The necessary ambivalence of David Smail: A critical realist reflection

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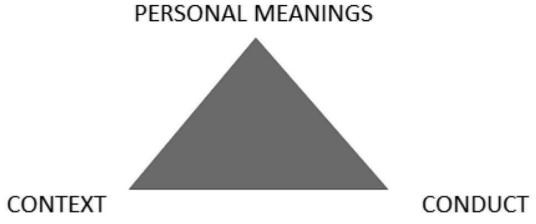
CERTAIN TRENDS and seeming contradictions can be spotted in the work of David Smail. His early work focused heavily upon justifying and offering a humanistic form of psychotherapy. Later, he began to question whether therapy was over-valued and possibly largely futile. Eventually, he located mental health status firmly in proximal and distal material social conditions. In this presentation, that ambivalence will be summarised as an example of a collective dilemma about psychosocial complexity. That dilemma was not David's alone but was, and is, present for anyone in the mental health industry, whether we are therapists, researchers or service users. My paper draws upon the philosophy of critical realism to illuminate that shared ambivalence for us all.

David's work moved over time from emphasising the unique dimension to personal experience, when working with people in distress, to the material conditions, past and present, relevant to their particular lives. His work also was infused with an ethical dimension: he returned often to the matters of power and human agency. As he knew, at all times we live in a world that is not a level playing field. This means that ambivalence or equivocation is present in the work of any serious-minded approach to lived experience, which is situated in time and place because we are dealing with extensive complexity about a triangle of factors in dynamic flux over time.

Everyone speaking at David's commemorative conference explored the precarious ambivalence we all necessarily experience when doing our best with the complexity he suggested. All of us have a limited capacity to deal with its totality. Each point and relationship between the points is a seductive resting place for our attention. We can offset this risk though.

Figure 1: Complexity over time.



First we can be honest self-critics within the iterative process of research or writing. Stop and think: 'What did I miss out?' Second, work with others – ask them why for them the whole triangle is not in full view. Third, explore topics that demand multi-factorial causal reasoning, which is about people, their construal of the world and the particular material conditions of their bodies and social settings, past and present. Moreover, that reasoning must include not exclude values (the error of naïve realism or positivism). We live in a moral order and human science is necessarily a moral science (Brinkman, 2011). Human scientists are part of what they study – they cannot be 'disinterested'. We need to be mindful of what we study and why, as well as what we ignore. An omissive critique is about our silences not only our research activity (Bhaskar, 2009): why do we study some aspects of reality and not others?

Multiple factors: George Albee's two formulae

Picking up on my third injunction, here are some examples which test our ability to expect and respect complexity. The first is the work of George Albee. For those who find arithmetical metaphors useful, here is his take on the relationship between the prevention of mental illness (MI) and the promotion of mental health (MHP) (Albee, 993).

MI= stress+ exploitation+ organic factors support+ self-esteem+ coping skills

MHP= coping skills+ benign env.+ self-esteem stress+ exploitation+ organic factors

Notice how in his attempt to be comprehensive, Albee has done a fair job. The material context is there in buckets, and so is conduct. He recognises experience in its inner and interpersonal sense. He does not deny our biological reality. He does not avoid the value judgements that must come with human science ('exploitation' is there to be seen). All good stuff – except that he has no conceptual or pre-empirical reflections about what he means by MI and MHP. Nonetheless, his formulae are very helpful and illuminating.

Reformist mental health promotion

Here is another example from some health economists (Knapp et al., 2011) about complexity when empirically calculating the cost-effectiveness of public mental health initiatives. They found that the three highest 'pay offs' were: the prevention of dysfunctional conduct through social and emotional learning programmes; suicide prevention through bridge safety barriers; and suicide prevention training in primary care. The three poorest interventions were: early intervention for depression in diabetes; befriending of older adults; and health visitor efforts to reduce post-natal depression.

This health economic approach is necessarily about limited resource allocation within the welfare state arrangements of capitalist economies. That context of realpolitik, so loved by neo-liberal politicians, constrains what is possible but it still prompts us to think of structures outside of people and their distress. Maybe it is a good idea to have safety barriers on bridges, just like it is a good idea to take guns out of society; suicide and homicide rates would be affected dramatically in countries like the US.

Layard's own goals

Here is another example that prompts us to think about multiple factors and ethics in context: the work of the labour economist Richard Layard. Basically, he points out that miserable people make poor workers and they are thus an impediment to socio-economic efficiency. Consequently, he argues that it is cost-effective for governments to treat mental illness in order to remove the burden it creates in lost productivity, poor fitness for work and the costs of long-term health care access. The ear of Gordon Brown meant Layard's Improving Access to Psychological Therapy initiative, which placed cognitive behaviour therapy centrally, became public policy under New Labour (Layard et al., 2006). Layard's book on happiness pointed out that the 'hedonic treadmill' and social inequality have led to no improvement in the mental health of developed societies of Western Europe, North America and Australasia, despite overall GDP increases in the past 50 years (Layard, 2005).

