Concepts from the Work of David Smail Discussed by Members of Walk and Talk

Abstract

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Full-Text

Concepts from the Work of David Smail Discussed by Members of Walk and Talk

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SUMMARY: This paper is based upon two one-hour discussions between members of a Walk and Talk group about four key concepts from the work of David Smail and the Midlands Psychology Group's Draft Manifesto for a Social Materialist Psychology of Distress.

KEY WORDS: group, distress, will-power, outsight, social-materialism

Walk and Talk is a weekly group that meets in Shrewsbury town centre and follows a picturesque route along the river Severn for a two mile walk with the option of a drink and something to eat at a local pub afterwards. One of the aims of the group is to enable people to get the psychological and physiological benefits of exercise, being in the countryside and being part of a safe and supportive group, all of which are well documented in the literature (Holmes and Evans, 2011; Thompson Coon et al, 2011; Powell et al, 2011; Priest, 2007; Pretty et al, 2005). The group is run by a collective of people who advertise the group, guarantee that there are always people at the meeting point each week to greet people and explain the route to newcomers, and who informally keep an eye on everyone to make sure people are okay and getting what they want from coming along. This facilitation style has been described as 'unobtrusive shepherding' (Holmes, 2010). Having a number of organisers also enables people with different needs and walking paces to be catered for. As the posters that advertise Walk and Talk indicate, it offers a general invite to people who might have an interest in nature, as well as those who feel they might benefit from getting out of their house and having a walk, and people who might be seeking some conversation with like-

All authors are members of the Shrewsbury Walk and Talk group.

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minded people (see www.psychologyintherealworld.co.uk). Posters are put up in various locations around town, including community mental health settings, education centres, libraries, shops, cafés, G.P. surgeries and along the walk route itself, as well as being emailed around through formal and informal networks and being advertised on the psychology in the real world website. Research in 2007, the first year of Walk and Talk, showed that 51 different people came that summer, with the average number of people each week being 10 (range 4–17), and subsequent summers have attracted similar numbers. After initially running solely in the summer months, members decided to keep the group running informally during the winter months when the effects of social isolation are often more keenly experienced.

As people are not formally referred to the group – they just turn up on the day – it is impossible to precisely estimate the number of participants who have had a history of psychiatric service involvement, but a majority of the regular attendees have revealed that they have experienced some mental health service interventions (ranging from counselling to forced treatment under the Mental Health Act). The group has had a collective of people who run it, each person making a commitment for a year as a group organiser. At its outset at least one psychologist was part of that collective, but the group now runs throughout the year independently of any mental health service input.

Walk and Talk follows the philosophies of other Psychology in the Real World groups (Holmes, 2010) that have run in various locations in Shropshire since the late 1990s and that underpin an increasing number of groups elsewhere in the U.K. Such groups, whilst often having an NHS psychologist involved in their planning and facilitation, bring people together not because they have a shared problem or diagnosis but because they have a shared interest. People are not referred to these groups but sign up as one might do for any local group or course, and the groups are open to all people. They are not skills for ills groups, but rather focus on enabling participants to share experiences and come together with an ultimate aim of not just developing a greater of understanding of what affects our own and other's well-being, but also to take various kinds of social action to improve the psycho-social and material environments that we inhabit. Newly formed groups tend to be inspired, planned and co-facilitated by people who previously attended other Psychology in the Real World groups and are born out of ideas that have generated from the discussions in these groups. For example, the first Toxic Mental Environments group (Holmes, 2010), which ran in 2006, led to explorations of the importance of accessing the countryside as a means of people detoxifying reactions to contemporary culture; Out of the Box (a support group for people trying to come off psychiatric drugs) led to participants highlighting the benefits of exercise in green spaces as an alternative

to medication (and as an aid to coming off psychiatric drugs) - participants from these groups, several of whom had had long-term involvement with psychiatric services, were instrumental in setting up and running Walk and Talk.

