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THE POLITICS OF CONSCIOUSNESS: ILLNESS OR INDIVIDUATION?

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ABSTRACT Mental health professionals are trained to treat clients who are experiencing psychological disturbance and they regard such symptomatology as signs of illness. This article proposes that psychological disturbances could be understood for their potential contribution towards growth and wholeness, as well as having value in bringing about self-actualization. We discuss findings from quality surveys that reflect the experiences of clients who attended an innovative group-therapy programme in a community mental-health setting. The therapeutic approach was informed by methods from the school of process-oriented psychology. The quality surveys demonstrate significant levels of subjective improvement in clients' quality of life, as well as identifying increased interest in working creatively with their presenting difficulties, which had previously been identified as problematic by both the professionals in the mental health system and the clients themselves. Copyright © 2006 John Wiley & Sons, Ltd.

Key words: mental health; politics; consciousness; individuation

ILLNESS OR INDIVIDUATION?

Individuation is a concept developed originally by the psychiatrist and psychologist Carl Jung. It is an active and dynamic process that reflects shifts in identity towards experiences of growth, which continue throughout a person's life. Jung perceived the individuation process as the psychic equivalent to physical maturation (Jacobi, 1968). The process of individuation is not limited to cultural contexts or definitions of identity (Brooks, 1991); Jung (1940) believed that a creative life was always to be found on the other side of convention. This is an important point when considering the experience of feeling like an 'outsider', as often occurs when a person experiences mental health difficulties in this society. Individuation occurs through a willingness to explore consciousness, to work with complexities that arise, and risk being creative. It is worth mentioning, that in his own process of individuation, Jung had an experience of psychosis (Jung, 1983). The process of individuation raises the possibility that life has a path of meaning and purpose that is far greater than any temporal situation or context that individuals find themselves in. The people who took part in the process

work therapy groups had all been given a psychiatric diagnosis and in many cases had been in the system for many years. It was common for many of them to identify themselves with the diagnostic label they had been given, and to explain their behaviour or character in terms of their diagnosis, for example, 'I'm a manic depressive'.

DIAGNOSTIC DILEMMAS

For many years now there has been an accelerating trend in psychiatric research towards closer assimilation to the natural sciences. As a consequence, neuroscientific research has attempted greater scientific validation of the aetiology of psychiatric illness (Detre, 1987; Pardes, 1991). The 1990s was declared the decade of the brain in terms of the research focus for psychiatry (Clements, 1993). More recently, the emphasis on psychiatric research and diagnosis has continued at considerable pace as reflected in the fourth edition of the Diagnostic and Statistical Manual (DSM IV) (American Psychiatric Association, 1994). The process of differential diagnosis is summed up by Bourne (1991, 247) who states: 'The task of the clinician is to identify the illness and label it correctly, and to administer the right remedy; the task of the patient is to submit to examination and to accept that remedy.'

The dominance of the medical model in relation to the field of mental health has important considerations for society as a whole, not only for the people who work in, or use the mental health services. Eisenberg (1988, 8) illustrates this quite clearly when he states, 'If professional ideology influences society, it also profoundly reflects the values of the society in which it is embedded'. This statement has quite profound implications with regard to the strong influence of medical-model thinking towards the evaluation of mental states. It is not evident in the mental health literature that clients are regarded as having a propensity towards individuation and growth. Maddux (2002) has suggested that our social values are now ultimately tied to concepts of psychological normality or abnormality. This is a crucial area for discussion as it touches into the political influences about 'legitimate' states of consciousness. Widiger and Trull (1991), argue that the diagnostic and statistical manual is a social document and not a scientific document. The diagnosis of mental states into categories of normal and abnormal is a huge socio-political process as Heizer and Jobe (1994, 5) illustrate: 'By and large the criteria for what is commonly considered "normal behaviour" are based on western European cultural standards. The rules which we consciously or unconsciously live by, in part define culture.'

