientific methodologies when making sense of their situations and experiences. This relates to the earlier post on Hanlon's and Ockham's razors as well as the general 'thinking errors' described previously. Delusion formation is essentially based upon errors in interpretation so helping people to make rational interpretations is extremely important.

I did consider writing a full account of the principles used for this blog but it occured to me that there's very little point in attempting to reinvent the wheel. So I have decided instead to simply post a link to Michael Shermer's excellent set of principles – the 'Baloney Detection kit'. Enjoy….

http://homepages.wmich.edu/~korista/baloney.html

For this, 'paper' copy of the Emotional Management series I've cut and pasted the contents of the above link below: The following passages are the work of Michael Shermer as credited above:

"*How to draw boundaries between science and pseudoscience*

  By MICHAEL SHERMER

When lecturing on science and pseudoscience at colleges and universities, I am inevitably asked, after challenging common beliefs held by many students,``Why should we believe you'' My answer: ``You shouldn't''

I then explain that we need to check things out for ourselves and, short of that, at least to ask basic questions that get to the heart of the validity of any claim. This is what I call baloney detection, in deference to Carl Sagan, who coined the phrase Baloney Detection Kit. To detect baloney--that is, to help discriminate between science and pseudoscience-- I suggest10 questions to ask when encountering any claim.

1. How reliable is the source of the claim?

Pseudoscientists often appear quite reliable, but when examined closely, the facts and figures they cite are distorted, taken out of context or occasionally even fabricated. Of course, everyone makes some mistakes. And as historian of science Daniel Kevles showed so effectively in his book The Baltimore Affair, it can be hard to detect a fraudulent signal within the background noise of sloppiness that is a normal part of the scientific process. The question is, Do the data and interpretations show signs of intentional distortion? When an independent committee established to investigate potential fraud scrutinized a set of research notes in Nobel laureate David Baltimore's laboratory, it revealed a surprising number of mistakes. Baltimore was exonerated because his lab's mistakes were random and nondirectional.

2. Does this source often make similar claims?

Pseudoscientists have a habit of going well beyond the facts. Flood geologists (creationists who believe that Noah's flood can account for many of the earth's geologic formations) consistently make outrageous claims that bear no relation to geological science. Of course, some great thinkers do frequently go beyond the data in their creative speculations. Thomas Gold of Cornell University is notorious for his radical ideas, but he has been right often enough that other scientists listen to what he has to say. Gold proposes, for example, that oil is not a fossil fuel at all but the by-product of a deep, hot biosphere (microorganisms living at unexpected depths within the crust). Hardly any earth scientists with whom I have spoken think Gold is right, yet they do not consider him a crank. Watch out for a pattern of fringe thinking that consistently ignores or distorts data.

3. Have the claims been verified by another source?

Typically pseudoscientists make statements that are unverified or verified only by a source within their own belief circle. We must ask, Who is checking the claims, and even who is checking the checkers? The biggest problem with the cold fusion debacle, for instance, was not that Stanley Pons and Martin Fleischman were wrong. It was that they announced their spectacular discovery at a press conference before other laboratories verified it. Worse, when cold fusion was not replicated, they continued to cling to their claim. Outside verification is crucial to good science.

4. How does the claim fit with what we know about how the world works?

An extraordinary claim must be placed into a larger context to see how it fits. When people claim that the Egyptian pyramids and the Sphinx were built more than 10,000 years ago by an unknown, advanced race, they are not presenting any context for that earlier civilization. Where are the rest of the artifacts of those people? Where are their works of art, their weapons, their clothing, their tools, their trash? Archaeology simply does not operate this way.

5. Has anyone gone out of the way to disprove the claim, or has only supportive evidence been sought?

This is the confirmation bias, or the tendency to seek confirmatory evidence and to reject or ignore disconfirmatory evidence. The confirmation bias is powerful, pervasive and almost impossible for any of us to avoid. It is why the methods of science that emphasize checking and rechecking, verification and replication, and especially attempts to falsify a claim, are so critical.

When exploring the borderlands of science, we often face a ``boundary problem'' of where to draw the line between science and pseudoscience. The boundary is the line of demarcation between geographies of knowledge, the border defining countries of claims. Knowledge sets are fuzzier entities than countries, however, and their edges are blurry. It is not always clear where to draw the line. Last month I suggested five questions to ask about a claim to determine whether it is legitimate or baloney. Continuing with the baloney-detection questions, we see that in the process we are also helping to solve the boundary problem of where to place a claim.

6. Does the preponderance of evidence point to the claimant's conclusion or to a different one?

The theory of evolution, for example, is ``proved'' through a convergence of evidence from a number of independent lines of inquiry. No one fossil, no one piece of biological or

paleontological evidence has ``evolution'' written on it; instead tens of thousands of evidentiary bits add up to a story of the evolution of life. Creationists conveniently ignore this confluence, focusing instead on trivial anomalies or currently unexplained phenomena in the history of life.

7. Is the claimant employing the accepted rules of reason and tools of research, or have these been abandoned in favor of others that lead to the desired conclusion?

A clear distinction can be made between SETI (Search for Extraterrestrial Intelligence) scientists and UFOlogists. SETI scientists begin with the null hypothesis that ETIs do not exist and that they must provide concrete evidence before making the extraordinary claim that we are not alone in the universe. UFOlogists begin with the positive hypothesis that ETIs exist and have visited us, then employ questionable research techniques to support that belief, such as hypnotic regression (revelations of abduction experiences), anecdotal reasoning (countless stories of UFO sightings), conspiratorial thinking (governmental cover-ups of alien encounters), low-quality visual evidence (blurry photographs and grainy videos), and anomalistic thinking (atmospheric anomalies and visual misperceptions by eyewitnesses).

8. Is the claimant providing an explanation for the observed phenomena or merely denying the existing explanation?

This is a classic debate strategy--criticize your opponent and never affirm what you believe to avoid criticism. It is next to impossible to get creationists to offer an explanation for life (other than ``God did it''). Intelligent Design (ID) creationists have done no better, picking away at weaknesses in scientific explanations for difficult problems and offering in their stead. ``ID did it.'' This stratagem is unacceptable in science.

9. If the claimant proffers a new explanation, does it account for as many phenomena as the old explanation did?

Many HIV/AIDS skeptics argue that lifestyle causes AIDS. Yet their alternative theory does not explain nearly as much of the data as the HIV theory does. To make their argument, they must ignore the diverse evidence in support of HIV as the causal vector in AIDS while ignoring the significant correlation between the rise in AIDS among hemophiliacs shortly after HIV was inadvertently introduced into the blood supply.

10. Do the claimant's personal beliefs and biases drive the conclusions, or vice versa?

All scientists hold social, political and ideological beliefs that could potentially slant their interpretations of the data, but how do those biases and beliefs affect their research in practice? Usually during the peer-review system, such biases and beliefs are rooted out, or the paper or book is rejected.

Clearly, there are no foolproof methods of detecting baloney or drawing the boundary between science and pseudoscience. Yet there is a solution: science deals in fuzzy fractions of certainties and uncertainties, where evolution and big bang cosmology may be assigned a 0.9 probability of being true, and creationism and UFOs a 0.1 probability of being true. In between are borderland claims: we might assign superstring theory a 0.7 and cryonics a 0.2. In all cases, we remain open-minded and flexible, willing to reconsider our assessments as new evidence arises. This is, undeniably, what makes science so fleeting and frustrating to many people; it is, at the same time, what makes science the most glorious product of the human mind."