Four key ideas from the work of David Smail and their relevance to Walk and Talk and its members

We were asked to write an article about Walk and Talk as the ideas of David Smail and the Midlands Psychology group have been helpful in the past to people involved in this and other Psychology in the Real World projects. In September 2014, at the end of a walk, we discussed David's obituary in the Guardian and some of the ideas expressed in his work (e.g., Smail, 2005) and agreed to meet a fortnight later to discuss in more detail four key ideas from his work. Four extracts from the Draft Manifesto for a Social Materialist Psychology of Distress (Midlands Psychology Group, 2012) were printed off for people to read and these structured the discussion. These extracts are reproduced below along with summaries of the comments, illustrated by direct quotations, from the eleven Walk and Talk members who discussed them. The initial discussion, which ten people attended, was structured around each concept, with group members encouraged to relate the ideas to their own experiences and Walk and Talk, but otherwise took the form of open dialogue. Notes were kept at this meeting, which were later transcribed and used as the basis of a first draft of this article, alongside four written submissions from group members. All eleven authors of this article subsequently read the initial draft, with ten of us discussing it at a follow-up meeting. Throughout this process we were able to add to or correct any part of the text, with views that differed from the majority opinion being actively sought.

The majority of us who contributed to this process have had a long-term involvement with Walk and Talk, both as members and as organisers. In the spirit of open dialogue we have not written a conclusion, preferring to leave readers to make up their own minds on what we have written.

Key Concept 1
Distress arises from the outside inwards, is produced by social and material influences and people may need to develop 'outsight' rather than 'insight'

> *Distress is not the consequence of inner flaws or weaknesses. All mainstream approaches to therapy locate the origin of psychological difficulty within the individual. Certainly we often experience our distress internally, but experience and explanation are two very different things. Professional therapy tends to presume that both the causes and the experience of distress are interior, since*

> *this affords the therapist a legitimate ground of intervention: individuals can be worked on in ways that social and material circumstances cannot. Individuals thus quickly learn to see themselves as in some way personally defective when in fact their troubled experience arises from a defective environment.*
>
> *Social and material influences are typically complex and multiple. None of them are either necessary causes or sufficient causes, but the more that they intersect the more likely clinical distress becomes. They include trauma, abuse and neglect; social inequality, (organised in hierarchies of class, gender, ethnicity, sexuality and disability); and life events, such as accidents, disabling experiences and severe illness. We are more likely to experience distress the more our experiences are invalidated and the more isolated we become from one another. Equally, the further we are from supportive, nurturing relationships, the more that invalidation and isolation will engender distress. People stripped of ameliorative influences such as a loving, supportive family and friends; comfortable, safe environments; and the trust, support and solidarity of others, are more likely to experience diagnosable distress. In other words, the effects of trauma, social inequality and life events interact with the less visible, less quantifiable effects of parenting, friendship, nurturing and caring.*

The regulars on Walk and Talk were in broad agreement with this core aspect of David's philosophy. In a vote, eight of us felt that it is mainly life events that cause distress and diagnosable mental health problems, with three people feeling it was an even mix of internal and external factors:

> *Some people can have maladaptive coping mechanisms but it is not an illness just a result of their own experiences and circumstances.*
>
> *Tackling yourself might seem easier than tackling society as a whole.*
>
> *Not many therapists think that outside factors are the cause – there is a message to pull your socks up even if they don't actually say that.*

Social isolation was also seen as a key cause of distress:

> *Being diagnosed with a mental illness can in itself install isolation because people who have not experienced depression etc., simply do not understand what it is, therefore increasing the anxiety of the person suffering and making the situation even worse, with the person becoming increasingly isolated.*
>
> *I was very isolated before Walk and Talk. No one in my village knew me even though I had lived there for 12 years. It took a lot to come to the first walk but it has helped, especially being able to feel safe in the group and being able to relate to everyone.*

People who talk about social inclusion often say it is important to be with people who are not depressed but that goes too far the other way – it is good to be with others that have had similar experiences too. We have this mix on Walk and Talk.

Group members felt Walk and Talk helped people in a range of ways and provided a place for members to have helpful discussions about a wide variety of things that are normally not possible in therapy:

I tried for years to explain my mental health problems to the various doctors in my GP practice. I was sent to see a psychiatrist who appeared more preoccupied with finding a label for me and prescribing me strong anti-psychotic drugs rather than offering me help to understand and come to terms with my altered perceptions and altered life [due to suffering Graves Disease].

Only through Walk and Talk have I found a place of safety, a group who understands me and I understand them. Walk and Talk saved my life, simple as that.

You don't have to say anything on Walk and Talk. If you don't feel like speaking you can just listen which is helpful. You can't do that in one-to-one therapy. Walk and Talk helps you to put your problems in perspective.

The group is not just focused on problems. In the group you can express different facets of your personality and this is therapeutic too – you can get outside your problems as the focus is not just on you and your problems.