Evaluating certain mental states as 'normal', and classifying the behaviours that fall outside of this norm as 'abnormal', has a powerful effect in determining how states of consciousness are discussed and understood. The authors of DSM IV (American Psychiatric Association, 1994) have undertaken the role of classifying all manner of psychopathology in recent years, which has had a significant influence on current thinking about mental health. The authors of an academic textbook on mental health go on to say that 'we do not accept DSM 1V uncritically. Those responsible for its completion are themselves aware of our incomplete understanding of psychological suffering' (Davison and Neale, 1994, viii). However, Davison and Neale chose to name their book *Abnormal Psychology*. Why do they chose to use the term 'abnormal psychology' when they clearly state that the issue under discussion is psychological suffering? Who is creating the agenda for classifying suffering into categories of normal and abnormal?

This paper supports the view that the diagnosis of mental states reflects as much about social commentary as it does about science

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and categories of illness. In a recent article, Nancy Andreasen (2005), Professor of Psychiatry at the University of Iowa and editor of the *American Journal of Psychiatry*, called for a more humanistic 'phenomenological' approach to treatment, including cultural, sociological, philosophical and political points of view. It is instructive to read that Professor Andreasen was one of the authors of the third edition of the Diagnostic and Statistical Manual. The article also reminds readers that in 1973 homosexuality was still classified as a mental illness. The political emphasis being made here is evident.

Having a range of diagnostic categories is only one aspect of this process. Health professionals then have to consider the extent to which the client's ideas and behaviour confirm and fulfil certain diagnostic criteria. Chadwick (1992) discusses the 'confirmation bias' that operates in the mind of a person who is experiencing a psychosis. Certain information is accepted as true and other information is refuted, or discarded if it does not conform with what is perceived or thought to be happening. Interestingly this same bias occurred in a psychiatric hospital when a group of people without mental health problems took part in a study. They were admitted into hospital without the psychiatric professionals who were caring for them knowing about the research. Interestingly the staff interpreted their behaviour as confirming their diagnosis (Rosenhan, 1973). Can we honestly believe that similar occurrence would not happen today if this study were repeated? Mental health services are still focused on confirming a correct diagnosis and treating the presenting problem.

THE POLITICS OF CONSCIOUSNESS AND POWER

Mindell (1988) has discussed the collective social values that create our notions of normal and abnormal. Mindell believes that the processes that become labelled in a mental health context actually represent a 'city shadow'. This means that individuals who are experiencing extreme states of consciousness are also reflecting the various states of consciousness that any human being could potentially experience. The city shadow represents what is split off from mainstream cultural values. Mindell (1988, 164) goes on to say: 'Everyone has such altered states. At one end is consciousness and awareness, while at the other there is literally no control. Everyone's psychotic corner can be accessed by touching upon a central, mythical, painful issue.'

Mindell (1995) highlights the need for society to work on these split-off processes, which he calls worldwork. The issue of labelling states of consciousness normal (healthy) and abnormal (ill) needs to be addressed. The political relevance of working creatively with extreme or altered states is based on the premise put forward by Mindell who suggests that 'Altered states are to "normal mental health" as relativity is to Newtonian physics' (Mindell, 1994, 8). The relative value of each individual's personal belief systems takes into account the difference between a consensus reality viewpoint and a non-consensus reality viewpoint (Mindell, 2000). The collective values, or the political consensus that defines what is regarded as normal behaviour, are really identifying that one mental state is healthy whilst another is not. Mindell suggests that, in relation to extreme states, 'We need a theory and practice which is not based upon health and illness, normal and abnormal' (1994, 8). This raises the issue of people in society being more willing to work creatively with their altered states (Mindell, 1992; Reiss, 2001). It is here that the mental health services could play a vital role in helping individuals who may be vulnerable and distressed in the early stages of a distur-

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bance. Mindell (1992, 53) believes that we need to get 'more fantasy and feeling involved in dealing with extreme states'; moreover, it is vital to understand the specific nature of a process that is presenting in any experience (Mindell, 2000). In short, finding the wisdom in the symptom.