Michael Shermer is founding publisher of Skeptic magazine and author of The Borderlands of Science.

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from the November & December 2001 issues of Scientific American

Often it is necessary to 'translate' these points into more accessible or familiar terms when working with real people who more often than not are untrained in scientific method to begin with but that doesn't usually create too much difficulty if we apply a little empathy and thought to the matter.

Emotional Management 28: Delusion formation

The traditional 'textbook' definition of a delusion is:

A fixed, false belief, not amenable to reason

To put it another way it's impossible to dissuade the delusional person from their belief by presenting them with evidence or by attempting to use reasoned argument to dissuade them. Delusions are classified as psychotic (one of Schneider's 'big 3') and the medical model assumption is that they are caused by abnormalities or chemical imbalances in the brain. This is because, since reason doesn't work there must be some other process going on. Psychiatrists are doctors and as such are trained to look for physical abnormalities – hence the biological assumption about chemical problems.

The reality is that the delusion is indeed formed in response to a different problem but it's not necessarily a chemical one – it might be but body chemistry and brain structure represent only a small part of the vulnerabilities and stressors we need to consider. Remember what we said about the stress and vulnerability model of mental disorder.

The stress and vulnerability model does accept the possibility of brain disorder (biological vulnerability) but also acknowledges and highlights several other, equally plausible explanations.

To demonstrate this I'm going to share a little of my own life story in this entry. I fully understand that in doing so I'll be outlining an argument that some people may find offensive. However I think that the point about delusion formation is far too important a part of this blog series to leave it out simply because some people might think that disagreement is a reason to take offence or a justification for hostility.

However forewarned is forearmed so let me be clear from the outset. I'm going to use an example of a very common delusion. It fits the definition because:

- It's fixed – the belief is not fluid. It doesn't adapt to circumstance but remains constant
- It's false – it doesn't match with the available evidence
- It's not amenable to reason – no amount of reasoned discussion will dissuade the person from holding this belief.

I am going to show why my previous religious belief was delusional and how various vulnerability factors came together to maintain it including social and psychological but not necessarily biological issues.

If you think you might find this post offensive this is your opportunity to go and do something else instead.

If you do read on please remember that I'm happy to discuss this stuff but please refrain from meaningless insults. As an apostate I've already been threatened with eternal damnation, accused of heresy and blasphemy, mistaken for Beelzebub and blamed for more unrelated disasters than you can shake a stick at. Rational debate and reasoned argument is far more likely to be taken seriously. Feel free to comment by Emailing me at the above address.

I also want to make it clear that I am not trying to tell people not to believe in God or whatever other religious opinions they hold. It is neither my place nor my right to tell another person what to believe. That's a matter for their own conscience. On the contrary I've been known to stand up for the rights of religious people to act in accordance with their conscience and to follow their own particular religious practices on a regular basis.

As someone once said (I wish I knew who):

***Until you believe in free speech for those with whom you disagree
you do not believe in free speech at all.***

However, just as the street evangelist who approached me and my stepson last Saturday afternoon was keen to demonstrate that my beliefs would lead me and my thirteen year old straight to Hell I think I have the same right to outline my opinion on the matter. At least, unlike the spiritual terrorist I encountered yesterday afternoon, I won't try to frighten your children and I am quite prepared to respect your right to disagree. After all – who says I'm right?

Mind you – had I not had 'the boy' with me I think he'd have been rather unprepared for the theological discussion about the nature of his God he'd have found himself involved in. But much as I would have enjoyed taking him on it would have been unfair to influence the developing beliefs of a 13 year old with my well constructed atheist arguments. He'll make his own mind up when he's old enough to understand.

If you disagree with me, that's alright. Disagreement is good – it helps us to discover both sides of an argument and in doing so all parties learn and grow.

Anyway – to the point:

When I was 16 I met my first real love. It's hard to describe the impact of this relationship upon me. This young woman helped me finally to get over the death of my grandfather several years earlier. Prior to meeting her I'd been emotionally lost, resentful, perpetually angry, generally aggressive and more than a little anxious about life and the world in general. Having lost touch with my father at the age of five my grandfather had been my only adult role model and his death when I was thirteen years old had left me lost and directionless as I headed into adolescence.

The young woman in question gave me a stability that in a very real sense allowed me to move on. She was, in a very real sense, my 'rock'. After we met I was able to put my life back together again and begin to move from boy to man without the 'baggage' of unresolved grief.

Unfortunately, eighteen months later we parted company. The reason for this was trivial and typically adolescent. The consequence was far more serious. Once again I was lost, depressed (I really did fit the clinical criteria) and intermittently suicidal. I was hopeless and helpless and desperately in need of comfort and reassurance. Emotionally speaking I'd plummeted right back to where I'd been before we met. To put it another way:

I was 'ripe for harvest'

Years later as a fundamentalist, evangelist, creationist Christian I'd actively seek out vulnerable and distressed people because they were ready to listen. But back then as a depressed teenager it was my turn to be targeted. I was desperate enough to listen.

I honestly believe that it wouldn't have mattered what group I joined or what they believed. What I needed was a sense of belonging and a belief in my own future. That was what the church offered me but at a price. The promise was a chance to be happy – the price was belief. I could be accepted as part of this ready made community so long as I accepted their world view. That was the price of admission.

If I'd taken solace in a group of Hell's angels the price of admission would have been to ride as motor cycle.

If I'd joined a photography club the price of admission would have been to own and use a camera.

Since I joined a Christian club the price of admission was belief. I could have the fellowship but only so long as I continued to believe 'the word' and not a moment longer. I could change my mind at any time but if I did I'd be right back to the isolation and depression I was so desperate to escape.

Just like other delusions, my belief in Jesus, creationism, the 6,000 year old planet earth, the need to despise homosexuals and the inferiority of women was my way to avoid a greater distress. It felt easier to believe the writings of a few bronze age nomads than to face life as an outsider. Consequently no amount of rational persuasion would dissuade me because my delusion depended not upon rational understanding but upon the need for social inclusion. My belief in creationism and the rest truly was

a fixed, false belief, not amenable to reason

It's interesting to note that according to the World Health Organisation's International Study of Schizophrenia the most inclusive societies also enjoy the highest recovery rates. In the next blog post we'll look at the cognitive processes that maintain delusional beliefs but first I'd like to put my former delusion into a context with other delusions I've encountered:

Need	Delusion
Social inclusion	Doctrine that allows membership of a group such as a religious or political affiliation
Denial of death	Reincarnation, eternal salvation, 'alien' cults
Specialness	Aliens, spirits, God talks to me, racism and other forms of discrimination, white supremacy,
Calm home life	'Folie a deux' (delusion shared by two)
Maintain safety	Paranoia – causes risk aversion and so maintains safety
Self esteem	Delusions of grandeur
Self concept/value	Paranoia (it's not my fault – **they** did it to me)

I remember working with a man who believed a successful singer songwriter had stolen all his songs. He believed this in spite of the fact that he couldn't play any instruments, couldn't read or write music and didn't understand many of the lyrics in question. It was also unimportant to him that several of these songs had been published while he was still a child in junior school. The belief did not depend upon rational thought – it was a self esteem tool used as an antidote to his father's repeated assertions that he was useless and would never amount to anything.

