Kellyan Hostility in Psychiatry and Psychology

Abstract

George Kelly's construct of 'hostility' is proposed as an explanation for why psychiatrists and psychologists hold on to bankrupt theories despite evidence to the contrary.

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Kellyan Hostility in Psychiatry and Psychology

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SUMMARY: George Kelly's construct of 'hostility' is proposed as an explanation for why psychiatrists and psychologists hold on to bankrupt theories despite evidence to the contrary.

KEY WORDS: Personal Construct Theory, hostility, making sense

Clinical psychologists like myself who find a great deal of explanatory value in George Kelly's Personal Construct Theory (PCT) are sometimes referred to as 'Kellyans'. This paper is an attempt at using one of the constructs that make up PCT, 'hostility', as a way of making sense of why many people who work as psychiatrists and psychologists hold on to theories of 'mental illness' whilst working in the various clinical settings of the psychiatric system.

Personal Construct Theory (PCT)

PCT is a theory concerned with how human beings make sense of the world (Bannister & Fransella, 1989). Kelly (1955) hypothesised that there is a 'real world', which is interconnected and in constant motion, but as humans we do not have access to this 'real world'; that is we cannot see 'reality' directly due to the limitations of our senses. Neuroscience research appears to support this view. Frith (2007) reports that what each of us sees is our brain's constructed picture of reality, and not reality itself. PCT states that we are constantly trying to make sense of the world, but due to the limits of our senses, we can only ever arrive at 'a best guess' as influenced by our personal construction of reality, which is never 'the truth'. Our personal constructions of reality reflect how our past experiences and conclusions

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drawn from these experiences shape how we anticipate events. This hypothesis of human understanding led Kelly to define the philosophy underpinning PCT as being that of 'constructive alternativism', which he summarised by stating:

> We take the stand that there are always some alternative constructions available to choose in dealing with our world. No-one needs to paint themselves into a corner; no-one needs to be completely hemmed in by circumstances; no-one needs to be the victim of their biography

In summary, Kelly (1955) suggested that all people are making their own idiosyncratic theories about 'the world' in order to anticipate and predict their future, and the personal constructs that make up our theories are inter-related and make up our personal construct system (in other words, the lenses from which we anticipate events). From this point of view, our behaviour in the world *becomes* our experiment, which can either validate or invalidate our theories. Predictions that are accurate make our world appear to be safer and more secure; predictions that are inaccurate make our world appear shaky and less certain. In the latter case this can be so threatening and unacceptable to us that we can deny what seems evident to keep our ideas about the world and ourselves intact. In PCT terms this would be called a 'hostile' response.

Kellyan hostility

PCT defines hostility as 'the continued effort to extort validational evidence in favour of a type of social prediction which has already been recognised as a failure' (Kelly, 1955). In other words, when the truth of a situation and its implications for our theories are too threatening, we might defend against this, not necessarily consciously, by looking for any evidence (however ludicrous) that supports our position and keeps our theories intact, 'shifting the goalposts' so to speak. Bannister & Fransella (1989) explain and elaborate Kelly's definition of hostility by stating:

> There are times when, if our construct system is to be preserved intact, we simply cannot afford to be wrong. If we acknowledge that some of our expectations are ill founded, we might have to modify or abandon the constructions on which these expectations were based. But if these constructions are central to the whole of our system, we might well be faced with chaos if we abandon them, as we have no alternative way of viewing our situation

Hostility might take the form of conspiracy theories, where of course all evidence is incontrovertible, and a common example might also take the form of say the

initial disbelief that our favourite celebrity from childhood has been convicted as a child abuser (he can't have done those things surely?) etc. These examples suggest that hostility can be thought of as an understandable means of self-preservation, which will only cease when we can find alternative ways of making sense of, and coming to terms with, the implications of our new situation. Indeed, Bannister (1977) suggested that the alternative to hostility might be psychosis, because when our theories about the world and ourselves prove to be distressingly inaccurate, then this can also have devastating implications for our past memories and lead to much fear and confusion. Think of the chaos a person might experience if finding out that there partner has been having an affair for the past ten years, or a person who has just found out that their parents are actually their adopted parents. Many of their past memories would have to be reconstrued, which would likely be difficult and potentially devastating for anyone.

