

Madness and the family – the re-emergence of Laingian ideas

LUCY JOHNSTONE

Abstract

This article explores the influence of Laing and Esterson's theories on the role of the family in 'psychosis', with reference to the school of Family Management and its subsequent modifications which emerged from the 1980s onwards. It is argued that these approaches have been shaped by the need to manage the threat to biomedical models of distress posed by Laing and Esterson's ideas. It is further suggested that despite these manoeuvres, many of their core contentions are receiving confirmation, for example through the controversy about psychiatric diagnosis, and that their central message that madness has meaning is as relevant as ever. Consideration is given to the re-emergence of Laingian ideas from a number of other directions.

Main article

Our question is: are the experience and behaviour that psychiatrists take as symptoms and signs of schizophrenia more socially intelligible than has come to be supposed?
(Laing and Esterson, 1964: 12).

Laing and Esterson's central and most important contention was that madness has meaning. *Sanity, Madness and the Family* (1964) set out to demonstrate that the particular form of madness diagnosed as 'schizophrenia' becomes intelligible within the context of family relationships. Then, as now, this is the most controversial claim that can be made in relation to the field of psychiatry. This is because 'schizophrenia' functions as the 'prototypical

psychiatric disease' (Boyle, 2002, or, as Szasz famously phrased it, 'the sacred symbol of psychiatry' (Szasz, 1976). It is perhaps not surprising that there was a strong backlash, echoes of which can still be felt today. This has led to a need to manage the threat posed by Laing and Esterson's theories and insights, to distance ourselves from troubling messages about what may be going on behind closed doors in families and indeed many other places, and to preserve the discipline of psychiatry from being revealed as 'something which is very hard to justify or defend – a medical speciality that does not treat medical illnesses' (Breggin, 1993).

I have discussed these issues in several previous publications (Johnstone, 1993; Johnstone, 1996; Johnstone, 1999). In 1993, I highlighted the most common strategy used to dismiss Laing and Esterson's insights, which is to describe them as 'family-blaming'. Thus, by the 1990s, there was widespread professional and public agreement that 'theories of family pathogenesis [have] resulted in relatives being blamed and stigmatized for the patient's illness' (Tarrier, 1991). In place of Laing and Esterson's ideas emerged another family intervention tradition, which has had a very different reception. It is taught and disseminated across the country in several large-scale training projects (e.g. the Thorn Programme and the Meriden Programme), and recommended in NICE guidelines (NICE, 2015). Known as Family Management, or Behavioural Family Therapy, the approach is based on the concept of High Expressed Emotion, or High EE (Kuipers, 2006). In a semi-structured interview, relatives of the identified patient are rated on scales of Hostility, Critical Comments and Over-involvement (which includes factors such as over-protectiveness, excessive self-sacrifice, and inability to lead separate lives). It is well established that patients from High EE families are more likely to relapse, and the intervention therefore focuses on reducing levels of EE and/or persuading family members to spend more time apart. This is achieved by 'psychoeducation', and implementing a structured, problem-solving approach alongside

medication compliance. This in turn appears to have a moderate impact on reducing relapse rates. There are now various manualized versions of these programmes (e.g. Falloon et al., 1984; Anderson et al., 1986; Barrowclough and Tarrier, 1992; Kuipers et al., 2002).

These interventions obviously have useful aspects, although the identified patients generally fall a long way short of making a full recovery: that is, being able to leave home, take up employment, and so on. However, what is particularly interesting is the way Family Management pioneers explicitly distanced themselves from any taint of Laingian ideas by presenting psychoeducational information to the effect that ‘schizophrenia’ is a medical illness: ‘Our aim is to help the family to cope better with the sick member who is suffering from a defined disease’. Within the so-called ‘vulnerability-stress model’ on which the approach is based, everything else that happens in a person’s life, however traumatic, is reduced to the ‘trigger’ of an underlying genetic illness. And while the concept of High EE strays dangerously close to Laingian territory, the programmes staunchly maintained that even the more extreme family dynamics could be attributed to the stress of living with the sick family member. Indeed, educational materials stated, in capitals, ‘THERE IS NO EVIDENCE THAT FAMILIES CAUSE SCHIZOPHRENIA’ (Smith and Birchwood, 1985). In other words, the Family Management position is that High EE can lead to relapse, but cannot lead to initial breakdown. This contradictory stance was maintained despite evidence from several longitudinal studies that High EE attitudes often pre-date initial breakdown by years (Doane et al 1981; Goldstein, 1984 Johnstone, 1996). Moreover, and in stark contrast to Laing and Esterson’s detailed analysis of family interactions, High EE is rated in purely quantitative terms. While acknowledging ‘the central problem of being unable to tolerate separation, so often seen in these families’ (Berkowitz, 1984), clinicians were at the same