Delusions are not always caused by dopamine imbalances. Often they are the solutions to emotional or psychological problems. The cure therefore is not necessarily tranquilising medication but social, emotional, psychological and lifestyle changes.

Emotional management 29: Delusional self-censorship

The assertion in the last post that religious belief is delusional will be hard for many people to accept. I understand that but please bear in mind that what we define as delusional is decided not by the nature of the belief so much as by social norms.

As society changes so too do the examples of delusional beliefs (what most people consider to be false) but that doesn't change the nature of the belief itself. For example the idea that the earth is flat and that the sun orbits around it was no less false just because many people used to believe it. It was still:

A false, fixed belief, not amenable to reason

In fact in some circles both these propositions are still held to be true. They are truly delusional. They are also both aspects of Abrahamic religious doctrine and can be found within the pages of the Old Testament. In this sense they are familiar ideas in Christianity, Judaism and Islam. They are no less inaccurate for that.

The same can be said for Creationism, the Australian Aboriginal 'Dream Time' myth, Krishna consciousness, Spiritualism. Mormonism and Scientology. If the evidence demonstrates that a belief is false then it doesn't matter how many people agree with it – it's still false. If reasonable argument has no effect upon the belief then it's a delusion.

I am making an assumption here, of course. Continuing in from a recent post referring to the 'Baloney Detection Kit' I'm assuming that beliefs that do not stand up to inspection with the baloney detector are false. In that sense, if the belief becomes entrenched and therefore **not amenable to reason** it is a true delusion whether society considers it to be an 'acceptable' belief or not.

Delusions need to be maintained and in large part this means that the deluded person needs to practice **self-censorship**. This means that they must be careful to ignore evidence that doesn't fit and accept as evidence only those things that seem to support their world view even though such 'evidences' wouldn't stand up to serious scrutiny. Below is a list of **some** of the evidence I had to ignore in order to maintain my belief in fundamentalist Christianity.

Evidence that must be ignored to maintain the creationist delusion

Belief	Ignored
Creationism, Eden, Adam and Eve	Fossil record, DNA, Population distribution, Story of Gilgamesh (predates OT flood myth)
6,000 year old earth	Geological record, Plate techtonics, Carbon 14 dating, Dendrochronology,
No 'missing link' fossil	Australopithecines and other pre-human hominids,
The bible is infallible	Biblical assertions about flat earth, earth as centre of the universe, Archeology of ancient cities such as Jericho, internal contradictions (for example two sets of 10 commandments in Exodus – and they're different)
Ask and ye shall receive	Most prayers go unanswered
Noah's flood	Genetic variation, geographical distribution of flora and fauna,
God is good	Biblical accounts of divine sadism, discrimination and ethnic cleansing.

There are, of course many, many more examples of ways that I ignored evidence but I think this illustrates the point without going on ad infinitum about it.

The other side of the delusion-maintenance coin is the weak assertions I deliberately allowed myself to mistake for real evidence. These 'evidences' included:

Apparent evidence	*Actual source*
The bible is factual and can be taken as proof	Bronze and Iron Age superstition and an attempt by ancient nomads to make sense of the natural world – not unlike the Volcano God cults of S. America or the Aboriginal Dream-Time myth mentioned earlier.
The word of God	Political dictates that met the needs of various rulers, some ancient and some historically verifiable such as the emperor Constantine. Also matches the agenda of prominent individuals such as St. Paul who needed to ally Christians with Rome or face extermination.
Christ fulfilled the prophecy of Isaiah	Invented (probably by Luke) – For example – in the time of the nativity Bethlehem wasn't a Roman province and so there could not possibly have been a census but the prophecy had to have Christ (a Nazarene) born in Bethlehem – hence the distortion decades after the fact.

There are of course many more examples of the weakness of delusion-supporting evidence but this makes the point well enough. As before I'm not going to labour the point.

It's not that I never heard these arguments when I was a Christian. I became quite the little evangelist over the years and so I was regularly exposed to massive amounts of information about reality. I simply chose to ignore the evidence because I needed to believe in order to maintain my membership of the Christian club. My belief really did fit the criteria:

Fixed, false belief, not amenable to reason

Fundamentalism becomes as entrenched as any other delusion from racism and white supremacy to ideas of reference and like other delusions it serves a purpose. It allowed me to feel safe, to feel involved, to feel accepted. It's the same process that prompts evangelists to seek out and target vulnerable, isolated and distressed people. They describe them as 'ripe for harvest'.

The way to combat delusions then begins with Zubin & Spring's areas of vulnerability. It is important to fill the hole that is plugged by the delusion - or rather by the thing that the delusion gives a person access to (in my case acceptance). Only once those wider needs have been met can we begin to work on the belief itself by presenting evidence and training the individual to make sense of it. That's the value of the Baloney detection Kit and also the Socratic technique outlined in an earlier post.

In my own case it took almost ten years to let go of my delusion and then it was only because it stopped working for me. For me it took a malicious false accusation from a former girlfriend (I dumped her because, understandably enough, she wouldn't accept her inferiority as described by St. Paul) to set me free. She slandered me and the church I belonged to prayed for guidance. Their God assured them of my guilt. I knew I was innocent but that made no difference – God had spoken.

This sordid little episode set me free from the chains of delusion for two reasons:

- I was no longer welcome in the Christian club so the delusion served no purpose.
- I had irrefutable evidence of the fallibility of Christian 'discernment'.

Only then – after a decade of delusion did I begin to recover from my religiosity. No amount of medication would have helped me. I needed a reason to stop paying the price of admission to the Christian club.

Of course I wouldn't recommend traumatising delusional people in the way that my church traumatised and abandoned me. It's better to discover what need the delusion fills and then rather than remove the benefit as happened to me meet that need in another way that doesn't depend upon a delusion to maintain it.

Of course I'm not suggesting that we attack people's religious beliefs – they have a perfect right to believe what they want. I'm simply using this very commonplace example of a delusion to demonstrate the nature of psychotic belief processes.

> *Actually I believe extremely strongly that it is very wrong to go around indiscriminately attacking people's cherished belief systems.*

These beliefs, however delusional they may be, serve a vital purpose in maintaining self-esteem or in keeping the individual safe. If the individual is having difficulty then there is a case for examining their belief systems with them but before we even attempt to help them to make any lasting change we must work to provide the benefit of that belief system in some other way. Otherwise we are guilty of nothing more than intellectual bullying in much the same way that the evangelist I mentioned in the previous post attempted to terrorise my 13 year old stepson into believing in his version of God.

In the next few posts we'll consider how other types of vulnerability contribute not only to delusions but to all of Schneider's 'big 3' groups of 'first rank psychotic symptoms':

- Hallucinations
- Delusions
- Thought disorders

Emotional Management 30: Biological stressors

There are many ways that biology can impact upon a person's wider mental state. This is not all that surprising given the fact that we are biological beings and that the brain and body are not really separate entities but rather two aspects of the same, human system. For those people who doubt that – those who believe that the mind and body are very separate entities I'd like to provide a little illustration that outlines the connection in real-life terms.