INNER WORK AND OUTER WORK

A significant feature exists within mental health systems to perpetuate a rigid divide between the members of staff and the clients. The majority of mental health professionals do not undergo any form of personal therapy. Training and practice revolve around understanding psychiatric theory and its clinical application. The mental health professionals' expertise does not include understanding their own mental health needs and processes. It is interesting that recent government initiatives have started to include mental health service users acting as experts by experience. This is an improvement in involving service users but it still perpetuates the 'client ill, staff healthy' divide. In addition, the recent inclusion of the recovery model is a significant improvement in the development of mental health services (Frese et al., 2001). The recovery model advocates for meaning, purpose, and growth beyond the catastrophic experience of mental illness (Anthony, 1993). The recovery model has been identified as being compatible with the medical view of mental illness (Munetz and Frese, 2001). However, the complexity inherent in this new partnership is that recovery is always recovery from mental illness. It requires a departure from conventional medical thinking to consider the notion of recovery being concerned with recovering wholeness after experiencing an extreme state – believing that something useful can lie within and come out of an extreme states of consciousness.

The training of mental health professionals does not generally cover understanding of their own psychological processes. The possibility of power dynamics surfacing in the helping professions is potentially high, as Guggenbuhl-Craig (1971) has identified. The medically dominated mental health services in the UK have very little interest in understanding what mental health means in terms of growth and awareness for people in the midst of disturbance. The current status quo appears to be concentrating on mental health as the absence of illness. In placing all the emphasis on diagnosing and treating illness, mainly with medication, the conditions are created that establish a potential power drama. The staff identified as healers and the client requiring healing. Maroda asks a penetrating question. She highlights the subtle imbalance within any so-called healing relationship as follows: 'How can a therapist who does not know the truth about herself facilitate the patients awareness of what is true about himself and the relationship?' (Maroda, 1994, 104). The mental health services mostly function from the certainty of their diagnostic manuals, however, there is very little debate in the mental health literature about uncertainty (Collins, 1999a). Mental health professionals are trained and encouraged to help clients gain 'insight' into their illness. However, Greenfield et al. (1989) have identified that there is no commonly accepted definition for the term 'insight'. Recovery for most clients in the mental health system is probably connected to recovering from the inconsistencies and paradoxes of the medical model. For example, Strauss and Estroff (1989) report that mental health professionals ignore many aspects of a client's subjective reports, thereby losing many possible avenues for understanding and healing.

The value of process-oriented psychology to the lives of clients who are using mental

DOI: 10.1002/ppi

health services is that it values uncertainty (Collins, 1999b) and is interested in finding out about the process that is unfolding (Mindell, 2000). Process work recognizes the relative value of the many viewpoints that shape our consensus reality, taking into account culture and context. However, as well as acknowledging consensus reality, process work also values the possibility that non-consensus experiences may be meaningful to an individual and the collective. The benefits of using process work within a mental health system have already been identified and developed (Mindell, 1988; McClelland, 1992; Audergon and Audergon, 1994). This article cannot possibly represent process work theory, which underpins the foundation of the group therapy outlined below (see Mindell, 1988, for further reading).

PROCESS WORK GROUP THERAPY

Over a 4-year period, three groups running for 12 weeks focused on 'self-esteem' and two groups running for 6 weeks focused on working with the 'inner critic'. In addition, a monthly process-work development group took place. In all, 30 people were assessed for the groups and 27 were offered places.

Presenting problems using conventional diagnostic groupings

Depression 100%
Anxiety 50%
Anger 25%
Psychotic features 20%
Physical symptoms 20%
Excess alcohol use 17%
Bi-Polar 11%

Duration of difficulties experienced by the clients ranged between 3 and 20 years. Of the 27 people offered places 88% completed the groups. The number of dropouts – three – is very small to begin to deduce a pattern of those who may not be suitable for this way of working. Differential diagnosis played no part in a person taking a place in the group. Rather, the responsibility and choice was given to the clients to determine whether they were able and willing to engage with this process in a creative way.