time strictly instructed to ‘focus on structure of expression, not content of problems’ (Falloon et al., 1984).

In a critique of the Family Management literature (Johnstone 1993), I argued that the appearance of progress in ‘treating schizophrenia’ has been bought at the high price of silencing and entrapping identified patients within a sick role. I also argued that Family Management’s own data suggest that medication is mainly effective not through treating a disease, but through enabling identified patients to block out hostile emotional environments. In response, senior practitioners of the approach alleged that I was ‘ill-informed’, had ‘dismissed [...] the severe problems faced by sufferers and their families’ (Lam and Kuipers 1993, p. 15), and ‘impugn(ed) our integrity as scientists’ (Leff and Vaughn, 1994: 115). Thus, blame – the unresolved issue in relation to the role of families – was passed around the system. Meanwhile, a vast amount of evidence about the causal impact of family dynamics, which dates back decades, has been swept under the carpet (as summarized in Johnstone 1996; Johnstone 1999.) My prediction that this body of work ‘will continue to preserve a safe distance from the crucial claim [...] that “schizophrenia” is, in form and content, a meaningful response to certain psychological and social dilemmas’ (Johnstone, 1993: 267) has proved to be correct. A modified version, known as Early Intervention in Psychosis, was granted £40 million in 2015/16 to support delivery in England of NICE-approved care packages to people experiencing a first episode of ‘psychosis’ (NHS England 2015). The Family Intervention element of the package is not as rigid as the parent version, but still recognizably from the same stable. The emphasis is on psychoeducation and problem-solving rather than more complex explorations of family dynamics; early use of medication is encouraged, if not absolutely mandated; and the package as a whole is based on the diagnostic category of ‘schizophrenia’ (NICE, 2015). However, this is not the whole story.

The field of mental health has undergone some profound shifts since the 1960s and 1970s, allowing Laing and Esterson's ideas to re-emerge in unforeseen ways.

The diagnostic paradigm

Rumblings of discontent with psychiatric diagnosis have not gone away, despite the production of successive editions of the Diagnostic and Statistical Manual of Mental Disorders in the USA, and the relevant chapter of the International Classification of Diseases in Europe. This came to a head with the publication of DSM-5 in 2013. In a development that would surely have astonished Laing and Esterson, the most forceful criticisms of this massive manual, which has now swelled to include over 400 descriptions of 'disorder', came from senior US psychiatrists, some of whom had presided over the production of previous editions. For example, Dr Allen Frances, chair of the DSM-IV committee, declared that: 'There is no reason to believe that DSM-5 is safe or scientifically sound [...] The science simply isn't there now [...] A research dead end' (Frances, 2014). Dr David Kupfer, chair of the DSM-5 committee, responded: 'We've been telling patients for several decades that we are waiting for biomarkers. We're still waiting' (Kupfer, 2013). These are extraordinary statements, amounting as they do to the admission that the entire psychiatric diagnostic system is fundamentally flawed, and that there are no biological research findings to support the idea that mental distress is best understood as disease.

This does not mean that these eminent critics are planning to abandon diagnosis, and in fact millions of dollars are being poured into the Research Domains Criteria project designed to identify the hypothesized causal biological dysfunctions once and for all (Insel, 2013).