Hostility observed in psychiatrists and psychologists

Due to the vast scope where hostility could be applied, this paper's focus will mainly be on the professions of psychiatry and clinical psychology, which are by personal observation a broad church ranging from those who hold fast to a medical account of 'mental illness' (i.e., Craddock et al, 2008) to those who attempt to contextualise distress (i.e., Thomas, 2014; Smail, 2005). In my experience the majority of mental health professionals adhere to the former and are consistently hostile to a contextualising approach. All of the psychiatrist's I have worked with tend to see 'mental illness' as a result of faulty genes and brain chemicals, which can sometimes be 'managed' by psychiatric drugs. Those who don't have their 'illness' managed by drugs might in the future when 'better drugs' are invented, so the rhetoric goes. Despite there not being credible evidence for this theory (Lynch, 2004; Moncrieff, 2008; Bracken et al, 2012) it is usually stated as if it is fact or, if challenged, dismissed with variants of 'absence of evidence doesn't mean evidence of absence', which I presume was a similar argument used by the phrenologists in their day.

Clinical psychologists and psychotherapists don't tend to fare any better. A brief glimpse through the extant literature (not to mention popular magazines and daytime television) suggests that cognitive-behavioural therapy (CBT) is a panacea for just about all ills. This impression has probably been strongly influenced by the Layard report (Layard et al, 2006), commissioned by the government of the time, which led to the formation of Improving Access to Psychological Therapies (IAPT), which seems to suggest that if only people learn and apply CBT then their problems will at the very least become 'manageable' and they can return to work and stop claiming benefits (it's all about the economy, stupid). Layard claims IAPT-style CBT is 'highly effective' (Layard & Clark, 2014)

but the methodological flaws of the types of studies he cites are highlighted by Newnes (2014) and Moloney (2013) amongst many others, but curiously hardly ever find their way through to the mainstream press, at least not with anywhere near the same frequency as the 'pro-CBT' headlines. I have observed that a number of mental health professionals cite these types of headlines uncritically. For example, few of my colleagues seemed aware that one report which stated that 'NHS psychological therapists enable four in 10 to recover' (news section of *Therapy Today*, 2010) was actually only 44% of the 12,338 people who completed therapy (McInnes, 2011). 137,285 people were initially referred; so how accurate is the reporting that lauds the effectiveness of CBT? Not very it would seem. In contradiction to Layard's conclusions, a recent review by Baardseth et al (2013) failed to provide corroborative evidence that CBT was any more effective than any other therapeutic approach, so I've concluded that either many of my colleagues don't know this or are hostile to the findings. Personally, I've found that using such contrary literature to challenge the prevailing CBT conjecture is usually met with either indifference or annoyance, both of which could be subsumed under Kelly's construct of 'hostility'. Newnes (2001) paper on 'speaking out' describes the personal consequences that can afflict the contrarian. I've been called a 'maverick' or an 'anti' by various colleagues over the years, which is ironic given that I cite reviews which psychiatrists write and publish in their own house journal (Bracken et al, 2012). That's 'mainstream' in my view.

On the surface, many colleagues claim to take a 'holistic' approach to their work, but I've often found these waters are quite shallow. In my experience, the term 'biopsychosocial model' (Engel, 1977) often quoted by such colleagues seems to essentially translate as a bio-medical model with a few add-ons, because the assumption of 'faulty biology' remains and most difficulties, whether termed as 'illness' or 'disorder', are assumed to be 'triggered' by underlying 'faulty biological mechanisms'. So a holistic psychiatrist might see social and psychological 'factors' as contributing to the 'triggering of the underlying illness' and think of CBT as a way of 'working on residual symptoms' and a holistic psychologist might cite the 'stress-vulnerability' hypothesis as a way of working on 'prodromal symptoms' while thinking they work outside of a medical model because they're not 'treating the illness/disorder with drugs'. Either way, the location of distress is planted firmly within the individual. Why does this happen so often? Maybe Kelly's construct of 'hostility' can help us out here? I don't think this can be credibly proposed without taking into account the context of political and social realities.

The political power and social realities contributing to the rules and maintenance of the psychiatric system have been persuasively argued by Smail (2005) and more recently Moloney (2013). Using Kelly's construct of 'hostility' it

is possible to hypothesise why individuals find ideas against the prevailing norm so uncomfortable and, at times, threatening for their own construct systems. The political, social, and family situation we are born into cannot but influence our conclusions drawn from our experiences, as can be found in the oft-repeated statements overheard in daily life of 'that's just how things are' or 'Peter tells it how it is' etc., as if some sort of comfort or consolation is taken in 'knowing how things work'. In reality, things are changing all the time, and 'we see things as we are', that is the picture we each construct in our heads, rather than as 'they are' (Frith, 2007). I'm generalising here (as my dear former supervisor Peggy Dalton used to tell me) and there are always rebels of course, but it is difficult for most people to consistently swim against the tide and state theories which go against whatever the current zeitgeist is for a variety of reasons i.e., wanting to be liked by others, too much contradictory information to absorb etc., especially as we need other people to help us confirm, reject, or modify our ideas. So the relative simplicity and at times comforting narrative of a medical account of 'mental illness' or a psychological/CBT account of 'disorder' can help make the complexity of life and feelings (and sometimes reality) of helplessness be reduced to a case of finding 'the right medication', learning 'the right knowledge' and utilising 'coping skills', all 'evidence-based' of course. This might initially be preferable for some people, if their actual reality is too distressing to acknowledge, and especially if what's on offer from mental health services is deemed to be irrelevant to help with the difficulties contributing to their distress i.e., the implications of the bedroom tax.