Layard's class background (public school and Oxbridge) and his coming into confident adulthood in the post-Second World War period (with a common cultural belief at the time in the 'technological fix') meant that he believed there could be an expert fix for any problem provided the right expert could be found. That is how he proceeded when faced with the social problem he called 'mental illness'. His chosen advisory group of psychiatrists and one clinical psychologist from his nearby metropolitan elite offered their solution: the mass availability of CBT. Unlike anti-depressants, CBT could not be put into the water supply but it could be made widely available on the NHS. This was linked to the Pathways to Work initiative, offering Gordon Brown the promise of fiscal savings, which he gladly and naively embraced.

This was all before the downturn of international capitalism in 2008. Gordon Brown and the metropolitan elite of the IAPT group and 'The Depression Report' were impotent in the face of the impact of the neo-liberal project, in a world in which the sub-prime mortgage crisis in the US rendered the poor of the UK and other countries even poorer. What we now have, post-2008, is a world of insecure employment; the very scenario which impacts negatively on mental health even more harshly than chronic unemployment (Kasl et al., 1998).

Layard scored a few truly dazzling goals in his upstream analysis about the emergence of misery in unequal societies that fetishise conspicuous consumption. Sadly, though, these were cancelled out completely. He offered us 'howlers' of 'own goals', when believing in a 'technological fix' for human misery. Worse than that, his commitment to the view that mental illness was the cause (sic) of misery, rather than being co-constituted by it, was flawed logic. This meant that the real causes of misery (childhood adversity, current poverty, bullying at work, domestic violence, status envy, etc.) could be expunged from his analysis. Moreover, the naïve realism of CBT, within IAPT, with its conveyer-belt reliance on a treatment-of-a-diagnosed-disorder approach (rather than one of rich formulations), also scorned a realist account of the insults and adversities that underpin distress. IAPT and CBT are yoked in a world which is out of touch with the complex reality of our mental health and our distress.

'Poverty Sucks' but 'Money Can't Buy Me Love'

My next example of a challenge in which we have to keep many balls in the air, or plates spinning, relates to the matter of money. A part of the current body of knowledge we have about the social context of mental health relates to wealth. The happiest countries are those in which 'post-materialist values' predominate (Richard Wilkinson's excellent contribution in this document elaborates why). The US is the richest country in the world but by no means the happiest. The relationship between gross national product (GNP) and happiness is not linear but curvilinear. Beyond a certain level of GNP, there is a flat-lining about happiness: slight ups and downs in wealth make no difference. For example, even with dramatic negative changes in economic circumstances, after years of growth in the 'noughties', there were only slight declines measured in self-rated happiness among the Irish.

However, in Europe there do remain variations between nation states. The European Social Survey shows that individuals in one of the richer countries, Denmark, report the highest level of happiness. By contrast, those in Bulgaria have the lowest because of its brutal transition to capitalism in the early 1990s. This savaged its welfare and educational systems and created an amplifying gap between the richest and the poorest.

The World Happiness Index is noteworthy because of the absence in the top-ranked countries of both the USA and the UK. The repeated measure of the global trends about happiness note that those in absolute poverty are certainly the most miserable but…

> *This process is not linear, however. The correlation weakens as one moves up the economic scale. Above $13,000 in 1995 purchasing power parity, there is no significant linkage between wealth and subjective wellbeing. The transition from a subsistence economy to moderate economic security has a large impact on happiness and life satisfaction, but above the level of Portugal or Spain, economic growth no longer makes a difference.* (Inglehart et al., 2004, p.134)

The authors also noted (this was pre-2008) that globally happiness had increased gradually since 1980, and they suggest that this was a function of three intersecting processes: increasing wealth, democratisation, and greater social tolerance. Conspicuous consumption diminishes the quality of our lives, but the prioritisation of mutually intimate relationships does the reverse, as does belonging to a faith group. Suddenly getting much richer does not generally make us happier (Brickman et al., 1978). Although richer people in a particular society are generally happier than poorer people, increasing one's personal wealth does not increase subjective wellbeing (Diener & Biswas-Diener, 2002).

Sen (1998) notes that routine and stable daily access to a set of benign experiences at home, in public spaces and at work, along with confidence in an adequate welfare state for when and if we become poor, sick or disabled, all underpin our wellbeing. By implication, the obverse is true: domestic violence, crime (or fear of it), noise pollution and bullying at work, or poor task control in one's job all have a negative impact on our mental health.