Many people insist that there is no connection between mind and body because they object to the assertion that illicit drugs can contribute to mental disorders. As a psychiatric nurse I can say that I have no doubt that they do but realistically it doesn't matter how many times I make this point from my own perspective by drawing upon my own experience it isn't the same as drawing upon the other person's own experience.

So let's consider illicit drugs for a moment. This isn't because I think that all people reading this blog will be drug users – but rather because it makes the point rather elegantly by building upon what most people already understand and accept.

If we consider a substance such as cannabis – people take it because it has an effect upon their mood. It changes perception and many people find this to be a pleasant experience. However it is essentially a physical stimulus – it's a chemical that acts upon the central nervous system to produce euphoria and in a number of cases actual hallucinations. That's a clear link between physical change and cognitive (perceptual) impact. It also affects mood (euphoria is common) by the same chemical or physical process.

When people tell me that there is no way that cannabis can cause mental disorder they are saying that it has no effect upon perception, affect (mood) and cognition (thinking). In reply I ask them why they bother to use it then since it has no effect.

In reality people use chemical substances precisely because they have an impact upon these things – precisely the processes that are affected in mental disorder. So it seems an inescapable truth to me that physical stressors such as drugs (prescribed or not) have an effect upon mental state.

- That's why amphetamine sulphate leads to anxiety and anger.
- That's why hallucinogens lead to psychosis.
- That's why depressants such and alcohol lead to depression and isolation.

This does not mean that every time someone has a couple of pints they will become depressed. Nor does it mean that every cannabis user will develop a psychotic illness but it does mean that the substance itself has the potential to cause these problems.

People have differing degrees of vulnerability to these substances in the same way that some people can drink caffeine all day without experiencing any significant effect whilst a single cup of coffee can leave other people unable to sleep all night. They have different levels of vulnerability.

This is a crucial element of the stress and vulnerability model and we need to make it clear before continuing. The vulnerability itself does not create the disorder. It simply makes people more susceptible to the other types of stressor that can cause difficulties. For example certain tribes of native Americans respond very badly to alcohol. They have a high vulnerability to it. However they do not experience any problems until and unless they drink alcohol – until they are exposed to the 'stressor'.

This is true for all types of vulnerability – they only matter when the person is exposed to the stressor itself. A person with psychological vulnerabilities is only affected when they come under psychological pressure. A person with social vulnerabilities only becomes disordered when faced with socials stressors.

An easier way to think of this is to consider physical disorders such as diabetes. It is well known that some people have a genetic (biological) vulnerability to cancers. However not everyone who has this vulnerability will develop cancer. Many people also need to be exposed to carcinogenic (cancer causing) substances as well – smoking for example or working with certain hazardous chemicals.

How much exposure is needed before cancer develops also varies depending upon the **level** of vulnerability. That's why not everyone exposed to tobacco smoke develops cancer and why not everyone exposed to psychological stress develops psychosis. We vary in the amount of stress we can comfortably manage.

However we all have a limit and sooner or later, given enough stress, we'll reach it and then exceed it. When this happens we become unwell.

In terms of biology there are a number of stressors that have an impact. In fact there are too many individual stressors to even attempt to list them all individually but we can categorise them and then list some of the categories. This seems to me to be a much more reasonable approach.

Categories of biological stressors:

Stressor	A few basic examples
Ingested substances	Medications and illicit substances, certain food groups, sugars, stimulants such as caffeine or depressants such as alcohol
Physical injury	Head trauma, Pain, Incapacity
Disease	Toxic confusion due to infection, pain, stomach problem etc
Exhaustion	Due to insomnia, overwork, anxiety

Other aspects of biological vulnerability might include the biomedical assumption of the cause of schizophrenia – an organic brain disorder. Unfortunately the evidence for this brain disorder is still not good in spite of decades of research aimed at demonstrating it. However……

Not proven is not the same as not true

There may well be a structural or chemical cause for schizophrenia. However as yet it has not been demonstrated particularly well. That's why the dopamine hypothesis is still just the dopamine hypothesis.

In their original article Zubin & Spring acknowledged this way back in 1977 (there's still no real proof over thirty years on) but they also made the point that often treatment cannot wait for absolute certainty because the person in question is suffering **now**. Whatever the truth about the biological brain disorder assumption it is true that medication can have a major positive impact upon the experience of mentally disordered people.

Where the stress and vulnerability model varies somewhat from the traditional medical model is that it allows for other interventions and suggests that since medication is not the only remedy then it can be used less and in lower doses so long as other areas of vulnerability are addressed as the same time. This can be extremely positive and in fact, many recovery based programmes begin with a relatively high amount of medication

because it brings initial relief but then reduce the medication gradually as the other coping skills are developed.

What we end up with then is a balanced but very clear assumption with regard to the stress and vulnerability model:

Biological vulnerability to mental disorder exists and research in genetics and familial morbidity rates (frequency of illness) strongly suggests a genetic or hereditary element to this.

This biological vulnerability causes problems when the individual is exposed to stressors (be they biological or otherwise) and biological interventions such as:

- medication;
- exercise;
- work, rest and recreation lifestyle balance;
- diet;
- avoidance of harmful substances

can have a major impact upon the development of illness. Attention to stressors such as these can also shorten the length of time the person is 'ill' and go a long way toward preventing any recurrence of the disorder.

Emotional Management 31: Environmental stressors

What do you do when you feel stressed? Where do you like to go?

Most people have their own favourite places. Often they're quiet or if there is sound involved it is carefully chosen, perhaps a favourite piece of music or somewhere near a gently babbling stream. Others enjoy a visit to the coast or maybe just the quiet solitude of their own home.

Whatever environment you choose it will most probably be somewhere where you can feel safe and where you can find the time to reflect upon your situation or to simply 'chill out' and escape from your troubles for a while. Environment can have a major impact upon your ability to cope with what life throws at you.

I remember when I first changed from living alone to sharing my life and my home with another person. It was a positive change and I was certainly pleased about it but it did create a few problems initially. I'm sure I'm not alone in that.

Before this change I used to relax by stretching out on the sofa and listening to various pieces of music. All the music I chose had a tempo that mirrors the human heart at rest and this helped me to relax. I would simply lie flat and stare up at the ceiling while my thoughts drifted and invariably I found that the solutions to any problems I faced would become clear within a relatively short space of time. That was my coping strategy.

Unfortunately it became more difficult to do this quite so regularly as I had been accustomed to with the presence of another person in the house and so my environment became less conducive to mental and emotional health. I no longer found it easy to relax and until I found a way around it this lack of 'down time' became a significant issue. The solution was relatively simple I'm happy to say and involved no more than a conversation and a little forward planning. Had I not been able to resolve this issue though I wouldn't like to think what would have happened to my mood and mental state – environment plays such a huge part in my preferred coping strategies.

Imagine how difficult it would be for you to deal with all that life throws at you if your environment wasn't right. If there was nowhere you could go to get a little peace and quiet or if you could never feel safe. Imagine trying to think things through from the starting place of an abusive relationship in a tiny flat. How would you fare in a bedsit surrounded by violent substance-users (not that all substance-users are violent but some are).

What would you do if your home was a cardboard box in the middle of a bustling city? How safe would you feel when it was time to sleep?

