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Debate

Making sense of the psychology of detention: A rejoinder to David Edwards

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Professor Edwards is hostile to psychoanalytic concepts and models, particularly as applied to the modern range of psychiatric disorders. On this basis he discounts the experience of those like myself for whom a psychoanalytic framework provides a measure of comprehension in the post-traumatic stress disorder (PTSD). He seems to believe that his own preference for a cognitive-behavioural explanatory model automatically invalidates a psychoanalytic one, ironically and revealingly providing no evidence or arguments to support his personal preferences or to refute the model to which he is antagonistic.

On a more serious note, he assumes an adversarial stance between the psychoanalytic and cognitive-behavioural models as though they were mutually exclusive and only one had the monopoly on psychological explanatory power or truth. This may well be Edwards' opinion and he is entitled to this view; it is not a view I share. Working clinically with ex-detainees suffering the PTSD syndrome has been a vexing, perplexing, baffling experience from the point of view of understanding as well as effective intervention. The service is provided by a number of therapists who represent a wide variety of differing theoretical approaches. We have been able to share our views and insights and enrich our understandings on the basis of a cross-fertilization of ideas. This has been and remains a particular strength of our service. Does Edwards wish us to amputate one limb of our body of understanding because it doesn't coincide with his theoretical preferences, because "psychodynamic concepts have contributed little to providing usable models of short term therapy or crisis counselling"? This latter absurd contention reveals the extent to which Edwards' distaste for things psychodynamic blind him to the distinctions between a theoretical framework and a practical way of working clinically that is able to draw on a variety of different theoretical models that are useful in a particular situation.

Confusion is not lacking in Professor Edwwards' letter. He confuses the theorizing in a professional journal with direct contact "with disadvantaged and oppressed communities". He seems to fail to understand that credibility is earned by work, by providing a service that meets needs in a community, rather than by the linguistic style of a theoretical article in a professional journal, or as he rather arrogantly suggests, by "being able to offer ways of thinking about and solving problems which makes sense to the communities we are working with". If Edwards wishes to provide solutions for communities and become credible thereby, good for him. My concern is to stimulate thought among therapists in the field that may enrich the service work we are providing to a particular population (in the scientific sense) group.

Edwards also ignores - is this a matter of convenience? - the obvious fact that in clinical work, we therapists communicate with our clients in language that is accessible to them; the style used to communicate with colleagues is not necessarily the same we use in the therapy room. This is so obvious that I can't help wandering whether Edwards is not setting up men of straw to knock them down, that he is looking to score trivial academic points in something that is not a contest.

The only substantive and constructive criticism I could find in his letter was that the case material does not support the theoretical propositions elaborated in my article. It is true that I refer to vignettes rather than detailed case studies and I accept that this may not be as helpful as the method suggested by him. The reason for the choice of method was straightforward; our clinical work has familiarised us with the symptomatology and phenomenology of the PTSD; the standard therapeutic interventions written about by experts in other settings proved inadequate in our situation; we needed to develop a deeper understanding of the dynamics involved in the disorder to help us develop new techniques and approaches to meet the problems we faced. The ideas in this article represent the condensation of insight that evolved over time drawing on work with many ex-detainees. It represents just one attempt to elucidate some of the elusive dynamics involved in this disorder, one which is so difficult to treat.

I am nevertheless grateful to Professor Edwards for drawing my attention to his work which shows that "case material to advance theory is a really important feature of clinical research". It is very thoughtful of him to share this epistomological gem with us. I for one, would never have known this but for his self-reference to the obvious.

It may be a matter of some surprise that there is a place for such ideas in our service; I'd be interested to learn of Edwards' approach to the understanding and treatment of PTSD - I'm sure his careful descriptions of his observations and interventions will be most instructive.