Perhaps a mainstream culture of individualism, which has been rampant in Western culture over the past thirty plus years, can also help explain the frequency of a hostile response to unwelcome realities. If you are raised in a competitive schooling system, and have worked through the rigours and challenges of medical school or (clinical training for psychologists) then it can be quite threatening to learn that your expert knowledge of psychological theories is often found to be irrelevant for the kinds of struggles people are engaged with in their everyday lives (Moloney, 2013; Smail, 2005), that the drugs don't work as the drug company literature suggests, and the therapies don't 'fix' people as the (small) effect sizes of the CBT meta-analyses suggest (Baardseth et al 2013; Newnes, 2014). This is a particularly bitter pill to swallow when there is a genuine desire to help people alleviate or resolve their distress, which in fairness would describe the majority of the colleagues I've worked with to date. Some colleagues respond to this bitter pill by becoming hostile in the sense of holding out the hope that neuroscience research will finally pinpoint the 'underlying mechanisms' of 'mental illness' or seeking further training in countless therapies (usually of a 'third wave' CBT variety or everyone's current favourite panacea, Mindfulness). These types of responses might enable clinician's to avoid an even bigger threat to their personal

theories about themselves, that of self-interest. NHS Trusts seem very much driven by a corporate agenda, and as Smail (2005) suggests, business ideology has no time for 'truth', only 'what works'. Of course 'what works' depends on who is deciding the rules and measuring the 'outcomes'. A person who scores a few points lower on a questionnaire can have their drug treatment or psychotherapy deemed as a 'success' by a clinician (Moloney, 2013), hence the hostility and ad hominem attacks on anyone who points out how flawed and meaningless such results are. After all, the implications for livelihoods are at stake in the current climate of 'payment by results', as is the illusory 'personal power' that an 'expert' clinician might hope (or believe) they have in 'fixing' people. When considering all this, perhaps becoming hostile and 'shifting the goal posts' so that personal theories are not threatened too much is probably inevitable, at least initially, given the current social and political context. As Bannister (1977) stated:

> The whole conception of the nature of change and resistance to change implied in the idea of hostility recalls the traditional philosopher's model which compares the problem of life to the problem of rebuilding a ship while at sea. If we have to rebuild our ship while sailing it we obviously do not begin by stripping out the keel. We use the strategy of removing one plank at a time and rapidly replacing it so that, given good fortune, we may eventually sail in an entirely new ship. We must remember that those whom we seek to change – and it may be ourselves that we seek to change – must maintain their lives while change continues.

I suppose this paper's common theme is, in one sense, about human fallibility. If Kellyan hostility is considered to be a credible explanation for the fear, threat of, and slowness of change amongst and between individuals then an understanding of this might help reduce the confusion, anger and frustration commonly experienced when non-medical accounts of a person's distress are met with at best indifference or at worst disdain amongst colleagues; and maybe that energy can be used more constructively. Significant change might be best thought of as being generational, and movements that work outside of the psychiatric system, such as The Hearing Voices Network (HVN) provide hope that lessons could be learned and services might gradually evolve and improve over time, in a similar way that corporal punishment was eventually outlawed in schools in the UK. After all, hearing voices no longer seems to be thought of as a 'first rank symptom of schizophrenia' by all psychiatrists thanks to the pioneering work of the HVN (Romme et al, 2009). For major change to occur there would have to be a paradigm shift and the political will of not essentially locating all distress in (and being the fault of) the individual (which might seem unimaginable but so did the rise of the HVN at one time).

In the meantime (while the current zeitgeist remains), helping people to make sense of their distress in the therapy room by endeavouring to provide 'clarification, comfort, and support' (Smail, 2005), and providing up to date (and as accurate as possible) material on the pros and cons of psychiatric medication (e.g., MIND, 2011; Breggin & Cohen, 2007) is probably the best (albeit marginal impact) that can be hoped for in the current political and social context, whilst being aware of and guarding against hostility i.e., forcing the theories to fit the people and maintain the illusion of being an expert who can fix people. I believe that if such a marginal impact can be made for some people then psychotherapy is still a worthwhile endeavour (I would say that wouldn't I?). Others will no doubt disagree, as some already have (Masson, 1988).

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