There are many ways that the environment can either help or hinder our ability to cope with stresses. The chart below outlines some of the environmental needs that people may have. As with previous charts this is designed simply to provide a few examples – not an exhaustive list of all possible environmental issues.

Positive environments provide	*Negative environments provide*
Safety	Danger
Peace	Over stimulation
Acceptance	Criticism
A sense of belonging	Alienation
Self respect	A sense of inadequacy
Freedom of choice and movement	Restriction and control by others
Opportunity	Barriers

Mentally disordered people tend to have a much greater need for a conducive environment than those who are not mentally disordered – they have more work to do on themselves. So it would make sense to help them to maintain a good, positive environment in which they can fulfil their environmental needs before beginning work on the other issues that trouble them. This is very similair to Maslow's hierarchy of needs which suggests that environmental needs for safety and shelter etc come before other forms of coping or social concerns.

What actually happens is a thing called 'social drift'. It is well understood in this country that people diagnosed with serious mental disorders are likely to lose contact with others, lose their jobs and end up living in much less positive environments than they did before they became ill.

Just as we said in a previous post:

The more inclusive societies have the best recovery rates.

It's no wonder that recovery from serious disorders such as schizophrenia is so unusual in the industrialised West that most British citizens believe it to be impossible. And yet research from the World Health Organisation's ISoS study demonstrates that many countries that lack our resources but that have more inclusive societies have much higher recovery rates.

If you want to help someone to overcome their psychotic or other problems you must help them to get their environment right first.

Emotional management 32: Social and Cultural stressors

I've mentioned the International Study of Schizophrenia (ISoS) several times already in this series. That's the World Health Organisation's study that followed people from all over the world from first diagnosis of schizophrenia for 25 years.

Actually it started out as just 15 years but the American Psychiatric Association protested that they weren't comparing 'like for like' so the WHO funded it for another 10 years using APA's own researchers to make sure there was no bias. The results after both 10 and 15 years were the same. Because they ran 'back to back' with the same subjects we now have a 25 year longitudinal study concerned with the outcomes for people diagnosed with schizophrenia from many different cultures.

The reason that the American Psychiatric Association didn't like it is the same reason that most Western psychiatrists don't like it. It demonstrates extremely clearly that in the industrialised West (the nations with most psychiatrists) recovery rates are much poorer than in other cultures where medication is limited or non-existent and where psychiatric professionals are scarce to say the least.

Here in the West we have a recovery rate (we actually tend to rediagnose rather than admit recovery is possible) of around 33%. It's interesting that this has remained constant since decent records began and certainly since before the advent of antipsychotic medications (major tranquilisers).

In the rest of the world rates vary and it's true that some cultures have even poorer recovery rates but some are very much better. In some communities the recovery rate rises to around 90%.

It's no accident that I used the word 'communities' in that last sentence. It seems that the quality of a person's social involvement and the nature of that group's cultural beliefs and expectations has a major impact upon the prognosis for psychotic disorders.

In a subsistence economy such as certain parts of rural India there's just no time to 'carry' someone who is too busy responding to voices to work in the fields. They have to do their part and so the community works hard to involve and include them for the good of the community. This provides them with other things to think about and to focus upon (remember the earlier posts on activity and on unhelpful thinking). It also maintains a link to the 'sane' society they belong to and these influences and distractions appear to have a very positive effect upon the psychotic individual.

The expectation then is positive because the community has seen people overcome psychotic problems many times before. Nobody sees any reason to consider this as *'an incurable illness of deteriorating course'* because they know better. The community involvement coupled with the cultural expectation of recovery becomes a self-fulfilling prophecy and people get 'better' (if we can use the term).

Of course here in the West we do things rather differently. We have a cultural expectation of incurability and a social exclusion practice that typically leaves people unemployed, isolated, living on benefits and funnelled into 'activities' involving other people who are also excluded from the mainstream society that exists outside the walls of the day hospital or the mental health resource centre.

This is the community based equivalent of the old Victorian asylum with it's policy of 'congregate and segregate' to keep the 'mentally ill' away from the rest of 'normal' society. This is the sectarianism that leads to 'social drift' and the pessimistic self-fulfilling prophecy that prevents so many from recovering in our society. This is an appalling state

of affairs for the most developed nations in the world to have to acknowledge – and we do have to acknowledge it because the evidence is there for all who wish to see it.

And yet in spite of the massive social and cultural problems our society causes with it's negative assumptions about incurability people can and do recover. We know from research dating back to the early 1950s that the effect of social involvement and the quality and type of social interaction has a massive impact upon the likelihood of relapse and conversely upon the probability of recovery.

We know from research in education and also on personality disorder work that expectation and socio-cultural norms make a massive difference to the likelihood of recovery from all forms of distress and mental disorder. We know that involvement is the key and yet our society persists in excluding those people who most need involvement.

However that doesn't have to spell futility and pessimism. It's surprising how little intervention and interaction can make the difference. The wider world of UK society may have its prejudices and ill-informed bigotries but those of us who work in mental health services need not be so limited in our outlook. We can use our therapeutic influence to model the world in microcosm and find valued roles for our service-users. We can help the families of service-users to practice principles of involvement and help them to understand what can be achieved. More than that – we can help them to learn how to make positive change come about. Society at large may be ignorant of the possibilities but society at large is usually far less important and far less instrumental than the small social group that the service-user belongs to.

By influencing this small group to be positive and inclusive, to be encouraging and active the social and cultural stressors associated with mental disorders from anxiety and depression to schizophrenia and bipolar disorder can be kept at bay – at least long enough for the individual to develop their own robust coping strategies – to change their degree of vulnerability.

Social interaction and social modelling is another, non-medical way to treat psychosis as part of a whole system affecting a fully rounded individual who is far, far more than mere chemistry.

Emotional management 33: Stress & vulnerability in practice

In practice the stress and vulnerability model requires much more thought and much more attention to detail and assessment than traditional biomedical psychiatry. It's not sufficient merely to identify symptoms and then intervene with medication. People are not simply machines to be reduced to their component parts and 'fixed' with a little tampering.

If we are to use the stress and vulnerability model in practice we need to take a much more careful look at the person, their lifestyle, their vulnerabilities and stressors but also their strengths.

We need to develop a proper formulation (more holistic than diagnosis) in co-operation with the service-user and then identify areas of need to work upon. At the same time we concentrate upon strengths and try to discover what can be built upon or what skills are transferrable. If the person has always been good at football for example then see if they can join a team.

This will have an enormous impact if they commit to it because it will affect various vulnerability factors:

Vulnerability	Activity	Benefit
Social	Join football team	Valued social role
Cultural - seen as useless 'schizophrenic'	Play well	Demonstrate value and effectiveness - become acknowledged in social group
Biological	Play regularly	Fitness, restores sleep pattern, enhances appetite, provides a reason not to use harmful substances
Psychological	Contribute to the team	Enhanced self esteem. Success breeds success.

By understanding the value of non pharmacological interventions such as this we can keep an eye upon the many aspects of a person's life that make the difference between misery and dependence or fulfilment and inter-dependence (nobody in our society is ever truly independent).

Of course there are many options and the above example of joining a football team is only one of them. It will not be suitable for everyone but there's always something.