Aims

The aim of these groups was to introduce a different approach towards treatment that recognized the complexity and needs of the clients, as well as their potential for growth and wholeness. This type of treatment approach had not been addressed in the mental health trust in this way before. People experiencing long-term depression and other conditions that lead to low self-worth often have a tendency to become stuck in the system and can eventually become treatment resistant, thereby placing additional strain on resources. These clients may have tried a variety of therapeutic approaches or interventions but over time they have often developed a sense of worthlessness and perceive their quality of life as very low. In many cases the clients present with ongoing risk to themselves or others. The mental health system often does not know how to engage with these clients and it is common for staff to express feelings of hopelessness in a team context when a client shows little sign of improvement. These groups were designed to provide an innovative approach to therapy while providing another dimension to mental health service provision. The following goals were put to the clients at initial interview: to have choice and encourage the development of awareness, as well as creating an environment where the clients could be supported to address any changes that they felt they would like to make, and to explore meaning within their experiences.

DOI: 10.1002/ppi

Orientation

The facilitator was focused on enabling people to engage with, follow, and unfold their process to consider new patterns of awareness that might be trying to emerge. An essential part of the work was designed to enable people to consider how they currently identify themselves – for example, as ill, mad, out of step with society, a victim and so on – and to find creative ways of working fluidly with the emerging process. The guiding principle of the therapeutic style was aimed at helping people understand that negative self-evaluations and identifications are not fixed and do not reflect the whole. Most of all, the facilitators were determined to create a depth of connection in the work and, wherever possible, have fun. Both facilitators agreed that they would relate consciously to their own experiences, recognizing the skill and experience that was required. (During this time both authors of this paper were students of process-oriented psychology and received process-work supervision.)

Preparation

Clients completed short questionnaires before and after the groups. Initially they were encouraged to focus on their perception of difficulties, as well as their hopes and fears for the future. At the end of groups all participants filled in a quality survey. In addition, for two of the groups, we introduced a Clinical Outcomes in Routine Evaluation (CORE) questionnaire, which was filled in before and after the group. The questionnaire measured perceptions of functioning, well-being, problems, and risk. The authors acknowledge that this procedure cannot be considered a formal research project, the good practice of taking a range of before-and-after measures indicated emerging trends that demonstrate improvements, which will be listed and discussed below.

The facilitators ensured that adequate preparation time was included for meeting before and after each group to process any issues arising or deal with any material left over from the previous week. This was in addition to engaging in formal process-work supervision. The facilitators also used a variety of creative ways of processing reactions and responses to the work, which included singing, painting, playing instruments, dream work and relationship work.

An example of the inner work that arose occurred when one of the facilitators found two images emerging during a piece of work. The first was a figure that was carrying a huge rock. The weight and size of the rock represented a burden to the figure carrying it and reflected the sheer weight of disturbance, marginalization and feelings that many of the clients endure. The second image was a figure that made contact with its shadow. The figure and its shadow held hands and started to dance. The facilitators felt that this represented a meeting with their own and society's split-off processes and reflected an opportunity to be creative with them. In many ways working with these figures enabled the facilitators to contact the depth, feeling and complexity of the work. It also identified where the facilitators' personal processes were involved and underlying within the work.