Nevertheless, a chill wind is blowing through the profession of psychiatry, with some of its UK members speculating openly that 'if it becomes apparent that the information obtained by

testing disease theories is incoherent, we may eventually jettison particular disease constructs [...] The disease constructs in psychiatry may be approaching this point' (Bebbington, 2014: 1119). The Division of Clinical Psychology, representing the UK's 10 000 clinical psychologists, has gone further, issuing an official statement which calls for 'a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system that is no longer based on a "disease" model' (DCP, 2013). These developments provide fertile ground for the growth of other non-medical approaches to 'schizophrenia', or in its recent version 'psychosis', as discussed below.

The trauma-informed model

The trauma-informed approach is well-established in many projects and services in the US, New Zealand, Canada and Australia, and is gaining prominence in the UK, particularly in Scotland. It is based on an awareness of the role of trauma and abuse as key causal factors in all human services systems, including mental health. Trauma is broadly defined to include sexual, physical and emotional abuse; emotional neglect; bullying; and witnessing or being a victim of domestic violence, along with a whole range of social adversities such as poverty, discrimination and unemployment (Kezelman and Stavropoulos, 2012). Child abuse and neglect of all forms result in attachment disruptions that prime the individual for the cumulative and synergistic impact of subsequent traumas, although they are not the only causes. Trauma-informed care seeks to avoid re-triggering of trauma reactions, inform service users about the psychological and neurobiological impacts of these devastating events and circumstances, establish safety, and offer the chance to process overwhelming memories and feelings through a variety of supports and interventions (Kezelman and Stavropoulos, 2012). Although often used in conjunction with diagnostic terms, there is a strong cross-diagnostic emphasis on the psychosocial factors underpinning all mental health presentations,

including the ones that are typically diagnosed as ‘schizophrenia’ (Read and Bentall, 2012; Read et al, 2005; Van der Kolk, 2014). In a trauma-informed perspective, ‘symptoms’ are seen as ‘survival strategies’: desperate attempts to cope with overwhelming memories, emotions and bodily reactions which arise from the experience of threat. This chimes very closely with Laing’s description of ‘schizophrenia’ as ‘a special strategy that a person invents in order to live in an unliveable situation’ (Laing, 1967: 95).

It is intriguing to re-visit some of the families interviewed by Laing and Esterson in this light. Public awareness of the prevalence of sexual abuse in particular has grown since the 1960s. With hindsight, we can see that even as astute a clinician as Laing may have missed some very obvious hints. Maya Abbott, for example, at age 15 ‘began to feel that her father was causing [...] sexual thoughts’ (Laing and Esterson, 1964: 42). Ruby Eden heard a voice telling her she was a prostitute. She said that at night ‘people were lying on top of her having sexual intercourse with her: she had given birth to a rat’ (p.131), and had a habit of ‘pawing’ her uncle, who claimed to dislike it. Lucie Blair ‘feels people put unpleasant sexual thoughts into her head’ (p.51). A footnote states that ‘we are fully alive to the inferences to which these facts point, namely Mr Blair’s struggles with his unconscious incestuous feelings towards Lucie’ (p.55). However, nowhere is it suggested that these impulses may have been acted out in real life, with all the profound impacts on mind, brain and body that recent evidence now confirms (Dillon, Johnstone and Longden, 2014).

The Hearing Voices Movement

The Hearing Voices Network is a service user/survivor-led organisation with branches in the UK and over 30 other countries (www.hearing-voices.org.) It originates in the work of a Dutch psychiatrist, Marius Romme, and science journalist, Sandra Escher, who started to

explore the experience of voice-hearing from the patient's perspective. Over the last 25 years or so, the HVN has offered information, support and understanding to people who hear voices, see visions, have tactile sensations or other unusual experiences. Voice-hearers are encouraged to build active relationships with their voices and to come to their own understanding of what they may signify, which is as likely to be spiritual, mystical, paranormal or psychological as medical. HVN research has found that hostile voices very often represent unresolved past or present trauma, for example, an attacking voice may stand for a harsh parent or a school bully (Romme and Escher, 1993). People who wish to do so are offered support to develop an understanding of the conflicts, memories and emotions that the voices represent, which often leads to an easier relationship with them. There are obvious links with the trauma-informed model, although the two traditions have arisen separately. A number of people formerly diagnosed with 'schizophrenia' have written movingly about how the HVN helped them to overcome their very severe and long-term difficulties and leave psychiatry behind (e.g. Coleman, 1999; Longden, 2013).