In the past I've enrolled and accompanied clients on evening classes or other training courses (and learned much myself in so doing). I got one man to teach me how to draw and sketch. He'd been a semi-professional artist before he became ill and the opportunity to teach someone else benefited him immensely in terms of self esteem and also in forcing him to organise his thoughts in a structured way with a set goal. It also beneffitted me – I learned how to draw people and represent perspective when sketching landscapes much more effectively than I had before.

Other clients have been encouraged to begin to venture outside of their comfort zones by building upon their strengths in various ways, gradually facing more and more difficult situations until they learned/developed progressively more difficult coping skills.

As the client develops better coping techniques in all the areas of vulnerability we have identified they become able to manage with gradually reducing doses of medication. It

may well be that in the most acute phases of mental disorder large amounts of medication is needed to suppress symptoms or even to provide a measure of containment as well as personal relief for the service-user. However the disadvantage to psychiatric medications is that they tend to interfere with thought processes – they slow down cognition. It's interesting that 'poverty of thought' is described as a symptom of schizophrenia even though antipsychotic medications blunt the thought processes.

Nevertheless it is true that medication has a very real place in the initial stages of disorder but true recovery requires the person to think through their difficulties. This is not helped by over reliance on medication. So gradually we reduce the medication over time as we help the client to develop new coping skills. It's a shifting balancing act with the emphasis moving inexorably away from medication and toward more natural and cognitive behavioural strategies.

Eventually the coping ability they have is sufficient that they do not need medication at all.

Medication		*Coping*	
	High	Low	
	High	Initial assessment	
	High	Install coping strategies	
	Medium	Self esteem grows	
	Medium	More coping & positive experiences (success breeds success)	
	Low	More coping strategies	
	Very low	Greater social role and more enhanced coping strategies	
	Discontinued	Maintain coping	

Systematic attention to coping skills moves people back along the vulnerability axis of the graph.
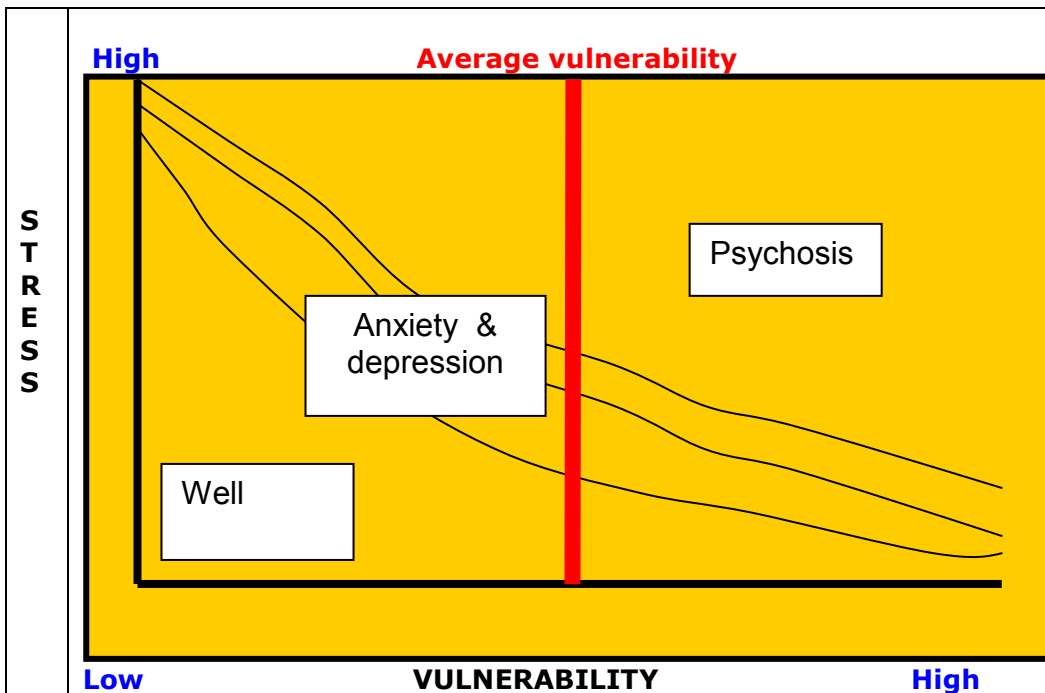
Eventually they become as robust as any other *average* person. This means that they will react in the same sorts of ways to normal stresses and are just as capable as the rest of us. They will, of course remain susceptible to stress and can react badly when overwhelmed but that is true for all of us. So long as they can handle as much stress as the average person that's enough.

It makes no sense to expect people to exceed the coping skills of the rest of society before we can call them recovered, even though in truth many people do exactly that.

The effective therapeutic process unpicks, examines and deliberately installs coping skills in a way that most people never do. It's not surprising then that many recovered people are significantly more 'emotionally robust' than their counterparts who have never been mentally disordered in the first place. They often have more coping skills than the rest of society because they have needed to develop them – and because (unlike most people) they have consciously worked hard to learn them.

This is meaningful recovery based around coping and function rather than around an increasingly meaningless catalogue of 'symptoms', most of which are really only choices or poor coping strategies themselves. For example one of the 'symptoms' of schizophrenia is said to be non-compliance with medication. It's clear just how silly this is when we consider that the compliance rates for people diagnosed with schizophrenia are no worse than the compliance rates for people with insulin dependent diabetes. We don't say that non-compliance is a symptom of diabetes so why should we decide it's a symptom of schizophrenia.

After all – if you were told that you'd have to take a medication for the rest of your life that would dull your thoughts, caused weight loss and blurred vision, lead to impotence in men and menstrual disturbances in women and that carry a risk of heart problems that just might kill you how keen would you be to take it?

Other 'symptoms' include responding to hallucinations (telling the voices to leave you alone for example) or avoiding others (bear in mind how people with mental disorders are treated by the general public), loss of volition, loss of libido and lack of self care (symptoms of depression and side effects of medication, not necessarily 'schizophrenia'), a sensation that your body doesn't work as it should (neuroleptic medications cause problems with motor control) and many other 'second rank' symptoms that really are more to do with coping or treatment than with the psychosis itself.

In the next post we'll look at what we mean by recovery itself and how it differs markedly from traditional (symptom based) medical definitions precisely because the emphasis is upon coping rather than upon diagnostic labelling.

Emotional management 34: Tripartite definition of recovery

There are many disagreements about what recovery from serious and enduring mental disorders might mean or even if it is possible at all. It should be clear from the preceding posts that I believe that recovery is not only possible – it is also a relatively simple concept. I think that when you add together the information from the preceding 33 posts in this series it becomes startlingly obvious that recovery from serious mental disorder is far from rocket science.

All it requires is the methodical and committed application of some very straightforward principles. Admittedly 'simple' isn't the same as 'easy' and there are an awful lot of simple principles to consider but that doesn't change the fact that it's straightforward to understand. By way of illustration let me demonstrate the difference between 'simple' and 'easy'.

I live in Workington, a medium sized town on the North West coast of England. By applying just a few 'simple' principles I can get myself to Newcastle – a town in the North East of England.

The principles are as follows:

- Walking involves repeatedly placing one foot in front of the other.
- To get from Workington to Cockermouth walk along the A66
- To get from Cockermouth to Carlisle walk along the A592
- To get from Carlisle to Newcastle walk along the A69

That's all there is to it – four simple principles will get me from Workington to Newcastle. It really is simple to understand. However it's not easy. The distance from Workington town centre to Newcastle city centre is around 92 miles. Simple but not easy.