Sen's assumptions about direct and contemporary environmental circumstances, are reinforced by studies of extreme events: being homeless impacts negatively, as does being tortured, sexually assaulted or raped. Floods, hurricanes, earthquakes or genocide leave measurable impacts, and the most obvious and common direct external impact comes from warfare (Keane, 1998).

In addition to poverty reduction and the closing of social inequalities, warfare remains one of the most important political challenges in improving mental health for us all. The wave of refugees from war-torn, post-colonial settings to Europe now means that we have to re-conceptualise our service philosophies about mental health. In the UK, our current approaches were predicated on 50 years' worth of political stability in the Western world. However, global war and 35 years of the neo-liberal project have left us having to start all over again in our thinking about what needs to be done.

Apart from the physical shock of sudden environmental events outside of the person's control, biographical disruption has both inner and outer impacts. A traumatised person may be impaired in their ability to trust others and may lose confidence in their ability to work. These inner aspects of life may be combined with external dislocation and loss. A person may lose their job and livelihood and with it their identity and social status.

The luck of the draw

From conception onwards, our chances of good mental health are inflected by social context. We do not decide whether to be born here and now or there and then. Our gender, class and race are wholly or overwhelmingly determined by the accident of our birth. We do not choose our parents, and we are lucky if we have ones that treat us lovingly and with respect and do not emotionally, physically or sexually abuse us. Some of us are simply luckier than others in all of these regards.

Warfare is probably the most horrible contingency for any of us but especially if we are civilians not combatants (Goldson, 1993). Our evolution and our early forms of societal organisation, based on hunting and gathering, had low levels of both competitive aggression and lethal technology. Once we settled rather than wandered, and territory and prized mates were protected by the willingness of men to be violent to other men, then our collective slow suicide as a species began, spurred on in its scale by the invention of distal weapons of mass destruction.

The power hierarchies that ensued with the transition from feudalism to capitalism, based on class and gender, and the colonial military adventures that wove casual racism into our social organisation and everyday norms of thought and action, ensured multiple forms of inequality. For this reason, when faced with a live person who is distressed or dysfunctional by their own admission or according to others, we have to formulate their problems using intersectionality.

The intersection of class, race, gender, age and sexuality will all inflect our particular experience of mental health. Social class is by far the strongest of these predictors but it is not the only one; other social group memberships have to be considered and they will vary in their salience from one person to another (Rogers & Pilgrim, 2014). Moreover, even the inclusive sociological notion of intersecting forms of 'social group membership' does not do the job fully. When we trace the role of childhood adversity in inflecting adult mental health status, we come to recognise that an actual social group (those with abusive experiences in childhood) are not empirically recorded in social epidemiology.

A final critical realist reflection

I have explored all of the above examples elsewhere in book-length detail (Pilgrim, 2015). There, I tried to summarise in tabular form the complexities of the triangle I introduced at the outset. The first table sets out the internal factors that increase or decrease our luck in life and the second sets out the factors which are external to our existence and often out of our control or awareness. Both are aspects of reality: this is not an 'either/or' logic but one of 'both/and'. We are both determined and determining beings.

With the summary implications of these tables in mind, I want to end on some points from the philosophy of critical realism (Bhaskar, 1986). This philosophy rejects the naïve realism of positivist natural science and social science and also highlights the perils of strong social constructionism from within idealist philosophy (traceable via Foucault to Nietzsche).

Critical realism is committed to the primacy of ontological realism (the world exists and it is mind-independent). It also recognises that

we individually and collectively, across time and space, construe that reality in variable ways (epistemological relativism). And at the end of it all, we can do our best in good faith to make sense about what is true (judgmental rationality). One of the early speakers at this conference emphasised how David's work impressed him so much because it told the truth about a complex and oppressive world in flux. All of us would do well to follow David's example.

Table 1: Self factors (modified from Pilgrim, 2015).

	Life affirming factors	**Life negating factors**
INTERNAL REALITY	Acceptance of given reality	Avoidance of given reality
	Stability of self	Instability of self
	Trust in self and others	Lack of trust in self and others
	Tolerance of change	Intolerance of change
	Meaning as process and outcome	Absence of meaningful life
	Free of bodily pain	In chronic pain
	Control over movement	Lack of control over movement
	Can enjoy pleasure as it arises	Absence of pleasurable experiences

Table 2: Societal factors (modified from Pilgrim, 2015).

	Life affirming factors	**Life negating factors**
	Adequate income	Poverty
	High social capital	Low social capital
EXTERNAL REALITY	Stable peace	Warfare
	Participatory democracy	Lack of participatory democracy
	Bodily health	Bodily disease
	Adequate welfare safety net	Inadequate welfare safety net
	Adequate diet	Inadequate diet
	Stable shelter	Unstable shelter
	Religious or other existential ordering	Poor existential ordering
	Benign neighbourhood	Malign neighbourhood

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