The ex-patient/survivor movement did not exist when Laing and Esterson were writing in the 1960s, and nor had this particularly successful and influential example of self-help come into being. The 'auditory hallucinations' experienced by the women who were interviewed for *Sanity, Madness and the Family* are not explored in detail, but the perspective we are offered is clearly compatible with a HVN one. For example, it is suggested that Maya Abbott's voices serve the function of avoiding invalidation of her views by expressing her thoughts for her (Laing and Esterson, 1964: 45). Lucie Blair's critical voices echo her father's harsh words about her (p.63). The voice of an electrician seems to represent Agnes Lawson's confusion about her sexuality (p.237).

Open Dialogue

One of the most intriguing features of the post-Laingian field is the high profile being accorded to an approach from a totally different tradition, known as Open Dialogue. Like Family Management, it dates back to the 1980s, but comes from a different part of the world, Northern Finland, where it is the standard approach for all new cases of ‘psychosis’. Open Dialogue projects have also been set up in Norway, Sweden, Lithuania, Estonia, Germany, Poland, New York and, recently, four pilots have been launched in the UK (Carter, 2015). It has been claimed that at five year follow-up, 84% of the ‘first episode’ patients have returned to work or study, and only 20% are on medication (summary in Whitaker, 2010). In stark contrast to Family Management, the Open Dialogue approach to family intervention in ‘psychosis’ is based on the principles of tolerance of uncertainty and, most importantly, dialogue. It is not a strategy, technique or treatment, but a way of thinking and relating. People with ‘psychosis’ are said to be experiencing ‘a temporary, radical and terrifying alienation from shared communicative practices [...] within the dialogical borderland where the person, the important others and the professionals meet, a language for suffering may be born that can give the suffering a voice’ (Seikkula and Olsen, 2003: 411). By gathering as many members of the person’s family and social network as possible, meeting regularly, and allowing shared dialogue to develop, new understandings and meanings can emerge. It is reported that overtly ‘psychotic’ behaviours typically vanish very quickly. Medication is used short term and in low doses, or not at all. In place of applying a label or imposing a manualized intervention plan, the collective dialogue itself produces a way forward, or else the need for specific action dissolves as a new shared understanding of the crisis emerges. Severe ‘symptoms’ may be understood as embodying inexpressible or unspeakable dilemmas, often rooted in traumatic experiences. The therapist’s task is to enable the

development of a new narrative; words must be found for traumatic experiences, and intense feelings must be acknowledged and shared.

Clearly, this is not an approach based on a view of ‘schizophrenia’ as a medical illness, although it is practised within standard multi-disciplinary teams. Among its intellectual sources is the Crisis Intervention Approach pioneered by R. D. Scott and colleagues in the 1970s (as acknowledged in Alanen et al, 2000). Scott himself had worked with Laing and been influenced by his theories. In his articles, Scott vividly described the moment at which member of a family gets diagnosed as ‘schizophrenic’ as a form of closure in which ‘inner disturbance in the family [...] becomes officially located as being disturbance in one member’, bringing relief to those involved, but creating an impenetrable barrier to dealing with the unbearably painful relationship issues (Scott, 1973: 48). Scott’s alternative approach offered an immediate crisis visit in which all family members were offered as much time as necessary to explore the background to the crisis and develop a shared understanding of its relational roots (Scott and Seccombe, 1976). Over time this led to a dramatic reduction in admissions.

In summary, Open Dialogue can be seen as a resurgence of Laingian influences, radically different from the didactic, biomedical, expert-based approach of Family Management. One might imagine that it would have appealed to Laing, whose most striking quality was ‘the time he spent *listening* to mad people [...] he created space that hadn’t before opened up, between himself and the “mad” [...] Someone heard them. They were not alone’ (Gans, 2001 quoted in Itten and Young, 2012: 36). It remains to be seen how successfully it can be implanted within the UK, and how deep a shift in theory and practice it will achieve.