The same is true of recovery from serious mental disorder. It's simple but it's not easy. Just like a walk from Workington to Newcastle it requires perseverance, commitment and stamina. But it is possible.

So what are we trying to achieve when we talk about 'recovery'? There are several different definitions. My own favourite is the tripartite model first proposed, I think, by Ron Coleman. He breaks down the components of recovery into three broad subgroups which he terms:

- medical recovery – absence of symptoms;
- social recovery – the person has a valued place in their society;
- psychological recovery – the person is not particularly distressed.

The idea is that any two of the three is enough.

For example many of us hear voices but that doesn't prevent us from functioning. Many voice-hearers have valued places in society and have learned to understand and deal with our experiences. They do not experience medical recovery – auditory hallucinations are a psychotic symptom after all – but quite frankly so what? If we're able to function and we're not distressed what does it matter if we hear voices?

After all – many of our most respected citizens hear voices. Religious leaders often describe hearing the voice of God or the virgin Mary and mediums such as Derek Acorah have grown very wealthy indeed from this phenomenon.

Social and psychological recovery are more than enough. Indeed any two of the three constitutes meaningful recovery in a practical sense. The psychiatrist may not agree –

indeed in my experience once diagnosed with a mental disorder most psychiatrists are only interested in the absence of symptoms to the exclusion of other concerns but that's neither practical nor, in most cases, achievable without heavy doses of medication that also robs the individual of much of their cognitive function.

Coleman also adds another dimension to the tripartite model – the person is off medication and paying tax. Off medication because that means they are no longer dependent upon chemicals to maintain their stability and have left the 'illness' model behind. Paying tax because until they are working they are still presumed to be part of an 'underclass' of disadvantaged people in our society.

Personally I'm not sure about that last part. I do believe that it is necessary for the person to be **capable** of working in order to be recovered or not but I think that whether or not they do has as much to do with the national economy and with personal choice as it might have with any measure of health or illness.

Others would say that recovery is possible even whilst taking medication because it doesn't matter how you achieve stability – it's simply important that you do. I have some sympathy with this view but the pedant in me insists that if a person needs treatment then they are not recovered. Why take medicine if there's nothing to treat?

However it's a pointless and relatively circular argument. The biological vulnerability is just as relevant as the others and if we achieve recovery by psychological or social intervention then it's equally reasonable to acknowledge recovery that's achieved by biological intervention. To insist otherwise is probably fairly irrational because all we're doing is pretending that biological intervention is somehow more like 'treatment' that other interventions which is hard to justify to say the least.

Still other talk about the life-changing experience of psychosis. The term 'Kundalini' is often used to signify the spiritual crisis and ultimate spiritual renewal that psychosis causes. Unlike the traditional medical model that aims to return people to their premorbid state (how they were before) this view of recovery insists that it is the spiritual growth that is important and that simply returning to previous functioning would be both undesirable and ultimately impossible. Psychosis changes a person's perspective on life forever – they can never be the same but then again why should they?

So we can see that there are several different ideas about what recovery means. What they all have in common (except the medical definition) is that they are rooted in the idea of function. So long as people can cope they are recovered. Only in traditional psychiatry do we find this insistence on absence of symptoms. For everyone else it is the ability to cope with life that matters.

So – the truly simplistic statement is this:

> **Recovery from serious mental disorder is all about learning to cope.**

What's so mysterious about that?

Emotional management 35: Some CBT based techniques

By now the point ought to have been made that recovery from serious mental disorders is not impossible. It requires some hard work and dedication but that's not the same as saying it can't be done. In this post I'd like to outline a few of the many techniques we use to help people to re-evaluate their interpretation of their experiences. This is by no means the entire 'arsenal' of techniques – just a taster really. Hopefully it'll shed some light on the sort of psychological interventions I've been referring to throughout this series.
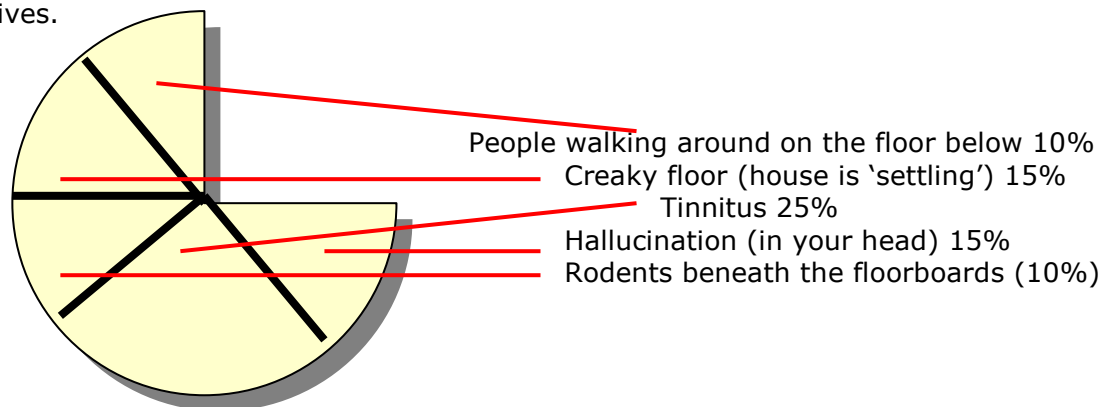
Pie chart

One common issue for people with psychotic disorders is the tendency to jump to conclusions. This interesting research article published in 2009 makes the point extremely well:

http://schizophreniabulletin.oxfordjournals.org/cgi/reprint/sbn165v1

The basic idea is that if they can't immediately explain a thing then the individual will simply light upon the first remotely plausible explanation they think of and decide that this must be the reality. The magical thinking notion that:

If I think it, it must be true.

One extremely effective technique is to offer (and get the other person to think up) possible alternative explanations that can then be allocated percentage points in a pie chart. The basic process is to decide for each possible explanation how likely it is to be the truth. By beginning with all the alternative explanations before introducing the delusion it is possible to get a genuine approximation of plausibility that leaves only a fraction of the pie chart for the delusion. This doesn't prove that the delusion is false – it simply introduces some doubt and so the individual is more willing to consider alternatives.

People walking around on the floor below 10%
Creaky floor (house is 'settling') 15%
Tinnitus 25%
Hallucination (in your head) 15%
Rodents beneath the floorboards (10%)

This only leaves 25% left for the delusional belief that the creaking noises the client hears are actually caused by the government agents sneaking around beneath the floor installing surveillance equipment.

Continuum

Many people with mentally disorders have an unrealistic view of themselves – be that good or bad. By working with them to create an increasingly long continuum it is possible to get them to review their understanding of their worth, goodness, wickedness or grandeur. As an example let's imagine that the client has delusions of guilt and believes themselves to be the most evil person in the world.