Therapeutic style

A typical process-work group-therapy session would last for 2 hours. Each week clients would be given a prepared exercise that focused on a different theme each week. The exercise handouts were primarily designed to build up the clients' confidence gradually. It was intended that working in this way could be both difficult and fun, as well as being experiential and experimental. For example, when working with an inner figure the client is asked to consider how the

DOI: 10.1002/ppi

Table 1. Before-and-after totals for each domain

Domain	*Before*	*After*	*Change (%)*
Functioning	193	117	25
Problems	230	142	28
Wellbeing	75	43	42
Risk	30	7	76
Self-esteem	16.5	40	60
Criticism	16	22	37

figure looks, what the figure might say, how would it move, and so forth. The facilitators always demonstrated the exercise first. Then the clients worked in pairs, taking turns to facilitate each other's process. The group facilitators would be on hand to help out but often the clients valued taking this role, which was considered an important part of the empowerment process. At the end of each session, time would be given for people to complete any work that was awkward or incomplete. The facilitators would work together with a client in the middle of the group.

Feedback and reflection

Two groups, totalling nine participants, completed the core questionnaires. Questions addressed four domains: risk, functioning, problems and wellbeing. The before-and-after totals for each domain, as well as the percentage changes are shown in Table 1. A reduction in the score indicates an improvement in perception of functioning and wellbeing and a reduction in perception of problems and risk. For self-esteem and ability to deal with criticism an increase in scores indicates an improvement in perception of self-esteem and ability to deal with criticism.

All scores show an improvement in participants' perception of ability to function and their sense of well being. Perception of problems significantly reduced and risk is dramatically reduced by 76%. Self-rating of self-esteem and ability to deal with inner criticism also indicate a more positive self-image emerging. This was maintained at follow up after 3 months.

SAMPLE FEEDBACK FROM THE PROCESS WORK QUALITY SURVEY

1. *What are your thoughts and feelings about process-oriented psychology (process work)?*

Under this heading some of the initial difficulties of engaging with the work were identified:

- At first I did not understand the direction that process work takes.
- I found it stressful at first.

However initial difficulties soon disappeared as demonstrated by these comments:

- I gained genuine self esteem rather than seeking external validation.
- It was extremely beneficial, it works, but requires discipline to continue at home.
- It successfully teaches techniques that may start unravelling the strands of overly self-critical thought.

2. *What did you find ineffective as a way of working therapeutically and creatively?*

Some participants found role work difficult. Others identified the short duration of groups as potentially difficult. One participant reflected that the emphasis was on looking forward rather than back.

- Twelve weeks is too short.
- Past difficulties resurfaced after the group.

DOI: 10.1002/ppi

- Process work was ineffective only on the days I couldn't open up.
- Perhaps it is not so applicable to the early sources of psychic trauma and the effects of these childhood neuroses.

3. *What did you find effective as a way of working therapeutically and creatively?*

Feedback here highlighted the sense of support and sharing and reduction in isolation that comes from groupwork as well as the creative aspects of the work:

- The support and sharing and the mix of groupwork, one-to-one and inner work.
- It eased the isolation of depression.
- The creative approaches and role play were good.
- Imagination and inner visions were worked on and encouraged.

4. *Have you noticed any changes in yourself or your situation as a result of the work you have done?*

The feedback to this question highlights a shift in identification:

- I have more self-knowledge and awareness.
- I'm a good person, not bad.
- I can stand up for myself and feel calmer and more creative.
- I identify myself as my ally.
- I have peeled away the last layers of hypercritical approach to self and others.
- I'm more emotional, but positively.

5. *In what way could you attribute any changes in yourself or your situation to the work you have done in process work?*

Comments here reflect the change in perception of ability to deal with problems:

- I am able to cope in situations that I was unable to cope in before.
- I have an internalized set of tools for problem solving.
- I deal with issues rather than avoid them.
- I have gained more insight into how and why my critic operates and I don't let it overwhelm me.
- My thought processes are different; I have shifted old patterns of mine.

6. *Could you list six words that sum up your experience of process work?*

Table 2 shows the words used in rank order of frequency used: 1 reflects the initial sense of excitement, 2 gets to the core difficulty, 3 and 4 reflect growing familiarity, confidence and sense of freedom, 5 reflects the importance of relationship, 6, 7, 8 and 9 the actualizing of the individuating potential.