We also spend time together in the pub afterwards, just mulling over what is going on in our lives as well as general world events… this reinforces the whole aspect of listening and understanding other people's viewpoints.

Key Concept 2
Distress cannot be removed by willpower

A notion of willpower inhabits just about every theory of psychotherapy. Having been led, one way or another, to confront their personal failings, mistakes, or cognitive errors, it is assumed that patients can make the necessary correction by an act of will. If not, they are being uncooperative, resistant, lacking in motivation to change, etc. The notion of willpower is typically assumed as an obvious, everyday human faculty that can be called on by all in extremis. Willpower constitutes a mysterious, interior moral force that cannot be measured or demonstrated because it doesn't exist. To assume that it does, and to call upon patients to demonstrate it, can be positively cruel.

Members of Walk and Talk were in broad agreement that distress could not be solved by will power alone:

> *I have suffered chronic clinical depression for most of my life. Will power does not help. Even though all people are different (e.g., some have stronger wills than others) will power alone will not help.*
>
> *The general public has an idea that people with mental health problems cannot get themselves together and are not trying.*
>
> *CBT exercises are heavily emphasised but people may not be in the right place to tackle their problems this way leading to further distress. Without changing the causes and situations behind your unhappiness any treatment will only be of limited success.*
>
> *I have been made to feel [by NHS staff] that I am not really suffering mental distress, as such, but rather I am a hypochondriac without the willpower or strength to overcome my distress.*
>
> *Doctors, including GPs, look down on you if you cannot draw on something to make yourself get better.*

Whereas David Smail said that 'supposed inner strengths were no more than outer advantage' (Smail, 1992), some members did feel that, in extremis, some people are able to call on inner resources in an astounding way and the concept of will power did fit with this. Several members said they sometimes 'have to drag themselves to the walk', especially in the winter, but they found they benefitted if they could just get themselves there. This felt like an act of will; something that required great inner effort to make your body do something that it does not want to do:

> *I have had to force myself to do things and if I hadn't I wouldn't be alive today.*
>
> *If you have a lot of inner strength you might not have so many problems in the first place.*

Others felt that there are alternative concepts to will power, which better fit their experience and perhaps have less potential to be used to make people feel worse:

> *Some writers report back that some people have an uncanny ability to call on 'infinite love', which is much easier than willpower; but when medicated it is a lot harder to achieve. This is when personal exchange of comfort, clarification and support is very important and can make all the difference.*

A majority (six) felt that will power was a useful concept, but five people felt that the concept did more harm than good. Some group members found motivation in being there for others, not just themselves:

I find it easier to do things for someone else rather than myself, for empathy… We come to see how others are getting on, not just for ourselves.

Key Concept 3
Distress cannot be cured by medication or therapy; they can be of some help, but not by curing

Distress is not an illness, so cannot be cured. It is not bad genes, faulty cognitions or the Oedipus Complex, but misfortune and the widespread abuse of power that mire so many people in madness, addiction and despair. These are not symptoms of illness: they are states of being that encapsulate how most of us might respond to chronic adversity.

Medication may harm some people but may help others, for example by anaesthetising distressed people to their woes and providing brief bubbles of respite or clarity. During these short, chemically induced holidays from their misery, those with the resources may initiate life changes that help to alleviate their problems. But this is not the same as being cured by the drugs.

Understood generically, talking therapies can provide comfort (you are not alone with your woes), clarification (there are sound reasons why you feel the way you do) and support (I will help you deal with your predicament). In an atomised, fragmented, society, where solidarity and collectivity are often derided, these are valuable and compassionate functions, but not cures.

The majority of us who took part in the discussion have had experience of taking psychiatric medication and receiving therapy. We felt that, although therapy and medication had sometimes been of some help for some of us with some of our problems, neither medication nor therapy had provided a cure, nor had they been experienced as treatments for an illness:

They can give you resources to fight what is troubling you.

With the help of the group I was able to wean myself off anti-depressants, but my sleep pattern was better on the medication and sleep is important.

Therapy has its place but so does connecting and engaging in a real world environment.

Mental health problems go so much deeper than many physical health problems – they often stay with you for life and are not easily cured.

Some group members felt that medication, therapy and other aspects of mental health services had been unhelpful and at times harmful, whereas Walk and Talk had not had such damaging impacts:

Medication was of no help and was damaging. One-to-one therapy was helpful but I became over-reliant on it and it did not help my social situation as it took place in a CMHT [community mental health team].

