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EDITORIAL

> 'Mental illness counts for more than a third of all illness in Britain, and 40 per cent of all disability.' (Rosie Winterton, UK Health Minister, quoted in Gray, 2007, 18)

The central question for the exploration of psychotherapy and politics is perhaps 'What is therapy *for?*' Is it, for example, a way to explore our conscious and unconscious organization of feelings, impulses and fantasies? Or is it a set of techniques for alleviating undesirable symptoms and behaviours? At one extreme, does it offer support for those oppressed and alienated by current social arrangements; or, at the other, a cost-effective way of lowering the uptake of incapacity benefit?

An odd thing about the current state of psychotherapy and counselling is that *all* of these views, and many others, are simultaneously in play. The unity of psychotherapy in other words, is somewhat like the unity of Native Americans and Hindus, based on a curious history that gives them all the same name – except that we are divided not only by difference but also by outright hostility. One might expect that this would create a state of effective civil war, or even anarchy, in the profession; that it would be apparent how the single title of 'psychotherapy' sews together a ragbag of incompatible and mutually antipathetic views.

However, this is not the case. By some subliminal agreement, therapists and counsellors generally pretend that we are all doing roughly the same sort of thing. This mutually convenient fiction papers over a number of deeply held disagreements, of which a particularly sharp example is the issue of 'mental illness', which runs through the whole history of therapy and counselling.

Psychoanalysis began by distinguishing itself from medicine, and distinguishing psychological suffering from physical illness. While Freud always maintained this position, many of his followers quickly revised it; the only issue on which Freud's position was successfully opposed in the IPA was that of lay analysis, with the US analysts successfully insisting that all analysts on their turf must be doctors (Gay, 1989, 489–500). And if analysts must be doctors, then presumably analysis must be a medical practice, a treatment of illness. The pendulum has continued to swing back and forth over the last century, with therapists of all persuasions on both sides of the argument.

There are (at least) two political issues here, one concerning the client – the use of the word 'patient' being one of many hangovers from the medical model – and one concerning the therapist. Both are complex. As regards the client, to be defined as 'ill' can be experienced as both empowering and disempowering. It is not my fault if I am ill! – whereas to be mad or miserable or lacking in judgement are all more morally ambiguous states. At the same time, though, to be 'mentally ill' is to lose responsibility for my own actions. In the final resort, I can be forcibly restrained and imprisoned; and well before this sort of sanction, there are innumerable subtle ways in which I am positioned as incapable of full choice. By denying

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responsibility, I lose responsibility. All of this has been described at length by Szasz (e.g. 1974), Laing (e.g. 1982) and their followers.

The issue for therapists has been less thoroughly treated and is only now unfolding fully. Under pressure from the large organizations in the field, the UK government has finally committed itself to regulating psychotherapy and counselling. However it has shied away from the familiar old style of independent regulatory organizations, and decided to regulate therapy through the Health Professions Council – a body responsible for 'professions ancillary to medicine'.

Here the full, dreadful consequences are revealed of a decades-long campaign for the provision of psychotherapy and counselling through the National Health Service – a campaign the success of which is marked by the epigraph to this editorial. In order to create the possibility of therapy which is free at the point of use, organizations have drawn on the long tradition referred to above and painted therapy as a form of medical treatment. Once convinced of this the government has then concluded, not unreasonably, that forms of medical treatment need to play by the rules of modern Western medicine. We are very thoroughly hoist by our own petard: likely to be constrained by an objectified and objectifying model of therapy bolted to an inappropriate notion of evidence-based practice.

This is not the fault of 'socialized medicine': private enterprise reaches the same conclusion. Closely parallel things have happened in the US with the 'managed care' system of health insurance; and must inevitably happen as a result of any method of getting psychotherapy that is free at the point of use by disguising it as a medical treatment. Two very different motivations combine to create this disaster: an altruistic wish to make therapy available to all, plus a self-interested desire for work. (This applies equally to trainers and training organizations who seek work for their trainees – so that they can attract more trainees).

This is the second editorial devoted to aspects of this issue; and we make no apology for that. This is the climate-change crisis of our little therapy world; and, on that microscale, likely to have equivalently huge consequences.

This issue of PPI has four large papers rather than several shorter ones. Each of them well deserves its space. Two concern one of the journal's recurring themes, conflict resolution; they are very different from each other in tone and content, but usefully complementary. Hilde Rapp's paper completes her extensive re-visioning of the field of what she calls 'peace-building', using throughout her four-quadrant approach. It is a large-scale and in a sense abstract approach, which can be applied as theoretical scaffolding at any level of approach from the general to the specific. As we have said before, Rapp's work is likely to be of great importance.

Maurice Apprey, by contrast, offers a detailed and theoretically dense account of one very specific issue, what he terms an 'ethic of transfer': in other words, a rationale and a procedure for returning ownership of conflict resolution projects to the hands of the communities where they have been carried out. As Apprey demonstrates, this detailed issue has large and significant ramifications. The paper is at times heavy going, but well worth the effort; it draws extensively on Elliot et al.'s work on Northern Ireland (2004), published in PPI.

Haaken, Fussell and Mankowski's paper on domestic violence issues in evangelical Christian culture is a departure for this journal; it does not cover obviously therapy-related issues. However, the whole question

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of fundamentalism is clearly directly relevant to the project of PPI; and it is rare to have the opportunity to experience such a sympathetic, yet external, view of a fundamentalist culture as it attempts to reform itself.

Dominik Havsteen-Frankl takes up what he himself describes as a perennial question about psychoanalysis: is it a Jewish cultural artefact? As part of creating a proper context for the question, he looks at themes of inclusion and otherness, and at the whole touchy matter of describing cultural characteristics; with great originality he employs Matte-Blanco for this purpose.

A wide-ranging issue of PPI, then; and the two reviews by Nicola Neath and Nicole Devarenne widen our range even further.

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