Begin with a straight line representing the extremes of good and evil. Draw this line in **the centre** of a large page:

Good   Evil

Then get them to put a X representing where they see themselves. It's likely that they'll put the X right at the evil end of the continuum:

Good   Evil
                                                        X

Then ask them what their evil attributes are before asking them where they would put other 'evil' characters on the continuum. Adolf Hitler (H) or Josef Fritzl (F) might be interesting examples. They'll probably find themselves having to extend the continuum to accommodate the newcomers:

Good   Evil
   X   F   H
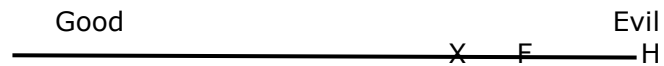
Then fill in the extreme good end of the scale. Ask them about people they admire who they know. They'll put them at the end of the scale. Their mother perhaps (M):

Good   Evil
M   X   F   H
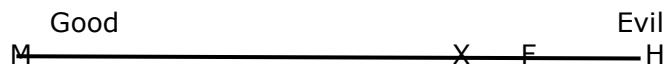
Ask how M compares with characters like Mother Teresa (T), Ghandi (G) ot the Dalai Lama (D). They'll probably need to extend the continuum in the opposite direction:

 Good   Evil
D   G   T M   X   F   H

Then finally we het them to put their friends and acquaintances in the continuum as well. For this illustration we'll simply give these extra people numbers from 1 – 5:

Good   Evil
D   G   T 1 M 5   2   4   X 3 F   H
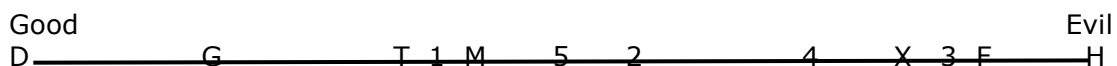
At the end of this process the service-user may still not like themselves very much but at least they will begin to question their assumption about being the most evil person on the planet. They may even have identified someone they know (in this case '3' as sharing more qualities with Hitler than they do themselves. This allows doubt which is the first chink in the delusional armour.

From this small insertion of doubt it is possible then to collaborate on experimentation to test out the service-user's own beliefs in the real world and discover just how much evidence exists to support or refute the delusion.

The process of experimentation is a little more complicated than it first appears and really it deserves a separate few blog posts to do it justice. So for now I'll simply say that experimentation is based upon the scientific method which involves generating a hypothesis, predicting what will happen in certain circumstances, testing the hypothesis by providing those circumstances and then debriefing before creating a new, revised hypothesis and starting again. By this process eventually it is possible to mover the

service user in gradual, incremental steps toward a reasoned and reasonable interpretation of their perceptions.

Another very useful habit to encourage is journal-keeping. The journal can take many forms but there are a few elements that are worth considering and really that are invaluable to the therapist. The first is a record of thoughts, feelings and behaviours in particular circumstances. This can be used to plot patterns in the person's experiences. For example it may look like this:

Date	Time	Situation	Thought	Feeling	Behaviour	Outcome

The completed record allows us to plot self-fulfilling prophecies, thinking errors, behavioural problems and a host of other potential issues that we might use as the basis of experimentation.

As well as plotting thoughts, feelings and emotions as record of coping strategies and their usefulness is helpful as is a narrative account of what happens on a daily basis, any thoughts that arise and any attempts to dispel delusions or hallucinations as well as records of successful ways to cope with thought disorders and other difficulties.

Emotional management 36:Lessons from research

"An enormous amount of research has examined possible physical causes of psychotic experiences. This research has yielded some interesting findings, but no definitive conclusions can yet be drawn. Work in understanding biological influences on psychotic experiences may have been hampered by a number of problems:

The use of unreliable and invalid diagnoses. If diagnoses are misleading, real physical processes that are related to only some of the psychotic experiences might be hidden.
The fact that two things happen together does not mean that one has caused the other. Few studies have made this distinction.

The effects of complicating factors (such as medication) have not always been taken into account.

It has often been assumed from the outset that the reason for these experiences is likely to be a biological one and so other possible reasons have not been investigated.
It has often been assumed that there is likely to be just one cause. It is of course possible (indeed likely) that a number of things need to come together for someone to have these kinds of experiences.

For example, someone may have an inherited sensitive temperament but only have psychotic experiences if at some point in their life they experience extreme stress.

There are, of course, biological and brain events that correlate with all aspects of our mental functioning. This is equally true for 'normal' and 'abnormal' experiences. However, it is incorrect therefore to conclude that biological abnormalities are the primary causes of a complex range of experiences. The undoubted existence of biological aspects to our experiences does not in itself justify categorising them as medical illnesses."

British Psychological Association (2000)
Recent advances in understanding mental illness and psychotic experiences
British Psychological Society, Leicester. P.24, p.25, p.29,

"The overarching message of ISoS is that schizophrenia and related psychoses are best seen developmentally as episodic disorders with a rather favourable outcome for a significant proportion of patients. Because expectation can be so powerful a factor in recovery, patients, families and clinicians need to hear this."

"Despite these notes of caution, the ISoS findings join others in relieving patients, carers and clinicians of the chronicity paradigm which dominated thinking throughout much of the twentieth century."

Harrison G. et al (2001)
Recovery from psychotic illness: a 15 and 25 year international follow up study
British Journal of Psychiatry: Number 178, pp.506-517

"The only well-established structural abnormality in schizophrenia is lateral ventricular enlargement; this is modest and there is a large overlap with the normal population."

Chua S.E. & Mckenna P.J. (1995)
Schizophrenia – a brain disease? A critical review of
structural and functional cerebral abnormality in the disorder.
The British Journal of Psychiatry: Number 166, pp. 563-582

Dissenting voices

"…the notion of schizophrenia is unsupported by scientific evidence and is unsustainable. Maintaining that schizophrenia exists is dishonest. It would be of more help to those in distress, and move forward the research effort to understand madness, if we stopped trying to fit their symptoms into a bogus diagnostic category."

King J, (2000)
What in fact is schizophrenia?
British Medical journal
Volume 320: p.800

David Whitwell challenges the Kraepelinian dogma of inevitable decline and cites the 'plateau' effect of deterioration levelling out after 2 – 5 years followed by stability or improvement. He argues that early intervention is the key to positive outcomes and recovery. This is the 'critical period' hypothesis.

Whitwell D. (2001)
Service innovations: early intervention in psychosis as a core task for general psychiatry
Psychiatric Bulletin
Vol. 25, pp.146-148

"(People with schizophrenia) improve without fanfare and frequently without much help from the mental health system. Many recover because of sheer persistence at fighting to get better, combined with family or community support. Though some shake off the illness in two to five years, others improve much more slowly. Yet people have recovered even after 30 or 40 years with schizophrenia."

Froggatt, D. 2007
Recovery Part 2: Concept of Recovery
WFSAD Newsletter: 2007, 3, P1.

For an overview of the research and theory concerning High Expressed Emotion in serious and enduring mental illness read:

Leff J. (1998)
Needs of the Families of People with Schizophrenia
Advances in Psychiatric treatment
Vol. 4 pp. 277-284

Hooley J.M. (1998)
Expressed Emotion and the Locus of Control
The Journal of Nervous and Mental Diseases
Vol. 186, No. 6, pp.374-378

We've now reached the end of the 'single document' version of the Emotional Management blog series. I hope it's been useful and perhaps even entertaining to read in places. Feel free to distribute it either physically or electronically to anyone who may find it interesting. All I ask is that you retain the original formatting, that you don't edit or alter my words and that you keep my contact details and copyright intact.

I'd also be very keen to receive any feedback about this. You can get in touch with me either through the blog or via Twitter (address at the top of every page).

Thankyou for reading.

Stuart Sorensen