Laing's legacy today

The contemporary picture of Laing's legacy is, as described, complex. There are plans to bring the Soteria model to the UK, based on the houses set up in the USA by one of Laing's contemporaries, Loren Mosher, in the 1970s. They offer a safe, non-medical sanctuary in which people can be supported while in a state of acute 'psychosis'

(<http://soteriabrighton.co.uk/about>). Within traditional mental health practice, some practitioners have modified Family Management into a more flexible and collaborative version which includes aspects of systemic therapy, and does not promote a narrow medical perspective (for example Burbach, 2016). Early Intervention Programmes can, if not too rigidly prescribed, offer a range of options, including those that are genuinely open-minded and service-user oriented (see the Sussex Partnership Trust video, <https://www.youtube.com/watch?v=GXh9hPzHHi4>). More generally, there is a kind of collective professional embarrassment about the stigmatizing term 'schizophrenia', which has led to a wholesale shift towards greater use of diagnoses such as 'bipolar disorder', 'borderline personality disorder' or the general term 'psychosis'. Classic 'symptoms' such as voice hearing and unusual beliefs no longer automatically lead to the invocation of Szasz's 'sacred symbol'. Thus, the flexibility of these unreliable and non-valid concepts allows for a shifting of the goalposts that preserves the profession's position. Archetypal claustrophobic Laingian nuclear families are much rarer, perhaps due partly to the influence of feminism on today's mothers – a perspective that is strikingly absent from Laing and Esterson's analyses. We have greater awareness of the impact of racism and discrimination, and the ways in which this distorts and inflates the figures on 'schizophrenia' (see Fernando, 2010 and also Fernando's article in this volume).

The truths that Laing and Esterson articulated do not apply only to family life, as he was well aware. Families live in wider environments that either facilitate or impede their ability to offer good enough care to their children. Parents who are not given the right support to overcome their own traumatic histories are more likely to pass such experiences down the generations (www.acestudy.org). We now have much more evidence about the toxic impact of inequality and all its social and psychological consequences to add context to our analysis of family interactions, and avoid a simplistic ‘blaming’ perspective (Wilkinson and Pickett, 2009). Looking even more broadly, we can see the roots of much ‘psychosis’ in the highly fragmented, competitive, individualistic ethos of Western industrialized societies (Warner, 2004). On the other hand, there are also indications of a long-standing tradition within psychiatry of stripping ideas of their radical aspects. Thus, rather than seeing extreme manifestations of distress as the understandable consequences of trauma and abuse, this knowledge may be assimilated back into the ever-useful ‘vulnerability-stress’ model, in which they simply become ‘triggers’ of an underlying genetic disease process (Johnstone, 2009). Most Adult Mental Health services now have Crisis Intervention Teams, but their primary aim is short-term management of the crisis situation, rather than in depth exploration of its origins. Similarly, the expanded Early Intervention Programme in England will force family work in ‘psychosis’ back into the box of NICE-defined competencies, i.e. psychoeducation, problem-solving, communication and crisis planning for families in which one person has been singled out as having ‘psychosis’ (Roth and Pilling, undated). Systemic and trauma-informed approaches are not even mentioned in this initiative.

Laing and Esterson’s legacy – the future?

We seem to be living through one of those times when ‘the knowledge of horrible events periodically intrudes into public awareness’ (Herman 1992, p.2). As Judith Herman says in

her remarkable book *Trauma and Recovery*, ‘the conflict between the will to deny horrible events and the will to proclaim them out loud is the central dialectic of psychological trauma. People who have survived atrocities often tell their stories in a highly emotional, contradictory and fragmented manner which undermines their credibility and thereby serves the twin imperatives of truth-telling and secrecy. When the truth is finally recognized, survivors can begin their recovery. But far too often secrecy prevails, and the story [...] emerges not as a verbal narrative but as a symptom’ (p.1). As a society, we have reluctantly and painfully begun to accept the reality of bullying, neglect, abuse and violence, not just within families, but in schools, children’s homes, institutions and communities. The trauma-informed perspective is gaining a hold in services, and even within traditional psychiatric practice there are signs of greater willingness to admit that ‘madness has meaning’. But can psychiatry afford the final joining of the dots in relation to ‘psychosis’, or are the developments described here more accurately seen as attempts to re-define and incorporate this threatening knowledge before it brings the whole house down? Only time will tell whether we can hold on to Laing and Esterson’s profound and dangerous message that ‘madness has meaning.’