7. *Would your experience of process work lead you to recommend it to others?*

The entire group responded 'yes'.

8. *How does process work fit with your impression of mental health care and what are your thoughts about providing process work in a mental health care setting?*

Feedback indicates the positive impact of this type of group work.

- Extremely important part of mental health care. It should be more readily available to those who need it.
- Invaluable.
- This has been my best experience of mental health care; my faith has been restored.
- Totally new and opposite to any other experiences. Should be highly regarded and used accordingly.

DOI: 10.1002/ppi

Table 2. Words used to sum up experience of process work

Rank order		*Frequency*
1	Fun, enjoyable, expanding, dreaming, creative, exciting, exhilarating, cathartic, dynamic	19
2	Upsetting, scary, stressful, powerful, hard, enduring, tiring, painful, puzzling	17
3	Natural, freeing, understanding, insightful, intuitive awareness, honesty	11
4	Spiritual, self-actualizing, liberating, enlightening, humane	9
5	Sharing, supportive, revealing, trust, holding, solidarity, empathy, inclusion	9
6	Harmonizing, calming, confidence, relaxing	8
7	Different, interesting, informative, surprise, fascinating, unexpected	6
8	Useful, helpful, beneficial, positive	5
9	Encouraging, rewarding, enabling, adult	4

- It surprised me to find something that looks at the person as a whole, in the face of whatever instabilities they may have suffered.
- Outside what is normally offered. Not what you would expect in a clinical context. Very good.
- A new, lighter way of dealing with mental health care.
- Mental health care of helpful, non-traditional and cutting-edge calibre.
- A refreshing proactive way of dealing with therapy.

DISCUSSION

The feedback and scores outlined above demonstrate that the group therapy approach that has been discussed in this paper has created an environment where clients have the freedom to experiment with their growth and wholeness. The scores outlined in Table 1 show a clear trend towards improvement in areas such as functioning, wellbeing, reduction in risk, higher self-esteem and an ability to manage negative self criticism, in addition, perceptions of problems were significantly reduced. The engagement with the treatment process is clearly outlined in Table 2. The frequency of the words that describe their experiences, show how the clients initial excitement and quality of trust is engendered early on. This allowed people to face some of their core difficulties. The safe container of the group experience allowed people to experiment and work with their difficulties and potential for growth.

The clients' feedback comments, quoted above, demonstrate the shifts in self-perception and self-belief that occurred during the group and were maintained at follow up appointments. The language of the comments is both assured and empowered. It is interesting to note, during the time that the facilitators ran these groups, that at no point was illness terminology used. This was not a deliberate ploy; rather the whole ethos of running these groups was informed through an emphasis on exploration, emotional release, having fun, and being willing to use dreams and imagination within the therapeutic process. Most importantly, the clients had a sense of ownership in the group process through being co-facilitators for each other. The following quotes from two of the clients are instructive: 'Process work is a real necessity in mental health care, it has given mental health care new meaning.' 'This is vital to mental health care work. A lot of people's problems stem from not being

DOI: 10.1002/ppi

allowed to move, sound, freely, be expressive. This is more caring. I prefer the spiritual approach to the medical.' The authors consider the need for future research and development that explores the longitudinal outcomes of clients experiences, and how patterns of recovery connect to patterns within their individuation process.

CONCLUSION

This paper identifies that recovery from mental health has political implications. Terms such as 'mental illness' unfairly segregate people's experiences into 'normal' and 'abnormal', which limits the scope that the mental health system and the client have for addressing change. The process-oriented psychology groups have demonstrated that it is possible to add another dimension to mental health practice, which complements the good work that already exists despite the mental health system's limitations, which have been outlined above.

This paper has identified a method for engaging with individual's growth and individuation that emphasizes the potential for finding meaning within disturbance. Recovery should be at the heart of the treatment ethic within mental health services. This article strongly proposes that recovery should not only be about recovery from illness, it should also be about recovering a sense of wholeness.

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