Focusing and ruminating on your problems, as people do in therapy, can be counter-productive and we can leave appointments feeling worse. On Walk and Talk there is room for more than just talk about problems.

Both psychiatric treatment and exercising in green spaces are calming activities, but the former is toxic whereas the latter is non-toxic; psychiatric drugs are depressing in effect whereas green spaces have a gentle uplifting effect.

Most members preferred the way they were treated by fellow group members to the relationships they had experienced with professionals:

Some therapists are just too inexperienced to help – they cannot understand what you have gone through, whereas people on the walk often can.

It has been unhelpful to be treated as a patient rather than as a friend, as happens on Walk and Talk.

For the best part of a decade everything in my life focused around my 'illness' with my confidence crushed and my failure absolute. My identity was shaped by my overdependence on services and by diagnoses. I did not perceive another part of me – a nature lover; a keen photographer; a poet; a website designer; a group facilitator.

Regarding the provision of comfort, clarification and support, members felt that Walk and Talk worked better than one-to-one therapy:

I am able to discuss my problems as well as listen to others' problems and get different perspectives as well as other solutions rather than looking inwardly all the time.

You can open up to others that may have had problems themselves rather than a therapist who you feel has had comparatively few.

I often found groups in mental health settings that have a sole purpose of addressing mental health problems, stigmatising and patronising. Subtle indirect groups that are open to all thus widening perspectives are far more powerful in my view.

On Walk and Talk there is always an easy escape route – unlike therapy groups, if you get upset you are not confined with everyone in one spot.

> *When you leave [a session of therapy] you sometimes feel like hell and you feel unsupported and just have to cope by yourself with what has been brought up. Walk and Talkers often provide each other with support during the week not just for one hour a week.*

One person felt that therapy had been more helpful than medication and did feel it could be thought of as a cure:

> *If the therapy leads to something being revealed that you have been unaware of this can lead to cure as it can stop hurting you and you can find a way to cope.*

Key Concept 4
Successful psychological therapy is not primarily a matter of technique

> *It is well established in the therapy literature that 'non-specific factors' are a consistent predictor of good outcomes: in other words, that the therapist and client are able to establish a good relationship. The one reliable finding in all the outcome literature on therapies is that emotionally warm and attentive practitioners are more appreciated and get better results – an observation that applies equally to politicians, salespeople and prostitutes. Unlike professional therapists, service users frequently declare the most ordinary aspects of therapy the most helpful e.g., listening, understanding, respectfulness. Despite this, therapy is mostly presented as a matter of technique. Like everyone else, therapists must earn a living, so it is only to be expected that they would present themselves and their work as needing specialist skills and training. But by doing so they distract attention from the actual causes of distress by bolstering the belief that it is a mysterious state amenable only to professional help; it disables friends and family, who may feel that they could not possibly understand; and it negates the contribution of community, solidarity and trust.*

Whilst three people felt that training was important, one person felt it was not important at all, and six felt it was an even mix between the personal qualities of the therapist and their training:

> *Good listeners are important, rather than training.*

> *I feel it is very important to have good rapport with your therapist/doctor, as if I feel they are listening to me I don't feel it has been a waste of time going to see them, even if they don't understand mental health issues.*

> *Therapy is fine if you get on with the therapist but this is hit and miss*

> *Professional boundaries with a therapist prevent you from getting close and feeling understood compared to what happens on Walk and Talk. It is more artificial with a therapist. You are always on your guard with them …*
>
> *… That's because you might get sectioned!*

There was also a mix of feelings about the pros and cons of having a trained, paid member of staff being on the walk:

> *Groups can help people get individual needs met within a collective rather than placing everything in the hands of a therapist to 'save me'.*
>
> *In Walk and Talk we get as much from each other as from trained people who might be on the walk. But it has been helpful to talk to a trained person sometimes.*
>
> *Trained people can crystallize things sometimes; make it succinct. I think that training makes me more reassured that the therapist will ask the most relevant questions, so long as they are human in approach.*
>
> *A trained person is more likely to make relevant comments – with one of us it is a stab in the dark, a bit hit and miss. But a good thing about being in a group is there are a variety of comments you get back. This also takes the pressure off the trained people who are there.*
>
> *It can be helpful to have experts but not experts who act like experts rather than human beings.*

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