References

- Alanen, Y.O., Lehtinen, V., Lehtinen, K., Aaltonen, J. and Rakkolainen, V. (2000), ‘The Finnish integrated model for early treatment of schizophrenia and related psychoses’, in B. Martindale, A. Bateman, M. Crowe and F. Margison (eds.) *Psychosis: Psychological Approaches and their Effectiveness*. London: Gaskell for ISPS, pp. 235-265.
- American Psychiatric Association (2000), *Diagnostic and statistical manual of mental disorders: DSM-IV-TR*. Washington, DC: American Psychiatric Association.

- American Psychiatric Association (2013), *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, DC: American Psychiatric Association.
- Anderson, C. M., Reiss, D. J. and Hogarty, G. E. (1986), *Schizophrenia and the Family*. New York: Guilford Press.
- Barrowclough, C. and Tarrier, N. (1992), *Families of Schizophrenic Patients: Cognitive Behavioural Intervention*. London: Chapman and Hall
- Bebbington, P. (2014), A commentary on Kendler. *Psychological Medicine*, 45, 6, 1119-1120.
- Berkowitz, R. (1984), Therapeutic intervention with schizophrenic patients and their families: a description of a clinical research project. *Journal of Family Therapy*, 6: 211-233.
- Boyle, M. (2002), *Schizophrenia: A Scientific Delusion? 2nd edn*, London: Routledge.
- Breggin, P. (1993), *Toxic Psychiatry*. London: Harper Collins.
- Burbach, F. (2016), 'Brief family interventions in psychosis', in B.Pradhan, N. Pinninti and S. Rathod (eds.), *Brief interventions for psychosis: a clinical compendium*. New York: Springer.
- Carter, R. (2015), 'Open dialogue: A care model that could put mental health social work back on the map?', *Community Care*, Feb 12, <http://www.communitycare.co.uk/2015/02/12/open-dialogue-care-model-put-mental-health-social-work-back-map/>
- Coleman, R. (1999), 'Hearing voices and the politics of oppression', in *This is Madness: A Critical Look at Psychiatry and the Future of Mental Health Services*, eds. C. Newnes, G. Holmes and C. Dunn, Ross-on-Wye: PCCS Books, pp. 149-164.
- Dillon, J., Johnstone, L. and Longden, E. (2014), 'Trauma, dissociation, attachment and neuroscience: A new paradigm for understanding severe mental distress', in E. Speed,

J. Moncrieff and M. Rapley (eds.), *De-Medicalising Misery II: Society, Politics and the Mental Health Industry*. Basingstoke: Palgrave Macmillan.

Division of Clinical Psychology (2013) *Classification of Behaviour and Experience in Relation to Functional Psychiatric Diagnoses: Time for a paradigm shift*. Leicester: British Psychological Society.

Doane, J. A., West, K. L., Goldstein, M. J., Rodnick, E. H. and Jones, J. E. (1981) Parental communication deviance and affective style. *Archives of General Psychiatry*, 38, 679-715.

Falloon, I., Boyd, J. and McGill, C. (1984) *Family care of schizophrenia*. New York: Guilford Press.

Fernando, S. (2010) *Mental Health, Race and Culture* 3rd edn. Basingstoke and New York: Palgrave Macmillan.

Frances, A. (2014) *One Manual Shouldn't Dictate Mental Health Research*.

http://www.newscientist.com/article/dn23490-one-manual-shouldnt-dictate-us-mental-health-research.html#.U0_jR3JeF1s

Goldstein, M. J. (1985) Family factors that antedate the onset of schizophrenia and related disorders. *Acta Psychiatrica Scandinavica*, 71, suppl. 319, 7-18.

Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.

Insel, T. (2013) *Transforming diagnosis*. NIMH Director's blog. Available at <http://www.nimh.nih.gov/about/director/index.shtml>

Itten, T. and Young, C. (2012) (eds) *RD Laing: 50 years since The Divided Self*. Ross-on-Wye: PCCS Books, p.330.

Johnstone, L. (1993) Family management in "schizophrenia": its assumptions and contradictions. *Journal of Mental Health*, 14, 255-261.

- Johnstone, L. (1996) The Genain Quadruplets. *Changes: an international journal of psychology and psychotherapy*, 14, 1, 43-50.
- Johnstone, L. (1999) Do families cause 'schizophrenia'? in C.Dunn, C. Newnes and G. Holmes (eds) *This is Madness: a critical look at psychiatry and the future of mental health services*, Ross-on Wye, PCCS Books. (Reprinted in *Changes*, 1999, vol 17, no. 2, 77-90.)
- Johnstone, L. (2009) Controversial issues in trauma and psychosis. *Psychosis: Psychological, Social and Integrative Approaches*, 1, 2, 185-190.
- Kezelman, C. and Stavropoulos, P. (2012) The last frontier: *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Adults Surviving Sexual Abuse* www.asca.org.au
- Kuipers, E., Leff, J. and Lam, D. (2002) *Family work for schizophrenia: a practical guide*. London: Gaskell Press.
- Kuipers, E. (2006) Family interventions in schizophrenia: evidence for efficacy and proposed mechanisms of change. *Journal of Family Therapy*, 28:73-80.
- Kupfer, D. (2013) *Chair of DSM-5 Task Force discusses future of mental health research*. News release, American Psychiatric Association, May 3rd.
- Laing, R.D. and Esterson, A. (1964) *Sanity, madness and the family*. London: Tavistock Publications
- Laing, R. D. (1967) *The politics of experience*. New York: Pantheon Books
- Lam, D. and Kuipers, L. (1993) Being critical is not a critical review: some facts about family management in schizophrenia. *Clinical Psychology Forum*, 57, pp 15-17.
- Leff, J. and Vaughn, C. (1994) Critics of family management in schizophrenia: their assumptions and contradictions. *Journal of Mental Health*, vol 3, no.1, pp 115-116.

Lucy Johnstone *Madness and the Family: the re-emergence of Laingian Ideas*

Longden, E. (2013) *Learning from the voices in my head* (TED Books, Book 39.) TED Conferences.

NHS England 2015 *Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16*. Feb 2015

NICE (2015) *Guidelines on Psychosis and Schizophrenia*

<https://www.nice.org.uk/guidance/qs80>

Read, J., van Os, J., Morrison, A., & Ross, C. (2005). Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*, 112(5), 330-350.

Read, J. and Bentall, R.B. (2012) Negative childhood experiences and mental health: theoretical, clinical and primary prevention implications. *British Journal of Psychiatry*, 200: 89-91.

Romme, M. and Escher, S. (1993) (eds) *Accepting voices*. London: MIND

Roth, A.D. and Pilling, S. (undated) *A competence framework for psychological interventions for people with psychosis and bipolar disorder*. Available from www.ucl.ac.uk/CORE

Scott, R. D. (1973) The treatment barrier. Part 1. *British Journal of Medical Psychology*, 46, 45-55.

Scott, R. D. and Seccombe, P. (1976) Community psychiatry: setting up a service on a shoestring. *Mindout* 17, 5-7.

Seikkula, J. and Olsen, M. E. (2003). The Open Dialogue approach to psychosis. *Family Process*, 42, 3, 403-418.

Szasz, T. (1976) Schizophrenia: the sacred symbol of psychiatry, *British Journal of Psychiatry*, 129, 308-316.

Smith, J. and Birchwood, M. (1985) *Understanding schizophrenia*. Health Promotion Unit, West Birmingham Health Authority.

Tarrier, N. (1991) Some aspects of family interventions in schizophrenia: 1 Adherence to intervention programmes. *British Journal of Psychiatry*, 159, 475-480.

Van der Kolk, B. (2014) *The body keeps the score*. London, New York: Viking

Warner, R. (2004) *Recovery from schizophrenia: psychiatry and political economy (3rd edn)*, Hove and New York: Brunner-Routledge.

Whitaker, R. (2010) *Anatomy of an epidemic*. New York: Crown Publishers.

Wilkinson, R. and Pickett, K. (2009) *The spirit level: why more equal societies almost always do better*. London: Allen Lane